Cheshire & Merseyside Cancer Alliance

Cheshire and Merseyside Cancer Alliance Programme Board

Minutes of the meeting held on Wednesday 20th June 2018

In attendance	Role	Initial
Ann Marr	SRO	**AM**
Chris Warburton	Medical Director	**CW**
Linda Devereux	Programme Director	**LD**
Debbie Harvey	Workstream Lead, Earlier Diagnosis	**DH**
Melanie Zeiderman	LWBC Programme Manager	**MZ**
Ann Farrar	Interim CEO, CCC	**AF**
Andrew Crawshaw	Director of Assurance & Delivery, NHS England	**AC**
Mark Greatrex	Finance Lead	**MG**
David McKinlay	Programme Manager	**DMc**
Stephen Fenwick	NM LDS Clinical Lead	**SF**
Sinead Clarke	Cheshire & Wirral LDS Clinical Lead	**SC**
Fiona Taylor	NM LDS Executive Lead	**FT**
Sandra Davies	Workstream Lead, Prevention & Public Health	**SD**
Paul Mansour	Mid Mersey LDS Clinical Lead	**PM**
Suzanne Fennah	Service Specialist, Specialised Commissioning, NHS England	**SuF**
In attendance		
Ed Gaynor	GP & Liverpool CCG Cancer Clinical Lead	**EG**
Jim Anson	Medical Director, Liverpool Clinical Laboratories	**JA**
Terry Whalley	Project Director for NHSI North 4 work and Carter at Scale	**TW**
Secretariat		
Debbie Moores	Admin & Project Support Officer	
Apologies	**Role**	
Mark Lipton	Cheshire & Wirral Exec LDS Lead	
Terry Jones	North West Coast Clinical Research Network	
Sheena Khanduri	High Quality Modern Services Workstream Lead	
Tony Murphy	Patient Representative	
Ray Murphy	Patient Representative	

065/18. Welcome, Introduction and Apologies
AM welcomed all to the meeting, introductions were made and apologies noted.

066/18. Declaration of Interests
No declarations of interest were made.
It was agreed to distribute a declaration of interest form for completion by each Board member.

Action: Debbie Moores to email all Board Members a Declaration of Interest Form for completion.

067/18. Minutes of the Meeting held on 12th March 2018
The minutes of the last meeting were agreed as a correct record.

068/18. Matters Arising

a. Eastern Sector Consultation Process

CW has received a reply from Dianne Johnson regarding the consultation process. AC advised that he is the NHS England Lead for the consultation process and that CCC have already presented the outline case with the full case for change being submitted to Dianne Johnson by mid July. It was noted that the timescale is defined by NHS England and CCGs in line with NHSE's assurance process and a decision may not be made regarding the clinical model/location until next calendar year. CW noted that the Alliance is concerned about where the change impacts on service provision. AF offered to share CCC's risk assessment. It was noted that an independent clinical evaluation will be obtained through the clinical senate.

b. Updated 2018/19 Cancer Plan

SD provided an update following the STP Prevention at Scale workshop. The outcome was that cancer specific prevention activities regarding PH48 should continue and are not duplicating work undertaken elsewhere. AM is meeting Jon Develing (SRO for Prevention) and Jane Tomkinson (SRO for CVD) to discuss common work streams and opportunities for working together.

069/18. MDT Review Update

DMc gave an overview of the MDT Optimisation Project. A clinically led informal steering group has already been established. The Cancer Alliance Team will provide project management and data support. An MDT Project Launch event for Clinical Leads and CQG Chairs is being held on 18th July.

SF acknowledged the work undertaken by Peter Kirkbride and commented that this presents a significant opportunity to create more effective and efficient MDTs through sector models which will also reflect changes in oncology workforce. AM asked how this project is likely to be received by the system; SF felt that it was important to allay any concerns that patients would be denied the opportunity to be discussed at an MDT. It is proposed that the project initially focusses on breast, colorectal, lung and prostate cancer MDTs.

Discussion took place around processes and governance. LD commented that good governance is essential as specialist MDTs may not have met patients prior to discussion and transfer of clinical responsibility needs to be clear. AC felt that organisational boundaries can be problematic, particularly for a three trust pathway. He felt that if this is tackled, this will have a positive impact on the 62 day pathway. AF emphasised the need for smart working and use of digital technologies. CW noted that the role of MDT Lead is not recognised in consultant job plans and AM suggested it would be helpful to develop a job description for an MDT Lead. The Board approved the project outline**.**

Action:

- **MDT project to develop an MDT Lead JD.**
- **Progress report to be presented in December 2018.**

070/18. Cancer Alliance Data, Evidence and Analysis Report

CADEAS is the centralised national team who work on behalf of Cancer Alliances to provide clinical and non-clinical data.

