NHS Improvement

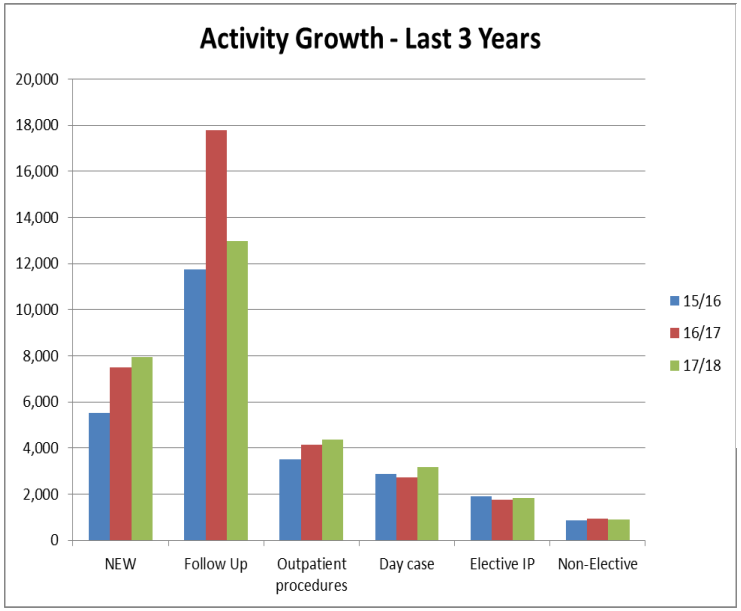
Yorkshire and Humber cancer stocktake

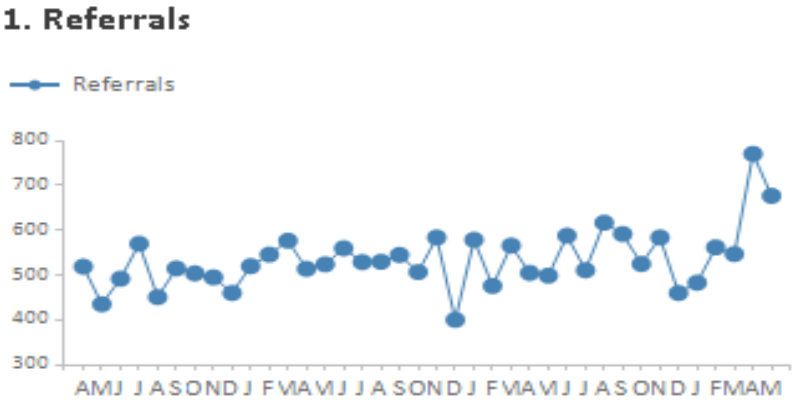
Introduction

- KLOE submission
  - What are the underlying issues?
  - What are the recovery actions?
  - What are the limiting factors?
  - What is a sustainable waiting?
  - What is being done and what can be done through collaboration?
  - What next?
- Discussion London South East Cancer alliance and Pennie Acute trust?

Underlying issues – HEYHT

- **Demand**
  - Increasing referrals in Skin and Urology.
  - Increasing size of PTL (from 900 to 1200)

