Peninsula Cancer Alliance Board Meeting - Notes

Date & time: **Wednesday, 29 January 2020** @ 10.30-12.00
Venue: Taunton & Pickeridge Golf Club, Corfe, Taunton, Somerset, TA3 7BY

PCA Board Attendance list	**KEY = Attended**	**KEY - Apologies**			
Organisation	**Forename**	**Surname**	**Initials**	**Job title**	**Attendance 29.1.2020**
Cancer Research UK	Deborah	Haworth	DH	Regional Manager	
Cancer Research UK	Christine	Nagle (Deputy to D Haworth)	CN	Facilitator Manager	
Claremont Medical Practice	Joe	Mays	JMa	Primary Care Clinical Lead	
Health Education England	Mark	Wilson	MW	Assoc Workforce Transformation Team	
Macmillan Cancer Support	Christopher	Scally	CS	Strategic Partnership Manager (SW)	
NHS Devon CCG	Sonja	Manton	SM	Director of Commissioning for Devon CCG	
NHS Devon Clinical Commissioning Group	Beverley	Parker	BP	Head of Planned Care Commissioning	
NHS England & NHS Improvement	Nigel	Andrews	NA	Prog of Care Manager, Cancer	
NHS England & NHS Improvement	Sunita	Berry	SB	Managing Director	
NHS England & NHS Improvement	Ruth	Carr	RC	Cancer Programme Manager	
NHS England & NHS Improvement	Sarah-Jane	Davies	SJD	Service Improvement Lead	
NHS England & NHS Improvement	Phil	Gordon	PG	Specialised Commissioning - Service Specialist	
NHS England & NHS Improvement	Lisa	Martin	LM	Macmillan Patient & Public Engagement Lead	
NHS England & NHS Improvement	Jonathan	Miller	JM	Cancer Alliance Programme Manager	
NHS England & NHS Improvement	Tobin	Savage	TS	Senior Performance Manager	
Patient Representative	Malcolm	Merrett	MM	Patient Representative	
Public Health England	Ulrike	Harrower	UH	Population Health & Public Health Consultant	
Public Health England	Julie	Yates	JY	Screening & Imms Lead	
Royal Cornwall Hospitals NHS Trust	Ethna	McCarthy	EM	Director of Planned Care CIOS Health & Card system	

Royal Cornwall Hospitals NHS Trust	Bryson	Pottinger	BP	Clinical Lead Consultant Haematology, Pathology	
Royal Cornwall Hospitals NHS Trust	Duncan	Wheatley	DW	Cancer Research Lead	
Royal Devon & Exeter NHS Foundation Trust	Tina	Grose	TG	Nurse Lead	
Royal Devon & Exeter NHS Foundation Trust	John	Renninson	JR	Medical Director Cancer Alliance	
University Hospitals Plymouth NHS Trust	Phil	Hughes	PH	Chair, Medical Director / Consultant Radiologist	

1. Welcome, Introductions and Apologies

PH, Chair welcomed everyone to the meeting and apologies were noted as above.

2. Notes of the last meeting, matters arising & actions feedback

The meeting notes of 23 October 2019 were agreed. There were no matters arising.

Actions feedback:

2.1 *Commissioners to describe local process for agreeing symptomatic FIT commissioning arrangements.*
NHS Kernow CCG agreed – *Complete.*
NHS Devon CCG, negotiating with Board still to approve.

2.2 Alliance to be represented at PCSS Diagnostics Group – *Complete.*

2.3 Review Governance and agree connection to STP governance especially for PCSS to ensure consistency and reduce duplication. – *SB explained there was a new team and structure to the Cancer Alliances now. Michael Marsh (Medical Director) and Elizabeth Mahoney (Regional Director), NHS England & NHS Improvement are currently reshaping governance support to the STP. This item will be brought back to the next meeting for discussion.*

2.4 Link to PHE re cervical screening uptake post primary HPV – *Completed.*

ACTION:

1. KF to add Governance Review regarding STP to next agenda.

3. Rapid Diagnosis Service

Paper discussed.
National guidance and funding for Rapid Diagnostic Services has been published for 202/21 to 2023/24. This requires RDS Services to be extended over this time to cover all Urgent GP Suspect Cancer Referrals (aka 2 week-wait referrals).
Funding for this 5-year programme has been confirmed.

