

## Board of Directors Meeting in Public

All reports **MUST** have a cover sheet

<b>Subject:</b>	Cancer Capacity		<b>Date:</b> 7 July 2022	
<b>Prepared By:</b>	Maggie McManus, Acting Chief Operating Officer			
<b>Approved By:</b>	Maggie McManus, Acting Chief Operating Officer			
<b>Presented By:</b>	Maggie McManus, Acting Chief Operating Officer			
<b>Purpose</b>				
To update the Board on the review of the benefit of converting routine elective capacity to cancer capacity			<b>Approval</b>	
			<b>Assurance</b>	
			<b>Update</b>	X
			<b>Consider</b>	
<b>Strategic Objectives</b>				
<b>To provide outstanding care</b>	<b>To promote and support health and wellbeing</b>	<b>To maximise the potential of our workforce</b>	<b>To continuously learn and improve</b>	<b>To achieve better value</b>
X			X	
Indicate which strategic objective(s) the report support				
<b>Overall Level of Assurance</b>				
	<b>Significant</b>	<b>Sufficient</b>	<b>Limited</b>	<b>None</b>
Indicate the overall level of assurance provided by the report -	External Reports/Audits	Triangulated internal reports X	Reports which refer to only one data source, no triangulation	Negative reports
<b>Risks/Issues</b>				
Indicate the risks or issues created or mitigated through the report				
<b>Financial</b>				
<b>Patient Impact</b>	X			
<b>Staff Impact</b>				
<b>Services</b>	X			
<b>Reputational</b>				
<b>Committees/groups where this item has been presented before</b>				
<b>Executive Summary</b>				
<p>Following a board request to review the benefit of converting routine elective capacity to cancer capacity, the Deputy Chief Operating Officer reviewed and consulted with clinical colleagues to understand any potential opportunities.</p> <p>The main findings of the investigation were:</p> <ul style="list-style-type: none"> <li>• Almost 21% of cancers which are picked up in the routine elective pathway would be missed, for some specialties that can be as high as 40%</li> <li>• The transfer of elective capacity would need to include the relevant diagnostic capacity which has its own capacity restrictions and may be carried out at a tertiary centre</li> <li>• The change of elective capacity to cancer would not necessarily be equal (cancer appointments and treatments traditionally take longer than a routine elective) so the impact on the elective pathway would be greater than 1:1</li> <li>• Some tumour sites only have cancer pathways (breast) and some have predominantly cancer pathways and little or no routine capacity to convert</li> <li>• Some of the tumour sites have backlogs that are significantly delayed at NUH awaiting complex surgery (Upper GI, Urology &amp; Gynaecology)</li> </ul>				

- Changes to estate at the Kingsmill Hospital Site to address winter/surge capacity pressure within the emergency pathway have had a detrimental effect on the cancer pathway by displacing other cancer focussed specialties, making them less efficient.

#### Conclusion

- The clinical chairs, cancer lead clinician and tumour site leads were unanimously opposed to converting routine elective capacity due to the clinical risk of missing almost 21% of patients who require cancer care.
- The operational impact is limited due to the number of specialties and clinicians who only see cancer patients and therefore have little or no routine capacity to convert.
- A third of the patients waiting on the backlog are at a tertiary provider awaiting surgery

#### The Board is asked to:

- Accept this report on the capacity considerations within the cancer and elective pathways
- Note the investigative actions taken
- Consider the outcomes and view of our clinical leaders
- Consider the limited impact and risks of converting routine capacity to cancer capacity

## **Background**

The Chief Operating Officer (COO) was asked by the board to consider what other actions could be taken to speed up the recovery of the cancer backlog to February 2020 levels and ensure that appropriate prioritisation had taken place. From this request, the suggestion was made that routine elective capacity could be transferred to cancer capacity. The Deputy Chief Operating Officer was asked to explore this as a solution and present back to board in July 2022.

The DCOO took the proposal to cancer board and clinical chair/divisional general managers meetings and also reviewed with the clinical chairs, cancer lead clinician, tumour site leads and operational managers. Data was presented that showed the backlog split, where the patient were delayed and what was required to resolve the issue.

The outcome of the investigation highlighted the following main themes:

- The Clinical Chairs, Cancer Lead and tumour site leads expressed concern due to the underlying clinical risk from 'missed' cancers that are identified through the routine elective pathway. As a monthly average, this equates to 39 of the total 188 per month, almost 21%.
- The transfer of elective capacity would need to include the relevant diagnostic capacity which has its own capacity restrictions and may be carried out at a tertiary centre
- The change of elective capacity to cancer would not necessarily be equal (cancer appointments and treatments traditionally take longer than a routine elective) and outpatient, theatre and diagnostic efficiency would be adversely affected
- Some of the tumour sites only have cancer pathways (breast) and some have predominantly cancer pathways and little or no routine capacity to convert
- Some of the tumour sites have backlogs that are significantly delayed at NUH awaiting complex surgery (Upper GI, Urology & Gynaecology)
- Changes to estate at the Kingsmill Hospital Site to address winter/surge capacity pressure within the emergency pathway have had a detrimental effect on the cancer pathway by displacing other cancer focussed specialties, making them less efficient.
- In May, a quarter of the backlog was awaiting surgery or a diagnostic procedure at a tertiary centre

## **Mitigations**

There are a number of other actions that are either taking place within the tumour sites or are planned which will aid our ability to recover capacity and reduce the backlog:

- Specialties are already converting routine capacity where appropriate
- Recruitment is taking place for substantive and locum consultants in specialties that have vacancies
- Mutual aid is being sought from other tertiary centres for appropriate patients
- A system cancer hub is being developed to provide mutual aid across pathways to reduce specialty specific backlogs. This will however need to be clinically led due to the complexity of the patient cohort.
- Mutual aid is being offered by SFHFT for less complex patients in an attempt to clear capacity for the longest waiters across the system to be operated on/have their diagnostic procedure at NUH
- There is a proposal to reassess the location of non elective beds to minimise the effect of the sustained emergency pressure on cancer and elective pathways (the number of beds required will not reduce)

## **Governance**

Cancer was previously reported as part of the SFH elective care steering group which may have inadvertently diluted the focus for the clinical, operational and nursing leadership teams. It was agreed that a new steering group solely for cancer (CSG) would be set up which would be clinically led, have membership that included the tumour site Clinical Leads, Divisional General Managers and Heads of Nursing and feed escalations and progress into Trust Management Team (TMT). The first CSG took place 6 June 2022, with the quadrant report due to be presented at Executive Team Meeting and TMT in July.

Cancer backlog has now also been added to the weekly NHSEI Midlands Region Elective Care Recovery programme oversight regime. Each provider is asked by the regional team to present their cancer backlogs and progress/escalations on a weekly basis.

## **Conclusion**

Upon investigation into the benefits and risks of converting routine capacity to cancer, there is a clear and significant risk of missing or delaying almost 21% of all cancers that are referred through the routine pathway. In some specialties, this can be as much as 40%. As a result of this risk, the cancer clinicians and most senior clinical leaders in the organisation were not in support.

### **The board is asked to:**

- Accept this report on the capacity considerations within the cancer and elective pathways
- Note the investigative actions taken
- Consider the outcomes and view of our clinical leaders
- Consider the limited impact and risks of converting routine capacity to cancer capacity