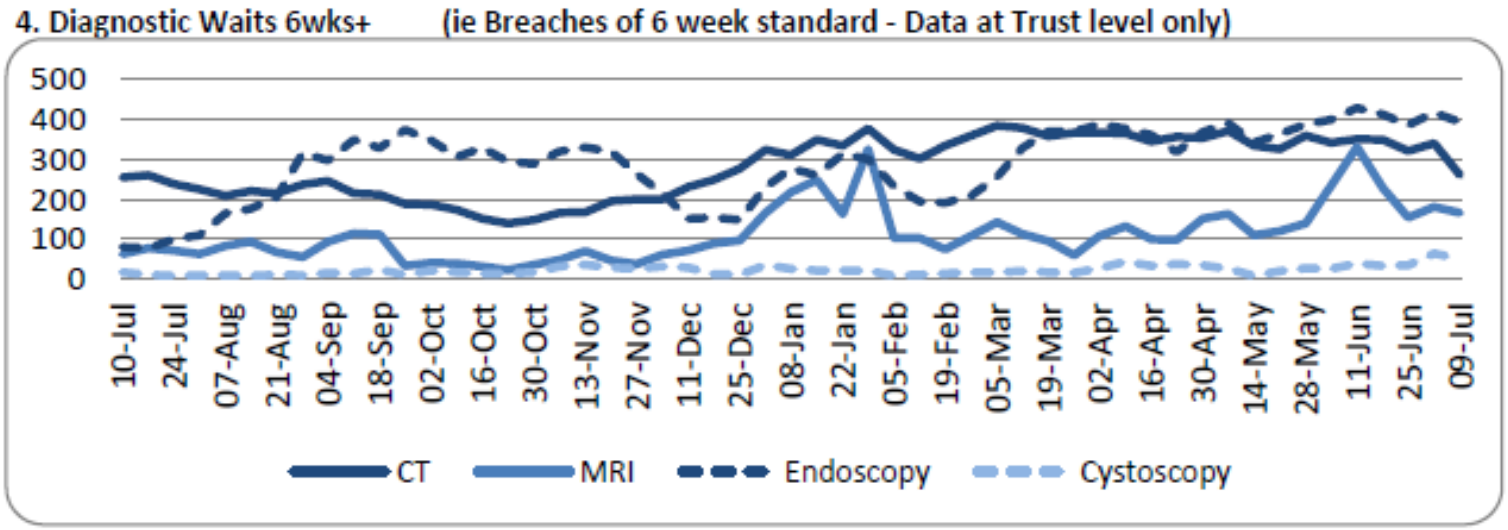




Underlying issues – HEYHT

- **Diagnostics**
  - Diagnostic capacity in CT/MRI/Cellular Pathology/Endoscopy.
  - Surgical robot capacity in Prostate.

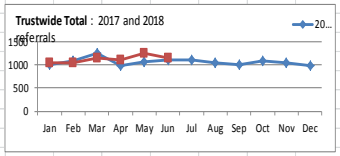
Diagnosis



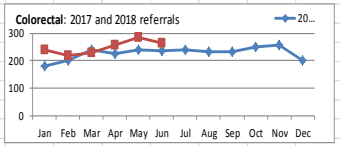
Underlying issues - NLAG

- Demand Increased levels of 2ww in some tumour sites above that anticipated

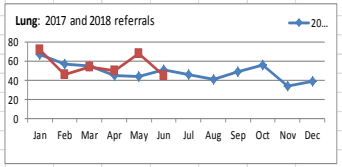
Trustwide total				
	2017	2018	Variance	% Var
Jan	1001	1039	38	3.80
Feb	1082	1044	-38	-3.51
Mar	1244	1152	-92	-7.40
Apr	973	1112	139	14.29
May	1058	1248	190	17.96
Jun	1107	1136	29	2.62



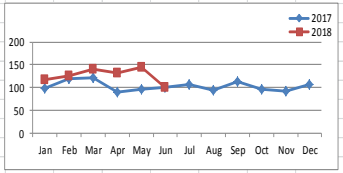
Colorectal				
	2017	2018	Variance	% Var
Jan	181	241	60	33.15
Feb	203	219	16	7.88
Mar	239	230	-9	-3.77
Apr	225	256	31	13.78
May	238	285	47	19.75
Jun	236	265	29	12.29



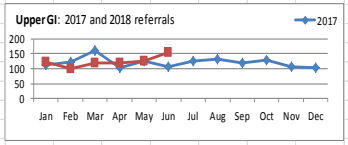
Lung				
	2017	2018	Variance	% Var
Jan	67	72	5	7.46
Feb	57	46	-11	-19.30
Mar	55	54	-1	-1.82
Apr	45	50	5	11.11
May	44	68	24	54.55
Jun	51	45	-6	-11.76



Urology				
	2017	2018	Variance	% Var
Jan	99	118	19	19.19
Feb	119	125	6	5.04
Mar	121	140	19	15.70
Apr	90	133	43	47.78
May	97	144	47	48.45
Jun	100	100	0	0.00



Upper GI				
	2017	2018	Variance	% Var
Jan	112	121	9	8.04
Feb	121	99	-22	-18.18
Mar	162	120	-42	-25.93
Apr	102	120	18	17.65
May	124	124	0	0.00
Jun	105	154	49	46.67



- 1st appointment booking by Day 7

Underlying issues - Continued

- Diagnostics – capacity to be able to reduce booking time from 14 days to 7 days (max) for patients on cancer pathways

		Analysis based on separate scans per body area (see note 2 & 3 above)			
Site	**Ultrasound Type**	**Requests per week (routine and urgent)**	**Current Capacity per week**	**Capacity Required per week (85%)**	**Shortfall per week**
DPoW	General	407	276	409	**133**
	Obstetrics	350	261	389	**128**
	Whole site	757	538	786	**248**
SGH & Goole	General	432	370	444	**74**
	Obstetrics	219	178	233	**56**
	Whole site	651	548	665	**117**

