Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors

All reports MUST have a cover sheet

Subject:	Cancer Performance	**Date:** 21/10/2019	
Prepared By:	Helen Hendley, Deputy Chief Operating Officer (Elective Care)		
Approved By:	Simon Barton, Chief Operating Officer		
Presented By:	Simon Barton, Chief Operating Officer		
Purpose			
This paper sets out the drivers for and actions in place to improve cancer performance		**Approval**	
		Assurance	X
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X			X	X

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -		X		

Risks/Issues	
Financial	X
Patient Impact	X
Staff Impact	X
Services	X
Reputational	X

Committees/groups where this item has been presented before

Trust/CCG monthly performance meeting 30/10/2019

Executive Summary

Ensuring cancer patients receive timely access to high-quality care, treatment and on-going support remains one of the key priorities for the Trust. Our aim for all patients is to rule out or diagnose cancer at a much earlier stage to support improved outcomes and patient experience. We do perform better than many of our peers particularly for patient experience however we are not consistently delivering our performance trajectory.

This paper aims to summarise the key challenges including increasing referrals, pressure on diagnostic capacity and the dependency on our main tertiary centre for some diagnostics and treatments. It outlines a recovery trajectory to March 2020 agreed with the CCG, shared with NHSI/E and underpinned by a set of joint CCG and Trust actions.

Key findings include:

- Demand in 2018/19 was 14% higher than in 2017/18. For 19/20 YTD growth is 5%
- Our focus must remain on reducing the time (or need) for 1st outpatient appointment and subsequent diagnostics. This will be met through increased quality of GP referrals, use of virtual clinics and straight to test pathways.
- Fundamental capacity gaps in Endoscopy and Radiology will need to be addressed as short to medium term solutions do not offer the stability required to deliver sustainable performance.
- Year to date 85% of treatments are completed by day 76 with 77% completed by day 62

- A joint Trust/CCG recovery action plan in place with clear timescales, month of impact and days saved on the pathway
- An agreed trajectory is in place to deliver 82% by the end of March 2020
- A backlog reduction trajectory in place to reduce to March 2019 volume by March 2020
- Risks to delivery include; underlying capacity gaps compounded by sickness, and annual leave, wait for some diagnostic tests and treatments provided by tertiary centre and the impact of the phased roll-out of the Lung CT Health checks from April 2020
- To support pathway and performance improvement £319k of Cancer Alliance funding has been secured in 2019/20.
- As requested at the October Board a 3rd party assurance of the management of cancer pathways has been sought, the NHSI/E Intensive Support Team will be on site for an initial visit on 3rd November 2019.

Cancer Performance Improvement

The key milestones in a cancer pathway are measured by time to first appointment (2WW), time from decision to treat to treatment (31 days) and time from referral to treatment (62 days). A 4th and more fundamental element that is currently being shadow measured is the time to diagnosis (28 day standard).

1. Demand

In terms of the volume of 2WW referrals (Figure 1) shows the combined data for the last 5 years mapped by CCG. This illustrates that Mansfield and Ashfield is within expected range and Newark and Sherwood is slightly higher than the average. However in 2018/19 demand for 2WW referrals rose by 14% when compared to 2017/18 (12,800 versus 14,600) and for the first 5 months of 2019/20 growth in referrals has been 5%. Despite this the Trust continues to deliver the 2WW standard failing only once in the last 24 months.