Peninsula Cancer Alliance advocate following the Oxford Scan Model including:

- Clear GP referral criteria, including primary care tests.
- Referral straight to CT (CAP)
- CT determines outcome:
    - On to Cancer MDT
    - On to another specialist
    - Back to GP

As reported at the previous Board, Rapid Diagnosis Services (RDS) for patients with non-site-specific symptoms are being established in all 5 providers.
Evaluations of the Oxford Scan Model are good and the LMC have approved its use. The model should not increase demand, and is the most cost effective to implement. The Board were asked to look at their totality of funding, not just the Cancer service alone and look at solutions which were transformational to fundamentally change the service.

Recommendation:

- **The Board are asked to note the national guidance and funding.**

The Alliance is establishing a Steering Group to oversee this work.

Key discussion points from Board members were as follows:

BP – Practice based referrals should be reviewed to identify areas to support, working with Cancer Research UK and Primary Care Champions
JM – confirmed Willy Hamilton had been involved with GPs to test the clinical randomised control and had engaged with work regarding direct to CT for chest patients.
JR – confirmed Willy Hamilton had sat on the group which designed the RDS service. There is no single national model for RDS methodology and Peninsula Alliance are developing the service locally alongside the health community.
SB – There will be close project management in Acute Trusts to deliver RDS and to redesign the front end of the cancer pathway, so patients are referred appropriately. Each of the acute hospitals will have a lead officer on RDS who will work with the Chief Operating Officer to deliver. By the end of January 2020, the proposal including the Oxford model will have been submitted to the Regional and National teams, including the process of roll out to the tumour sites. SB requested providers look at the totality of their funding, not just that provided for cancer, and look at solutions to fundamentally change the service.
SM – raised concerns regarding challenges in delivering CT, as cardiac developments also required CT and the significant challenge regarding picking up the on-going costs once the funding ends. JM said there were opportunities for faster diagnosis piloted by Torbay, the biggest challenge would be the lead into reporting and reporting capacity. He also said the Trusts would have 4 years to plan for the end of funding. JMa stated the funding was transformational, and not just for filling holes to manage demand within the pathway.
PH – stated the Board gave their support.

The Board noted the national guidance and funding and gave support to the development of Rapid Diagnostic Services to include all urgent GP suspected referrals (2 week waits).

4. Peninsula Clinical Services Strategy, Cancer Services Review

Paper discussed.

The Peninsula Clinical Services Strategy Groups (PCSS) proposed cancer priorities for focus over the next 12 months that will form the work within the Cancer workstream of PCSS.
The identified cancer priorities are:

- Single sarcoma service
- Specialist urology cancer surgery – robotic surgery provision
- Lung cancer – MDT specialist input for consistent surgical decisions and service pathway review for compliance with National Optimal Lung Pathway.

The Executive Summary document (circulated with meeting papers) contained arrangements and next steps to take forward this programme of work.

Recommendation:

- **The Alliance Board are asked to approve that the Peninsula Clinical Services Strategy (PCSS) proceed with this work.**

Key discussion points from Board members were as follows:

BP – relayed work undertaken by NHS Devon CCG in its PCSS Cancer services review and identified priorities (above).
EM – raised concerns that NHS Kernow CCG had not been party to PCSS work from the beginning. NHS Kernow agreed the 3 priorities named above but were concerned regarding plans for Urology and Robotics. They did not share the PCSS view that these services should be placed in Devon.
SB – Recognised the concerns of NHS Kernow regarding inclusiveness, and the impact on Cornwall was recognised. PCA will be working across the alliance areas to ensure all interests are protected. Outcome, timelines and options appraisal would be produced. There will be close project management in the Trusts to ensure delivery, with each Acute Trust having a lead officer working with the Chief Operating Officer responsible for delivery.
BP – suggested there would be 3-6 months of work to produce scenarios for consideration by the wider group.
PH – suggested Sarcoma needed to be moved to 3 months. He said North Devon was an outlier regarding Lung cancer surgery, in terms of no people receiving operations. He has spoken to MDT Leads on target for report out in June.
JR – PCSS need to start work before the GIRFT Lung reviews commence. Work such as optimising diagnostic bundles via MDT modernising can be started, there is guidance already, so PCSS can move quickly and link in with the GIRFT via the first visits. SWAG Senior Management Team (SMT) have requested a review on demand and capacity for robotic surgery as this currently includes Devon and Cornwall patients, of which significant numbers go for treatment to Bristol. Further information on how many centres treating neurological cancers exist and benchmarking would be required. JR assumed there would be no other commissioned work for robots to do, but over time they may take on more work with is not commissioned.
SM – the work would be done SW wide.

EM – queried the establishment of the Partnership Board for Specialised Commissioning and how PCSS connect with it regarding specific types of cancer and other items.
SB – confirmed it would be a 3-way Partnership Board and confirmed sufficient governance was in place. The recommendation is to help the two providers work together collectively and the solution will consider a whole range of things eg the work of robots in other areas, this will be led by Specialised Commissioning. Peninsula Cancer Alliance's (PCA) role will be to help existing services work better via the Prostate SSG Group (already in existence) and five Robotic suppliers, in order to achieve the 60-day target.
EM – stated that if this was a whole pathway review (focussing on improvement between the two sites) then this needed to be articulated, with a clear focus described.

The Board approved recommendations with the following actions:

ACTIONS:

2. **JR/JM - Sarcoma project plan recommendations to be developed within 3 months by PCSS**
3. **To note: Lung GIRFT reviews are in planning**
4. **SB/JM - Next meeting to present Terms of Reference for the Prostate Surgery Working group and confirmed membership (including Cornwall within the leadership).**

5. Multi-disciplinary Team Modernisation

Paper discussed.

National guidance for modernising MDTs has been published (circulated with meeting papers). The Alliance proposed practical actions for implementing this guidance.

Recommendation:

- **The Board are asked to support the proposed approach to implementing this MDT national guidance.**

Key discussion points from Board members were as follows:

JR – stated there would be a tight 12-18-month timeline to review standards of care (SoC), which would be co-ordinated via Site Specific Group (SSGs).
BB – SSG SoC to be agreed across Peninsula Alliance.
DW – SoC change very quickly, with patients discussed when all elements are ready for MDT discussion. JR stated specific triage would need to be in place eg an MDT co-ordinator and Nurse to identify the SoC and if information was missing then the case would be taken off the MDT list. The SoC criteria needs to determine specialists regarding specific tumour sites including staff in other Trusts, and biopsies will be reviewed by those tumour specialists.
JR – the dateline regarding the SoC for tumour sites is being discussed with all providers, and a timeline will be produced. SSGs and Clinical Leads will need to communicate between quarterly SSG meetings eg to discuss new trials, to ensure adoption across the Peninsula.
JR – the proposal was to have one tumour site, one MDT adoption across the area and horizontal. Urology and Lung cancer already have a SoC pathway defined. SW Urology Group

have neurology SoCs agreed by Prostate Group. Lung cancer Soc approved. There is a need to encourage all Lung MDT's to adopt the SoC agreed pathway.

The Board approved recommendations to implement MDT modernisation national guidance.

6. Priorities for 2020/21 including funding.

SB outlined the key priorities, as agreed with the NHS England and NHS Improvement Regional Team are as follows:

- Operational performance – significant focus with Cancer Alliances supporting with funding and infrastructure.
- Rapid Diagnosis Service - request for Board members to promote RDS in both Acute and Primary care settings. JMa and JR will request support.
- MDT modernisation – a strong focus on getting MDT's ready with new SoCs. TS will be liaising on this with Trusts.
- Early diagnosis of Cancers. SB and JMa leading on this workstream. There have been delays with the development of Primary Care Networks but RDS and Lung work will be brought forward in the interim. (Graham Robinson's work re RDS and early CT on lungs of symptomatic patients to be included).

