West Yorkshire & Harrogate Cancer Alliance

Board Meeting

Wednesday 23rd January 2019, 14:00 – 16:30hrs

Sandal Rugby Club, Standbridge Lane, Milnthorpe Green, Wakefield, WF2 7DY

Attended:	Sean Duffy, Cancer Programme Clinical Director, WY&H Cancer Alliance	SD
	Michele Ezro, Ass Dir Acute Comm Wakefield CCG	ME
	Carol Ferguson,Cancer Programme Director, WY&H Cancer Alliance	CF
	Mike Frazer, Board Layperson, Patient Representative	MF
	Jo Halliwell, Director of Operations, Surgery MYHT	JHa
	Robert Harrison, Chief Operating Officer, Harrogate & DFT	RH
	Mike Harvey, on behalf of David Berridge	MH
	Jane Hazelgrave, Director of Finance, MYFHT	JHz
	Fiona Hibbits, Senior Delivery Improvement Lead, NHSI	FH
	Jules Hoole, Strategic Partnership Manager (Yorkshire), Macmillan	JHo
	Stacey Hunter, Chief Operating Officer, Airedale HT	SH
	Clive Kay **(Chair)**, Chief Executive Officer, Bradford THT	CK
	Matt Kaye, GH CCG GP Cancer Lead and WY&H CRUK GP Lead	MK
	Akram Khan, Clinical Chair, Bradford City CCG	AK
	Kath Nuttall, Regional Manager, CRUK	KN
	Maureen Overton on behalf of Ashwin Verma	MO
	Visseh Pejhan-Sykes, Chief Finance Officer, Leeds CCG	VPS
	Kevin Peters, Specialised Commissioning Cancer, NHSE	KP
	Amanda Procter, Lead Cancer Nurse, Bradford THT	AP
	Sandra Shannon, Chief Operating Officer, Bradford THT	SS
	Nigel Taylor, GP Member of Governing Body, Calderdale CCG	NT
	Ashwin Verma, Consultant Gastroenterology, Calderdale & Huddersfield Trust	AV
	Paul Vose, Board Layperson, Patient Representative	PV
In Attendance:	Tracy Holmes, Comms & Engagement Lead, WY&H Cancer Alliance	TH
	Fiona Stephenson, Head of Quality & Optimal Pathways, WY&H Cancer Alliance	FS
	Lindsay Springall, Senior Commissioning Manager, NHS Leeds CCG	LS
	Catherine Weir, Senior Lecturer, Birmingham University	CW
	Sue Ellis, OD Consultant, WY&H OD Network	SE
	Keith Derbyshire, Consultant, Health Informatics	KD
	Craig Shenton, Consultant, Health Informatics	CS
Apologies:	Amanda Bloor**,** CCG Chief Officer, HaRD CCG	AB
	David Berridge, Deputy Chief Medical Officer, Leeds THT	DB
	Anna Hartley, Deputy Director of Public Health, Wakefield Council	AH
	Helen Lewis, Head of Planned Care & LTC Commissioning, Leeds CCG	HL
	Lyn Sowray, Assistant Director Social Care, Bradford Council	LS
Secretariat:	Tracy Short (Minutes)	TS

1.0 Welcome, Introductions & Apologies

1.1 CK welcomed the attendees and round the table introductions were made. CK advised members that he has accepted the position of Chief Executive of Kings College, London however his start date is yet unknown. He advised that discussions for a replacement Chair has already commenced.

	Actions
2.0 Declarations of Interest:	
2.1 There were no declarations of interest made.	
3.0 Minutes of meeting held on 30th October 2018:	
3.1 The minutes of the meeting were checked for accuracy and were agreed to be a true record.	
4.0 Actions/Matters Arising:	
4.1 There were a number of outstanding actions or matters arising that were not covered on the agenda and CF provided an update to the members.	
4.2 **Highlight Report & Risk Register:**	
4.2.1 It had been agreed at the last meeting that these documents would be issued with meeting papers and questions and comments sought in advance of the meeting. MF has raised a number of issues that had been picked up by FS.	
4.3 **Data Sharing Agreement:**	
4.3.1 CF advised that the Health and Care Partnership (HCP) Programme Management Office is still waiting for colleagues in Information Governance to provide the appropriate advice regarding wording. CF agreed to follow this up.	**CF to follow up with HC Partnership PMO colleagues. CK & AB to request early resolution via SOAG**
4.4 **Smoke free Statement:**	
4.4.1 CF advised that Scott Crosby (Tobacco Control Lead) would be attending the next Board meeting to provide an update.	
4.5 **Clinical Engagement:**	
4.5.1 As there a number of outstanding issues regarding clinical engagement it was suggested by CF to add Delivery of Optimal Pathways which delivers both performance and outcomes, to the next meeting agenda.	**TS to include delivery of optimal pathways discussion to March agenda.**
4.6 **System Oversight and Assurance Group (SOAG):**	
4.6.1 CF advised that this would be discussed at agenda item 10.	
4.7 **Organisational Development (OD) Support:**	
4.7.1 CF introduced Sue Ellis who was in attendance to observe the meeting. Sue is part of the WYH OD network offering OD support in helping the Board develop as a mutually supportive system leadership for cancer. SE advised that the joined up approach by the network should alleviate duplication across the programmes.	
4.8 **NHS England Self-Assessment:**	
4.8.1 CF advised that formal feedback from the national team is still	

awaited, although informal feedback would suggest that it will take the form of guidance regarding structures for the Alliance and interdependencies with HCPs.