- Multiple tests per patient –repeated endoscopy tests, MRI and CT
- Late diagnosis – beyond day 62 of the pathway
- Pathology - capacity to report on all 31/62 marked samples within 7 days
- Surgical capacity at HEY (robotic prostatectomy).
- Oncology – capacity (delays in 1st appointment – visiting consultant service from HEY) – upto 21 days delay in pathways
- Late Inter Provider Transfers

Underlying issues - York

- Demand - Up 3.3% this quarter compared to Q1 last year, with significant rises in tumour sites already struggling with capacity -
  - Urological 29% increase in FT,
  - Skin 11.5% increase in FT,
  - Colorectal 11% increase in FT.

- Access to timely diagnostics.
  - The workforce gaps in diagnostics have been reported through the capacity and demand work, IST supporting with demand and capacity modelling.
  - Significant demand for **radiology** and **endoscopy** services, this is not unique to Cancer, and rises are being seen in acute, urgent and surveillance demand, which all contribute to an in balance of capacity and demand.

Recovery plans in place - HEYHT

- Rapid pathways for Lung via fast tracked Radiology – in place
- Rapid pathways in Urology via ultrasound and MRI. – Q3 2018
- Rapid pathways for PMB clinics in Gynae – in place
- Planned rapid pathway improvement in Colorectal in planning stage
- Review of PET scanning with a view to increase capacity – Q3 2018
- Increase capacity in MRI through hiring of mobile capacity – Q2-3 2018
- Recovery plans for **endoscopy** through **additional sessions**
- **Recovery plan** being pulled together for **robot capacity.** Business case for 2nd robot being prepared and full service review I embedded

Governance- HEYHT

- The plans are monitored at the **weekly Performance and Access meeting** for cancer. A number of actions are medium to long term such as specialist recruitment.
- Performance is also discussed at the **Cancer Operations Group** and the **Cancer Strategy Board**. The Trust Performance and Finance group receive a monthly report on Cancer performance, this group then reports into the Trust Board.

Recovery plans in place - NLAG

- The Trust is working towards reducing the 1st appointment and diagnostic pathways, however, the recent reduction in funding for cancer transformation monies within the HCV CA will inhibit progress.
- The top 5 actions:
  - **Vetting referrals** – reduction in unnecessary diagnostics/patient in right place first time
  - **Implement Best Practice treatment** pathways (faster diagnosis pathways)
  - **Capacity and demand** work across the pathway (using the IST toolkits)
  - Implementation of **risk stratified** follow up pathway s
  - **EBUS implementation** (part funded by HCV CA).
- Generic actions all tumor sites.
- **Tumor specific plans** – colorectal, lung, upper GI – medicine, upper GI – surgery, Urology (prostate pathway), skin,

Governance- NLAG

- **Weekly** reporting to Divisions/Executive Team through the **Cancer Performance Report**
- Monthly reporting to the Executive Team through the **internal NLAG Planned Care Board.**
- **Quarterly** monitoring through the **Cancer Board meeting** – by exception (areas/tumour sites going off track)
- Regular dialogue/escalation through the Chief Operating Officer highlighting areas/tumour sites going off track).

Recovery plans in place - York

- The **IST action plan** is currently being updated by the teams, this is based upon the self-assessment completed at the start of the year
- **Tumor site recovery plans** being refreshed which are based upon the implementation and monitoring of timed pathways.
- Requested support from NHS elect to help determine what the impact would be on routine radiological diagnostics to work towards improved turnaround times for Cancer Patients.
- Several initiatives with **primary care** to contain **demand** – this includes a pilot of **colorectal FT triage with Selby GP practices** in August, **refreshed urology FT referrals forms, skin – Dermatoscopes** and **GPSI training to enable primary care** to remove non-cancerous skin lesions and improve triage for FT referrals.
- **Additional capacity** is in place in **Endoscopy, colorectal, urology and skin through locums,** WLI and additional lists to manage the PTL. Trust relatively successful in delivering the 31 days surgery, but this comes at significant additional cost to the Trust.
- **Outsourcing** is in place for **radiology**, and this could be extended for endoscopy, but funding implications

Governance - York

- The Trust has a **Cancer Board** that has oversight of cancer performance and strategy.
    - There are a number of workstreams that report into cancer Board via workstream updated which provide oversight on delivery of plans against milestones.
- Escalations from Cancer Board should be taken to the Trust executive Board via the Lead cancer clinician.
- Directorate will also discuss Cancer Performance and delivery against the standards at the **Operational and Executive Performance Assurance Meetings** which are held with executive representatives and escalations can be made via this route.