CW tabled 2 summary documents, Cancer Alliance and CCG/STP levels.

CADEAS Presentation - 20.06.

It was noted that:

- 1 year survival rates are variable but the gap with England has reduced
- Lung cancer survival rates (40%) are in line with the national average
- Under 75s mortality is significantly higher with variation across C&M

- Patient experience survey outcomes are rated as 'green'
- C&M are outliers with lower uptake and coverage in breast and bowel screening compared with other Alliances - Knowsley, Liverpool, South Sefton and Halton and outliers
- High incidence of emergency presentation in Liverpool, South Sefton, Knowsley & Wirral
- Early stage diagnosis – 8 out of 12 CCGs are below the national average

The low uptake of screening was discussed. SD noted that there are various reasons why people do not attend, deprivation plays a part and that it would be helpful to understand trends over time. She advised that it was important to target areas which will have the greatest impact. FT noted that bowel screening is commissioned through Public Health England and asked if there is anything further that could be done to improve uptake. SC advised the Board that public health interventions in South Cheshire have realised benefits in survival and led to further CCG funding. DH agreed that this was important as GPs are not paid for bowel screening.

The group felt it would be very useful to have more current data including longer term survival rates by tumour/CCG.

CW and LD will be meeting Hayley Mercer, Screening & Immunisation Lead at NHSE who has been asked to present data at the next Board meeting.

Action: Prevention Group will review the screening plan at its July meeting in preparation for the September Board.

071/18. Diagnosing lung cancer at an early stage – Healthy Lung Update

Ed Gaynor
Presentation - 20.06.

EG gave a presentation on Liverpool CCG's Healthy Lung Project which involves pro-active case finding in higher risk populations. It was noted that:

- Primary care data has been used to identify people aged 58 – 75 years who have smoked or have COPD. The programme has one further year to run.
- Uptake is 40% (6120 attendances) which exceeds other pilots. Liverpool CCG will be exploring ways to increase uptake and understand why people do not take up the offer of screening.
- 2087 CT scans were undertaken resulting in 37 (1.9%) confirmed cases of lung cancer.
- 70% of diagnosed cases were stage 1 & 2.
- There are significant numbers of patients diagnosed with COPD during the pilot.
- Patient satisfaction survey has been positive.
- More information from European studies are due to be published later in 2018.
- Programme costs approx. £450k per year in Liverpool; £13k per quality adjusted life year.
- National policy is unclear but may focus on proactive case finding rather than screening.

SF commented that the 60% non-attenders could be at higher risk and asked if there is a mechanism to re-intervene. EG advised that the project is a one off intervention but they are considering rescanning at 1 or 2 years. At commencement it was anticipated that a national Lung Screening Programme would be up and running by now. CW felt that careful consideration needs to be given to re-scanning the existing cohort. LD explained that David Fitzgerald, National Programme Director for Cancer is meeting the team on 3rd July and he will be asked for his perspective on the priority of lung cancer in national policy.

There was discussion about a potential roll out if funding is available and the need to consider impact on follow up and diagnostic capacity. AM felt it was important to have a methodology for making decisions on priorities. It was agreed that the Alliance would invite proposals that could be ready if additional funding becomes available.

072/18. NHS England Transformation funding Agreement / Prioritisation Process

NSF presentation - 20.06.18.pptx

LD advised the Board that a National Support Fund has been established to address disparity in the original submissions by Cancer Alliances. C&M will receive an additional £535k for Q1 & Q2. Further funding will be received in Q3 & Q4 and conditions linking continued transformation funding and recovery of the 62 day waiting time standard will apply. The Board agreed that further funding in Q3 & Q4 could be used to support the digital pathology programme.

The Alliance team have identified three potential projects for Q1 & Q2 funding:

- Healthy Lung
- CURE (intensive smoking cessation for patients admitted to hospital)
- FIT

SC and SF commented that LDSs should be invited to put forward other proposals and the Board agreed this approach to ensure there was appropriate engagement across C&M. A panel will be convened using the criteria in the prioritisation process developed by the Alliance.

Post meeting note: A panel comprising LDS, patient and core Alliance team representatives will take place on 16th July.

Action:

- **LD to write to stakeholders inviting proposals against the £535k.**
- **Core team to advise NHS England at its Regional Assurance meeting on 25th June.**

073/18. Programme Governance

a. Highlight Report

LD updated the Board on progress to deliver the transformation projects and wider recommendations in the national cancer strategy. The Alliance has been identified as a national 'trailblazer' due to the strength of our plans and performance against the 62 day standard. It was noted that all projects have a 'green' status.