5.0 Cancer Waiting Times:

5.1 FS introduced this paper which has been provided to highlight some of the challenges faced and to ask the Board for guidance on some of these issues.

5.2 FS advised that although there has been some slight improvement in performance the Trusts are still some way from achieving the target.

5.3 She informed the group that West Yorkshire Association of Acute Trusts (WYAAT) Strategy and Operations Group is working with the Alliance, NHS England and NHS Improvement and operating as an effective vehicle to enable coordination and deployment of resources and effort and providing strategic forward planning for cancer within wider system pressures.

5.4 FS drew attention to the three main points discussed in section 4 of the paper:

5.4.1 **Prostate & Lung Pathway**: all organisations have action plans in respect of the prostate pathway and are working collaboratively. The diagnostic part of the lung pathways are being overseen by pathway improvement groups, however guidance from the Board was being sought as it was acknowledged that not all issues can be addressed by those groups alone.

5.4.2 **Demand & Capacity Diagnostics**: FS advised that work is underway to commission a piece of work which will provide a significant standardised approach to assessing capacity and demand across the whole system. The establishment of a cancer hub to provide dedicated resource to interprovider working will be explored and should provide a shared resource and learning from the outputs of the modelling exercise.

5.4.3 **CWT Analysis:** this will provide the opportunity to undertake deep dives into the performance of individual Trusts and collectively as a system and look for improvements.

5.5 Discussion followed regarding specifics particularly around the prostate figures and the diagnostic end of the pathways.

5.6 JHz commented about the danger of assessing performance without understanding volume and demand.

5.7 MF made reference to 4.1 of the paper which referred to the national problem of the availability of the PET CT Scans and asked if anything could be done.

5.8 SD advised that NHS England Specialised Commissioning team are responsible for the contract and KP is working closely with NHSE north of England to resolve these issues. He advised that though there isn't much we can do as an Alliance Board, we could ensure that communication is maintained and mitigation is in place.

5.9 MF also questioned whether the Board can do anything to speed up the development of the Cancer Hub and CF advised that the CT Fund supports this, that design work is underway. FS stated that the three asks of the Board were to steer the improvement work with focus and to prioritise the prostate pathway. Endorse the demand and capacity analysis across diagnostics for all disease areas to establish which is cancer specific and support the development of the cancer hub.

5.10 FS agreed to bring this item back to the Board in 6 months with data showing demonstrable improvement. **Schedule update paper for July's Board agenda**

5.11 Discussion followed regarding the evident signs of maturity of system leadership and the success of collaboration which FHi stated was the driving force.

5.12 CK questioned how much further the Board was prepared to hold one another to account across the system regarding delivery and whether members were comfortable so far with the approach.

5.13 MHa commented that the approach is not just entering into discussions but is actually assisting in the streamlining of pathways.

6.0 Lynch Syndrome Testing:

6.1 LS attended the meeting to present the paper which recommends a consistent approach to Lynch Syndrome Testing across the Alliance. For the past three years, activity has been funded by Yorkshire Cancer Research and to ensure that this becomes business as usual, LS has worked extensively with stakeholders and other Alliances.

6.2 The paper sets out the delivery costs if the tests are undertaken at LTHT (which has capacity to undertake BRAF & MLH1 tests from April), explains the tests required and outlines the costs pressures for each CCG.

6.3 SD advised members that the recommendations are in line with the ambitions of the Alliance e.g. stage shift, it also delivers consistency of approach, alleviating some forms of chemotherapy that adds no benefit to patients.

6.4 CK asked if the savings to the system have been modelled but was advised that the outcomes are the biggest benefit.

6.5 The paper sought three recommendations from the Board:

- To support the consistent policy

- Providers to confirm whether they will undertake their own IHC or MSI testing (LTHT is able to undertake BRAF and MLH1 tests for all if required)…….
- Agree the strategy for risk sharing e.g. pursue through Joint Committee of CCGs.

6.6 SH advised that these issues of where the tests should be undertaken should be considered by the WYAAT Pathology group.