Backlog clearance/ sustainable waiting list

York

- *Work underway with IST on demand and capacity modelling. Work is needed to understand the sustainable backlog.*

HEYHT

- The PTL is currently at 1200 patients and needs to be 950 to achieve the 85% target

NLAG

- 5% (56) of PTL (based on average 1136 on live ptl), a (% conversion rate to confirmed cancers, and estimated treatment of 80 average per month.

10 high impact changes

1. Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?
2. Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?
3. Does the Trust have a cancer operational policy in place and approved by the Trust Board?
4. Does the Trust maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast?
5. Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance?
6. Is root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching)?
7. Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out?
8. Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard.
9. Is the national guidance on reporting methodology being consistently applied? (NEW MAY 2017)
10. Has a clinical review of excessive waits been undertaken? (to support the elimination of >104 day breaches)

10 high impact changes

York

- Compliant with 4/10, partially 5 and one non compliant.
- The High impact changes were aligned to the original performance recovery plan, which is just being updated.

NLAG

- Compliant with 7/10 recommendation and partially compliant with 3.

HEYHT

- To be confirmed

PTL Monitoring

York

- **PTL supplied twice** a week to directorates, with a **weekly meeting (Tuesday)** to review all patients on the PTL. Each directorate manager and cancer tracker attends to provide an update on the plan, escalate any issues or actions that require corporate, radiological or histopathological support. An action plan is circulated straight after the meeting with updates required by Thursday. Any non-actions are reported on Friday to the COO and Directorates are asked to account for the delay (this has not happened since the process has been instigated).

HEYHT

- Performance is **monitored weekly** for all Health groups at the Cancer Performance and Access meeting. A **weekly meeting** for individual tumour sites is held with the Cancer Manager to review all high risk patients and agree actions to put them back on track.. All patients are discussed at the **tumour site MDT's** and waiting time issues are picked up in the clinical discussion.
- Tumour site performance is also discussed at each Health Groups individual performance meeting

NLAG

- There is a **weekly cancer PTL** meeting which is held on Thursday – there is a regular agenda detailing order and content of discussions. A generic PTL is produced on Wed afternoon and circulated so all participants are working to the same version of the PTL. The PTL (and the PTL meeting) covers all tumour sites and all cancer waiting times standards.

Limiting factors

- Competing demands for RTT, cancer, 62 day and finance
- Workforce shortfalls in histology, radiology and endoscopy
- Equipment shortfalls – diagnostics (radiology and endoscopy)
- Workforce shortfalls – Surgeons.
- MRI and CT capacity.
- Joint pathways with HEY and NLAG
- Finance – conflicting priorities
- Reduce transformational funding

Collaborative working

- A Partnership Group is being developed between NLAG and HEY – led by the Chief Operating Officer (supported by the Clinical Cancer Lead and Senior Cancer Manager) from each organisation. A potential limiting factor at present is the management capacity to put this in place.
- Informal cancer managers meeting
- IPT Co-ordinators
- Development of IPT pathways including the minimum diagnostic workup and dataset

Collaborative working - opportunities

- Early discussions have taken place between NLAG and HEYHT to divert benign cases to funded capacity in NLAG to free up additional operating sessions for Urology at CHH
- Dermatology are currently receiving support from NLAG who are providing additional consultant capacity to HEY.
- NLAG is having discussions with HEY re providing access to theatre capacity at Goole Hospital for non-cancer procedures, to free up theatre capacity at HEY for Urology cancer surgical treatments
- Willingness to collaborate and learn from each other – limited by time and head space, need to develop relationships and trust at managerial and clinical levels.

Collaborative working – areas for consideration

- A joint recovery plan:
  - Primary care demand.
  - Complex diagnostic pathways across multiple providers.
- Review of the urology pathway?
- Accelerate implementing cancer best practice pathways?
- IPT tracking
- Standardised access/ referral criteria
- There are limited arrangements across providers for working collaboratively on performance – role of the SPAM group?

Next steps?

- Facilitated session on ways of working and improving collaborative working
- OD work to improve networking
- Relationship building