Figure 1: Demand by CCG

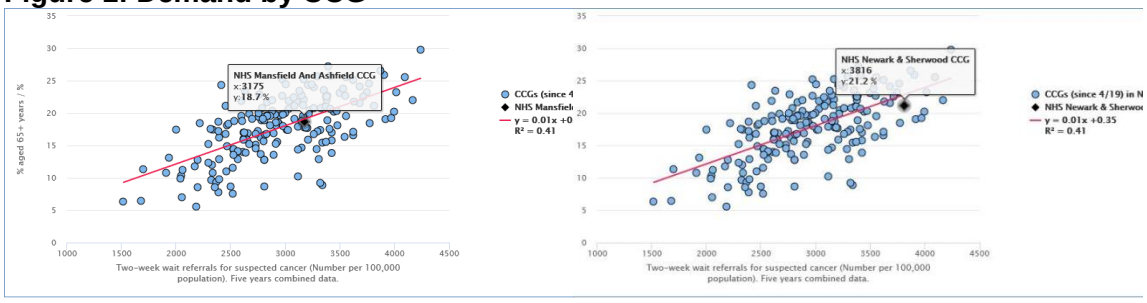


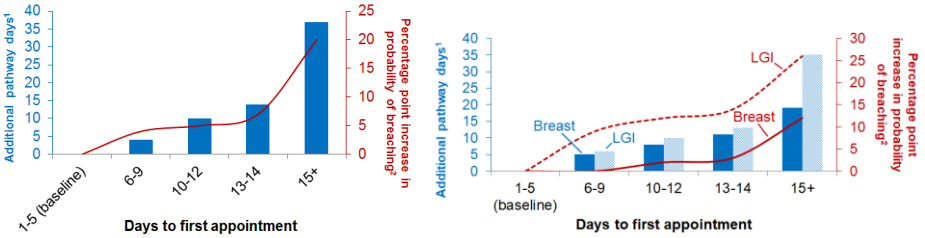
Table 1: Variation in referrals by tumour site

	Full year			Year to date		
Tumour site	**17/18**	**18/19**	**% change**	**17/18**	**18/19**	**19/20**
Breast	2413	2,851	18.15%	1,036	1,175	1181
Lung	734	574	-21.80%	286	224	263
Haematology	69	82	18.84%	29	27	28
Upper GI	1329	1,359	2.26%	576	578	565
Lower GI	2159	2,507	16.12%	976	983	1217
Skin	2445	2,882	17.87%	1,117	1,290	1267
Gynaecology	1038	1,215	17.05%	473	470	615
Urology	1620	1,858	14.69%	645	796	741
Head & Neck	897	1,186	32.22%	396	504	458
Other	34	43	26.47%	15	27	17
Trustwide Total	**12738**	**14,557**	**14.28%**	**5,549**	**6,074**	**6,352**

Breast, Lower GI and Gynaecology continue to see year on year growth and whilst lung saw a decrease in 2018/19 it has increased again YTD 2019/20. The importance of understanding an increase at tumour site level is relevant when considering the volume of tests associated with confirming or ruling out cancer - the number of contacts per patient is the most important determinant of waiting times. On average a referral will generate 3 contacts before cancer is confirmed or can be ruled out. In 2018/19 this equated to 5,600 additional contacts, year to date 2019 it is an additional 800 contacts.

"Using patient data to improve cancer performance" NHSI Economics team September 2018 (Figure 2) evidences time to first appointment as the second most important determinant of waiting times. Both graphs show the percentage point increase in the probability of breaching. Graph 2 gives an example of the varying impact by tumour site. A delay to 1st appointment for LGI has a more significant impact on performance when compared to a delay for a 1st Breast appointment.

Figure 2: Time to first appointment as a determinant of waiting times



Demand and capacity modelling for 2WW referrals has been refreshed twice in the last 12 months with gaps filled by converting routine capacity to 2WW, sourcing additional medical staff or by reducing the need for a first outpatient by introducing straight to test models of care (Lung, Upper GI and latterly Urology).

It is critical that we remain focussed on reducing the time or need for 1st appointment to deliver sustainable 62 day performance. The year to date wait range for patients having received their 1st appointment by 14 days can be seen in table 2 below, a straight to test pathway negates the need for a 1st outpatient but is not suitable for all pathways or patients.