The Board was advised of two risks:

- Continuation of transformation funding and links to 62 day performance in May, June and July
- Imaging capacity and ability to deliver turnaround times within optimal pathways.

Ash Bassi & Neil Haslam have been invited to present progress on the Endoscopy project at the next meeting. It was agreed that David White, Lead for the STP Imaging Board would also be invited.

Action:

- **Clinical leads to present Endoscopy project at the September meeting.**
- **David White to be invited**

b. Cancer Waiting Time Performance

CWT presentation - 20.06.18.pptx

AC referred to a paper outlining the role of the Cancer Delivery Group which is comprises NHSE, NHSI and the Cancer Alliance. This was established in response to the national 62 day recovery plan published in 2017. It was noted that performance is variable across the trusts with three trusts accounting for the majority

of late referrals to CCC. Regular calls and meetings are taking place to monitor and recover performance. Achievement remains challenging with issues cited around infrastructure (particularly diagnostics), pathways and trust tracking processes. AF advised that the CCC Board receives a report on 7 day appointment and treatment times and a systematic review of performance is essential at Board level.

AC agreed to review the ToR for the Cancer Delivery Group and metrics for presentation at the Board. AM asked that the group should identify the five things that should be achieved to improve performance.

DMc suggested that project managers within the Alliance could re-prioritise to support the imaging board given its importance in cancer pathways.

LD referred to the attached presentation following an analysis of referral and treatment trends from 15/16 to 17/18. 2 week wait referrals have grown by 5.4% however conversion rates have remained the same. Lower GI, head & neck and upper GI pathways remain the most challenged based on data presented.

Action:

- **Cancer Delivery Group to revise ToR**
- **AC to develop metrics**
- **Cancer Delivery Group to identify top 5 actions to improve performance**

074/18. C&M Pathology Update

Jim Anson Presentation - 20.06.

Jim Anson had been invited to provide an update on pathology initiatives in C&M. Terry Whalley was welcomed as Project Director for NHSI North 4 work and Carter at Scale. National and regional drivers for change were outlined including the Carter Report and NHSI proposed hub & spoke model. JA outlined progress being made in the three LDS footprints which includes pathology services merging and integration of regional genetics services. Three large transformation programmes are underway; NHSI North 4, reconfiguration of genomics and digital pathology. There are challenges in capacity compounded by a national issue with recruitment of pathologists.

LCL performance is improving with a KPI of 90% in 10 days however this will not be achieved with existing capacity. There is a business case to address these issues. CW asked whether 3-5 day turnaround time is an achievable turnaround time in the longer term. AC asked JA to share the business case and trajectories for achieving improved turnaround times.

Action: JA to share business case and trajectories.

075/18. FIT briefing

CW referred to the paper proposing that a steering group is established to explore implementation of FIT testing for symptomatic patients and develop a business case if required. It was noted that this is an alternative test to faecal occult blood test and is a rule out test for colorectal cancer. NICE guidance exists for low risk patients but this is not currently implemented across Cheshire and Merseyside. Pathways need to be designed to incorporate FIT testing. DH advised that use of FIT in primary care is currently at the ethics stage and offered alongside standard referral. Evidence suggests that the test can exclude need for colonoscopy, potentially releasing capacity in secondary care. The case is separate to FIT as a screening test which is being rolled out nationally. The Board approved the recommendation.

Action:

- **Cancer Alliance to establish a steering group and identify project manager resource.**
- **Progress report to be provided at December Board meeting.**

076/18. NHS Cancer Programme – Self Assessment Framework for Cancer Alliances

Cancer Alliances have been asked to complete a self-assessment framework to help identify where they need to develop as system leaders and enable the national team to determine what their offer of support should be. The recommendation is that this is completed by 10 stakeholders along with the Executive Alliance Lead.

Action: LD to ask clinical and non-clinical stakeholders to complete the self-assessment framework.

077/18. Any Other Business

PM and AM to discuss role of the Mid Mersey LDS Group and its work plan.

AF advised that CCC Board have been considering their 10 year strategic direction. There will be a 3 year strategic implementation plan which will be shared for comment after the CCC July Board meeting. This will be brought to the Alliance Board in September. It is hoped that the substantive Chief Executive will be in post by October.

Date of future meetings

Friday 28th September 2018, 2.00pm – 4.30pm *(changed from 10th September)*
Tuesday 11th December 2018, 2.00pm – 4.30pm