6.7 SS added that workforce issues should be considered as a result of more test and more diagnoses.

6.8 Following further discussion it was agreed that the decision regarding the commissioning approach would need further consideration and CK suggested that PMO colleagues approach AB to progress this.

CF to approach AB re commissioning arrangements

6.9 CK concluded that the approach was endorsed in principle subject to agreement re commissioning and laboratory provision.

7.0 Macmillan Evaluation of Alliance/Leeds Integrated Cancer System (LICS) Update:

7.1 CW attended the Board to provide an update to colleagues on the evaluation of the Alliance which is being undertaken by Birmingham University. A short presentation was sent out with the papers.

7.2 CW advised that the joint working, collaboration and mutual accountability have been stretched and developed over the period that the evaluation has been taking place.

7.3 She also advised that what has emerged from the evaluation so far is that local relationships and the local story is key.

7.4 MF raised the issue that in the NHS Plan it stated that they would provide extra capacity for engagement with the public and in particular seldom heard groups. MF questioned how the Board communicates with the patients and public and if there is anything that we can improve on.

7.5 CF suggested that an update on Patient and Public Engagement is provided at the next meeting and that perhaps MF could assist what further action may be required.

Comms & engagement to be added to March agenda

8.0 Macmillan Strategy:

8.1 JHo talked through the presentation, which outlined Macmillan's national strategy with particular emphasis on the 6 priorities, and how these align with the Cancer Alliance.

8.2 Main focus includes:

- Personalised care & improved patient experience
- Cancer workforce investment
- Integrated pathway – diagnosis to EoLC

- Times of need

8.3 She advised that the Cancer Workforce investment would be heavily focused on the acute and secondary care sector in 2019 and primary and community care in 2019/20 and was pleased to announce that funding had been secured to fund 3 Band 7 posts.

8.4 These posts will provide practical support for front-line staff across the system and will deliver interventions that are proven to improve personalised support for people beyond their cancer diagnosis.

8.5 CF raised the significant issue of Wakefield CCG hosting the posts and the mitigation of risk. She advised that it is sensible for the posts holders to be managed through the existing Alliance arrangements; however this adds to the burden of the CCG, though the CCG have agreed host them.

8.6 CF asked for agreement in principle to share the risk across the system, advising that the HCP is undertaking a bigger piece of work to identify a more sustainable solution and that this would supersede any agreement reached here.

8.7 SHu stated that there should be confidence to do this and was happy to sign Airedale up to this mutual accountability.

8.8 VPS questioned whether the system should underwrite the redundancy and suggested in reality we should guarantee the post holders employment in a redundancy situation.

9.0 Cancer Outcomes Assessment Framework:

9.1 KD and CS attended the meeting to provide an overview on the development of the Cancer Outcomes Assessment Framework (COAF). The framework supports the Alliance and the six places to focus on outcomes and track meaningful and realistic strategic plans.

9.2 KD described the functionality of the tool which is based on a series of links between several specific risk factors including socio-economic, demography, cancer prevalence, and selected cancer outcomes e.g. smoking prevalence, screening uptake CWT and patient experience etc., therefore making it an improvement on RightCare.

9.3 This allows for comparison and benchmarking against like for like organisations, rather than the England average and will enable realistic planned improvements in performance.

9.4 SD advised that all the data used is in the public domain but not in this format**.** Two main questions to the Board members were:

- Do the Board members wish to adopt the tool
- Should this tool drive the Board's improvement agenda in being a method of measuring one another.

9.5 A positive discussion followed amongst members.

9.6 KD directed the attendees to table 2 of the paper which identifies four possible uses for the tool. It was agreed that the following would be useful approaches:

1. **Oversight:** discuss and share at Board level where the current strengths, weaknesses and future opportunities and threats may lie for the Alliance.
4. **Support:** identify areas of weakness and opportunity where resources could be deployed to support improvements with generalizable lessons reported back.

9.7 The members were optimistic that the following approaches would follow once the clinicians become engaged:

2. **Assess:** reporting of risk adjusted outcomes that are significantly better or worse than statistical neighbours

3. **Monitor:** routinely consider in the same format the movement of risk adjusted outcomes over an agreed period.

10.0 Strategy Oversight and Assurance Group:

10.1 CK advised that this item had been covered throughout the meeting.

11 Any Other Business

11.1 **Alliance Plan**: CF advised that it was still not known what the Alliance budget would be for 19/20 but NHSE have advised that we may know by the end of January.

11.2 Indications are that the Alliance will be required to submit a plan by the end of February and as the next meeting of the Board isn't until March, CF asked for volunteers to shape this. SHu, RH & JH all volunteered to assist. CF also invited PV & MF to help.

11.3 Clive Kay: Shu thanked CK for his leadership and chairmanship to the Alliance Board, wishing him every success for the future and members also passed on their best wishes.

12 Date & Time of Next Meeting:
Wednesday 20th March 2019, 14:30 – 17:00.