Table 2: Tumour sites ranked by % Year to date seen within 7 days

Straight to test	0 - 7 days	8 - 10 days	11 - 14 days	> 14 days
Lung	76%	12%	10%	3%
Urology	48%	14%	23%	15%
UGI	34%	23%	31%	12%
Seen in clinic	**0 - 7 days**	**8 - 10 days**	**11 - 14 days**	**> 14 days**
Lung	61%	19%	13%	7%
Breast	60%	23%	14%	2%
Haematology	54%	23%	20%	3%
UGI	49%	25%	20%	5%
Gynaecology	47%	32%	18%	3%
Breast Symp.	47%	25%	23%	4%
Head & Neck	37%	32%	25%	7%
Urology	36%	29%	27%	8%
LGI	30%	33%	31%	6%
Skin	19%	26%	48%	7%

Note: 86% of the >14 day appointments are patient choice to delay or patient cancellation.

The most significant shift has been in the wait for 1st appointment in Lower GI due to an increase in referrals following the introduction of Faecal Immunochemical Test (FIT) in Quarter 4 2018/19.

Actions to address demand:

Tumour site / Action	Timescale	Month of Impact	Impact
Urology – audit 2WW referrals	October 2019	N/A	N/A
Lower GI – Re-audit of 2WW referrals	October 2019	N/A	N/A
Lower GI – Pre-requisite tests to be undertaken and reported prior to referral	Action progressed and signed off by the CCG clinical effectiveness committee on 16/10/2019	January 2020	Reduce referrals by up to 20%
Upper GI – Re-audit of 2WW referrals following implementation of the Optimal pathway	Optimal pathway in place. Audit to be undertaken in January 2020.	N/A	N/A
Head and Neck – Review of Outpatient capacity	Complete	October 2019	Reduce wait by 7 days
Gynaecology – Review clinic slots & expand the pre-menstrual bleed one-stop clinic	December 2019	January 2020	Reduce wait by 3-10 days

2. Time to diagnosis

From 1st April 2019 Trusts were required (in shadow format) to collect information on the day at which patients are told they have a confirmed cancer or cancer has been ruled out. This is known as the 28 day Faster Diagnosis Standard (FDS). It is expected that this will supersede the 14 day standard in the future and will be a key pathway milestone to deliver the 62 day standard. We have made significant progress on the recording of this data and are addressing the underlying themes by tumour site within the recovery action plan.

A dashboard has been developed and whilst it will require further refinement when national guidance is finalised it currently shows that 74% of pathways completed (diagnosed or ruled out) in August 2019 were completed by day 28. The average time to diagnosis or ruling out of cancer was 21.6 days with 95% of patients given their diagnosis (or all clear) in a face to face setting.

Table 3 shows the best performing tumour site is skin at 99% the worst performing is Lower GI at 47%. Again it is important to note the variation in the pathway for each tumour site. Skin is relatively straightforward with a decision to treat often made at 1st Outpatient. For Lower GI an endoscopic test can be required which can take up to a further 14 days following 1st Outpatient and is subject to patients taking their preparation correctly, can often be cancelled or rearranged by patients or may not be suitable leading to a request for an alternative diagnostic test such as a CT colon. Urology (prostate pathway) requires a MRI followed by a biopsy, Upper GI and Lung benefit from straight to test pathways to deliver a relatively quick diagnosis; the waits within these pathways are often at the treatment planning or "staging" element for which we are reliant on our tertiary centre.

Table 3: Indicative 28 day (faster diagnosis) performance by tumour site.

Tumour site	April 2019	May 2019	June 2019	July 2019	August 2019	Total YTD
Skin	97.94%	94.57%	93.17%	97.29%	99.31%	96.48%
Breast	93.12%	96.04%	94.93%	96.27%	96.39%	95.33%
Upper GI	87.78%	84.71%	79.00%	85.50%	83.50%	84.09%
Gynae	84.62%	66.67%	65.57%	72.00%	68.32%	70.23%
Lung	61.90%	74.47%	69.35%	66.67%	72.00%	68.89%
Head and Neck	80.00%	62.67%	55.79%	55.56%	70.13%	63.27%
Urology	55.22%	58.44%	55.94%	67.31%	56.69%	58.96%
Lower GI	64.94%	63.79%	58.19%	50.35%	47.14%	55.84%

The waits for key diagnostic tests are tracked by 7, 10 and 14 day on a monthly basis. Performance does fluctuate due to annual leave or where we have specific workforce gaps. As noted in previous Board reports there are significant underlying physical capacity gaps within both Endoscopy (c27 lists per week) and Radiology (2nd static MRI) both of which require significant capital and could take up to 2 years to be fully operational.