Key discussion points from Board members were as follows:

SB – Operational performance the 28-day standard comes into play in April, therefore data reports need to be ready. SB to discuss data with the Chief Executive Officers (CEO) and Chief Operating Officers (COO)of Trusts, who should have oversight of the standards.
TS – work is being undertaken to understand the longer breaches/risks associated and the reason behind the delays. There is learning to be shared from Torbay. He asked providers to share breach reports in order to share learning.
EM – the COOs were already setting performance in operational plans but diagnostics was a vital part of cancer performance, she queried whether goals needed to be set with tertiary centres. JR agreed all elements of the patient pathway needed to be reviewed, in particular, system responses for diagnostic processes should be prioritised eg collective radiography, establishment of home working stations has identified a need to improve histopathology digitalisation.
JR – System responses are required to include resources available for collective spend. SoC best practice pathways to be determined and any development needs identified.
DW – stated research was essential to improvements but there was limited cancer research input in each area.
RC – National Team planning guidance will be agreed by April.

ACTION:
5. Trusts - to share breach reports with other Trusts to share learning.

The Board approved the PCA priorities for 2020/21.

7. Personalised Care for Cancer

The Long-Term plan mandates Personalised Care for Cancer. The national Cancer Alliances Five Year Planning Guidance confirms the milestones as follows:

- By 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2020 all breast cancer patients will move to a personalised (stratified) follow-up pathway once their treatment ends, and all prostate and colorectal cancer patients by 2021.
- By 2023 All Alliances to implement personalised (stratified) follow up for other cancers

Recommendation:

- **The Alliance Board are asked to recommend that providers use this support to secure the recurrent Personalised Care for Cancer services that were funded by the Cancer Transformation Fund, such that providers can comply with national requirements to deliver Personalised Care for Cancer for all patients.**

A business case to support sustainable funding of Cancer Personalised Care and Support Service had been circulated with the meeting papers. Each provider needs to articulate how to maintain their services to deliver the Personalised Care for Cancer national requirement. The plans need to be sustainable and have regular rigorous tests.

Key discussion points from Board members were as follows:

JM – Funding has been offered to establish monitoring to ensure patients are following directions given to them by clinicians eg phone call to patient to check they are taking medication prescribed.
SB - stated this programme of work had been funded for 3 years.
JM – the programme so far had established the acute care element and discharge, the next area to develop was improved community-based support and better integration of the service.
JR – there are good examples regarding colorectal tracking systems where diagnosis is requested further down the pathway. The key element of a self-supported pathway is the route back into the system if required, not just an extra primary care element to manage.
JM – There is a RAG rated Project Manager Senior Nurses Group, this RAG rated mechanism to be discussed next meeting.

ACTIONS:

6. **Providers and Commissioners to update the Board on progress regarding Personalised Care for Cancer at the next meeting.**
7. **JM – RAG rated mechanism re Project Manager/Snr Nurses Group to be added to next Board agenda.**

The Board agreed to recommend providers comply with national requirements to deliver Personalised Care for Cancer for all patients.

8. Any other business

EM - requested that the PCSS Oncology workstream should sit under the Cancer Alliance including the outcomes of the second workshop which should be discussed by the Board.

ACTION:

8. **Outputs from Diagnostic and Endoscopy work to be presented to the PCA Board.**
9. **CS - Macmillan changes regarding Personalised Care to be presented at the next Board meeting.**

Thanks, were given to PH for his work as Chair to PCA Board.

9. Date of the future Board meeting(s):

- **Weds, 29 April 2020 @ 13.30 - Strawberry Field Farm Shop, Lifton, Devon, PL16 0DE**
- Weds, 22 July 2020 @ 10.30 - Strawberry Field Farm Shop, Lifton, Devon, PL16 0DE
- Weds, 28 October 2020 @ 10.30 - Strawberry Field Farm Shop, Lifton, Devon, PL16 0DE
- Weds, 27 January 2021 @ 10.30 - Strawberry Field Farm Shop, Lifton, Devon, PL16 0DE

RSVP regarding attendance to: karen.ford2@nhs.net