As a short to medium term measure additional in-sourcing capacity has been secured for weekend Endoscopy sessions to protect in-week sessions for cancer and urgent patients. For radiology a second mobile MRI has been secured however this does not offer the same level of flexibility as that of a static MRI.

In addition to physical capacity; workforce constraints are also a leading factor in variable waits for a diagnostic test. Often tests are requested for a specific consultant to do or within radiology there is a capacity gap specific radiologists for example Head and Neck which when annual leave, etc is factored in can lead to a short burst of extended waits. The impact of changes to pensions and tax allowances has impacted in the main within Endoscopy where usual additional activity has reduced by c.50%. Within radiology the effect has been felt on the time to report scans.

Actions to address time to diagnosis

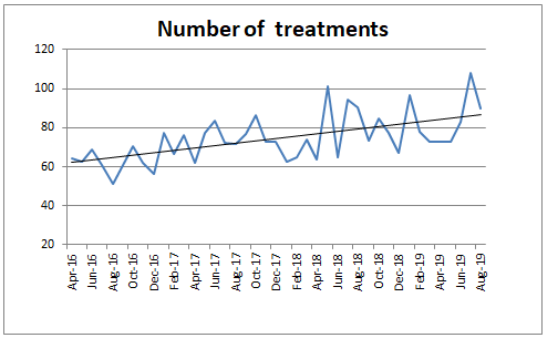
Tumour site / Action	Timescale	Month of Impact	Impact
Urology – Implement straight to test pathway	Complete	September 2019	Reduce wait by 10 days
Urology - D&C model for template biopsy	Complete – 6 week forward look at capacity in place	N/A	N/A
Urology – Increase template capacity by 2 cases per list	November – Fusion machine ordered	December 2019	Reduce wait by 7 days
Urology – Recruit nurse practitioner to undertake TRUS biopsies	Complete – in post from 11th October	November 2019	Sustain 5 day wait for TRUS biopsy
Urology – Increase cystoscopy capacity	Complete – additional capacity secured from the Independent sector	October 2019	Reduce wait by 10 days
Lower GI – understand feasibility to reduce time for CT colon from 14 days to 7 days	November	N/A	N/A
Lung – Introduce point of care testing	Business case to be completed in October and alliance funds secured	January 2020	Reduce wait by 5 days
Head and Neck – virtual review of diagnostic results	Complete	October 2019	Reduce wait by 3 days
Upper GI – Introduce point of care testing	Business case to be completed in October and alliance funds secured	January 2020	Reduce wait by 5 days
Upper GI - NUH to share weekly data on waits for EUS	September	N/A	N/A
Gynae – Audit appropriateness of hysteroscopy referrals	Complete – potential to reduce activity by 30%	TBC	N/A
Endoscopy – Secure additional insourcing capacity	Complete – in place in September	October	2WW capacity maintained

3. Treatments and Time to Treatment (31 days)

Year on year we continue to treat more patients with cancer (Table 5). Year to date 77% of patients have been treated within day 62, 85% have been treated by day 76.

We know that the vast majority of patients are treated within 31 days of the decision to treat, however many of our tumour sites are dependent on the specialist tertiary centre to ensure patients are ready (staged) for their treatment and to deliver the treatment. This is particularly evident in terms of staging for Upper GI and Lung patients; surgical treatment for Prostate and across all tumour sites for Oncology treatment.

Table 5: Volume of treatments from April 2016 to August 2019



	Full Year	Year to date
2016/17	776.5	307.5
2017/18	875.5	366
2018/19	964	414.5
2019/20		423.5

Days wait	April	May	June	July	August	Year to date
0-27 days	13.5	15	12	8	11	59.5
28-62 days	44	42	43.5	74.5	63	267
63-76 days	8	4.5	9	8.5	2	32
77-103 days	2.5	8	10.5	11	8	40
104+ days	4	4	5	6	6	25
Grand Total	**72**	**73.5**	**80**	**108**	**90**	**423.5**

Actions to address time to treatment

Tumour site / Action	Timescale	Month of Impact	Impact
Joint Urology and Oncology clinic	In place from 18th November	December 2019	Reduce wait by 10 days
Upper GI – Staging laparoscopies to be undertaken at SFHFT	In place	September 2019	Reduce wait by 10 days
Oncology – Agree revised SLA with NUH and re-allocation of activity	Quarter 3 2019	To be agreed	To be agreed

4. Performance Improvement

For the month of August performance against the 62 day standard was 82.2% this was the 2nd highest in the East Midlands Cancer Alliance with only 1 Trust delivering the standard. Our performance generally tracks better than the national position; but dipped significantly in 2 months (July 2018 and June 2019). It is well recognised that Urology impacts substantially on performance and in June 2019, if the volume of Urology breaches had remained within historical normal limits performance would have improved by 10.7% from 68.1% to 78.8%. Again in July 2018 if Urology had been within historical normal limits performance would have been 15% higher and would have delivered the standard. Many of the actions in the recovery plan continue to focus on Urology as we know it is a key tumour site to deliver sustainable performance.

Based on the actions in the recovery plan a trajectory has
been agreed with the CCG and shared with NHSI/E to deliver the following improvement:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
19/20 Trajectory	82.28%	85.20%	85.56%	80.65%	81.40%	85.06%	85.86%	85.06%	82.14%	83.70%	85.47%	85.23%
19/20 Actual	80.00%	77.40%	68.10%	76.40%	82.20%							
Revised Trajectory						71%	71%	73%	79%	78%	80%	82%
19/20 Quarter Trajectory			84.4%			82.4%			84.4%			84.8%
Revised Quarterly Trajectory			75.2%	*Actual Q1		76%			79%			82%

Assumptions:

- Volume of patients treated is based on previous 12 months activity
- Volume of breaches starts to decrease from December as the impact of the actions in the recovery plan will be in October/November for patients in the early stages of their pathway
- 15-20 diagnosed patients will continue to be in the backlog with 50% requiring treatment at the tertiary centre – the breach allocation will shift to the tertiary centre based on the actions in place to diagnose and transfer by day 38
- Historically patient choice is a key breach reason in the January performance position as patients delay treatment until after Christmas

In addition to the actions listed in the recovery plan, a senior member of the cancer services team has been assigned to undertake daily oversight of all day 90+ and day 42+ patients to identify and expedite any unnecessary delays. The impact will be to reduce the volume of patients waiting 104+ and 62+ days.

Risks to delivery

We know we carry a number of long term risks to sustainable cancer performance – notably physical capacity gaps within Endoscopy and Radiology. Other risks include:

- Continuing growth in demand
- Ability to implement short term mitigating actions (such as additional sessions) is reducing
- Underlying workforce capacity gaps compounded by sickness or annual leave
- Waits for surgery, oncology and pathology provided by the tertiary centre
- The impact of the phased roll-out of Lung CT checks from April 2020

Next steps

This paper has outlined the drivers for performance and the actions that can be taken now to reduce the wait to rule out or confirm and treat our cancer patients. A strategic paper is under development to review the dependencies and longer term capacity gaps that will require significant investment to deliver sustained cancer performance. This paper will be available for Board by the end of Quarter 3.

Helen Hendley
Deputy Chief Operating Officer (Elective Care)
October 2019