University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board paper G

TRUST BOARD – 30th October 2014

Cancer Centre Highlight Report

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DATE:	23 October 2014
PURPOSE:	**To update the Board on UHL cancer performance and patient experience, and recommendations for improvement;** • Support is sought for the multi-faceted approach suggested for sustainable recovery in Cancer Performance (as set out in point 6), capable of recovering performance standard by December 2014 • Assurance is derived from the actions to mitigate risk as set out in section 7.0
PREVIOUSLY CONSIDERED BY:	**N/A**
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [Y] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [Y] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T
Patient and Public Involvement actions taken or to be taken in relation to this matter:	Establishment of patient user group to support the Patient Experience work plan
Equality Impact assessment undertaken in relation to this matter:	To be undertaken by user group
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [ ] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	For decision [X] For assurance [X] For information [X]

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

1.0 Executive Summary

The delivery of timely, high quality cancer care, as reflected by performance against cancer waiting times standards, was transformed during 2013/14 through a Cancer Centre work programme. UHL became a high performing cancer centre, sustained over 12 consecutive months. This transformation has been reversed abruptly, starting in Q1 of 2014/15.

Increased referral rates, particularly for breast cancer, have not been associated with an increase in cancers diagnosed, and so do not entirely account for the deterioration in performance. Referral rates for suspected cancer are likely to continue to increase, and this needs to be planned for.

Cancer pathways are complex requiring the integration and coordination of multiple services through diagnosis to treatment. The waiting times are short. Cancer pathways are therefore inherently fragile. Performance depends on process and systems that prioritise and expedite patients through these pathways.

The system for integration of care for cancer patients and promoting clinical engagement remains in place. Diagnostic support for the CMGs "hosting" individual types of cancer (tumour sites) remains excellent. Operating theatre capacity (surgery) and access to oncology services (radiotherapy and chemotherapy) are sufficient to support timely treatment for patients once diagnosed. Delivery of performance for individual types of cancer therefore lies within the gift of the host CMGs. The host CMG processes to support cancer pathways need to be effective in the face of parallel priorities. Cancer recovery plans from the CMGs produced at the end of Q1 have not resulted in recovery by end of Q2.

Welcome improvements in cancer patient experience at UHL across a broad range of measures are probably a reflection of improvements in the quality and timeliness of cancer pathways. Restoring the timeliness is therefore also a pre-requisite for continuing improvement to cancer patient experience in addition to recovering performance.

UHL has demonstrated the ability to deliver and maintain excellent cancer performance against waiting times standards. Learning from the recent experience of challenges in sustaining cancer performance whilst attending to other key priorities, the following actions are now agreed;

I. CMGs to assume and plan for a further 20% growth in urgent suspected cancer referral (2WW) over the next 12 months, and anticipate and accommodate peaks associated with awareness campaigns for individual types of cancer
II. CMGs to implement SOPs covering their internal structure and process to provide dedicated cancer pathway support
III. Monthly exception reports by tumour site where predicted performance not meeting internal standards to Cancer Board and Executive Performance Board.

2.0 Background and Introduction

In June 2013 after 6 consecutive months of not meeting the 62 day standard for the treatment of cancer patients referred under 2WW criteria the Cancer Centre was re-structured and undertook a programme of work to recover the standard. This programme focussed on the timely delivery of high quality clinical pathways rather than pushing through bursts of reactive additional activity, having agreed a cumulative recovery trajectory with the CCGs.

The main elements of this work programme were;

1) Establishment of a weekly Cancer Action Board (CAB) for the then CBU managers to develop and deliver recovery plans for the elements of cancer pathways they were responsible for.
2) Development of individual tumour site dashboards with performance data and patient level detail for those delayed on pathway to monitor and pro-actively manage care. Patients with delayed pathways were discussed individually with all relevant departments present at CAB meetings.
3) Introduction of a monthly clinically lead Cancer Board for clinical feedback on the challenges in delivering high quality and timely cancer care within UHL. The membership of this board includes the MDT lead clinicians for the individual tumour sites.
4) A transformational project within the imaging service to deliver 80% of cancer related imaging reports within 7 days of the request, compared with the previous 15%, was implemented

This work programme delivered 12 consecutive months of achieving cancer waiting times standards, and in particular the 62 day urgent referral to treatment standard at UHL. As the elements of the work programme gained traction performance continued to improve. UHL was in the bottom quartile for cancer treatment providers nationally in Q1 of 2013/14, and 7th of 7 peer large tertiary service acute trusts. In Q4 UHL was an upper quartile performer nationally, outperforming our peer organisations. The improvements in performance at UHL were achieved against a national picture of a gradual decline in performance against the 62 day standard.

This period of continuous improvement came to an abrupt halt with a sharp decline in 62 day performance by the end of Q1 of 2014/15, which has proved refractory to early measures taken to restore high performance.

This paper sets out;

I. A summary of current performance
II. A summary of the 2013/14 National Cancer Patient Experience Survey
III. An analysis of the causes of the deterioration in performance within UHL
IV. The planned recovery of the cancer waiting times standards

V. The measures in place to monitor and mitigate clinical risk associated with current performance

3.0 Current performance

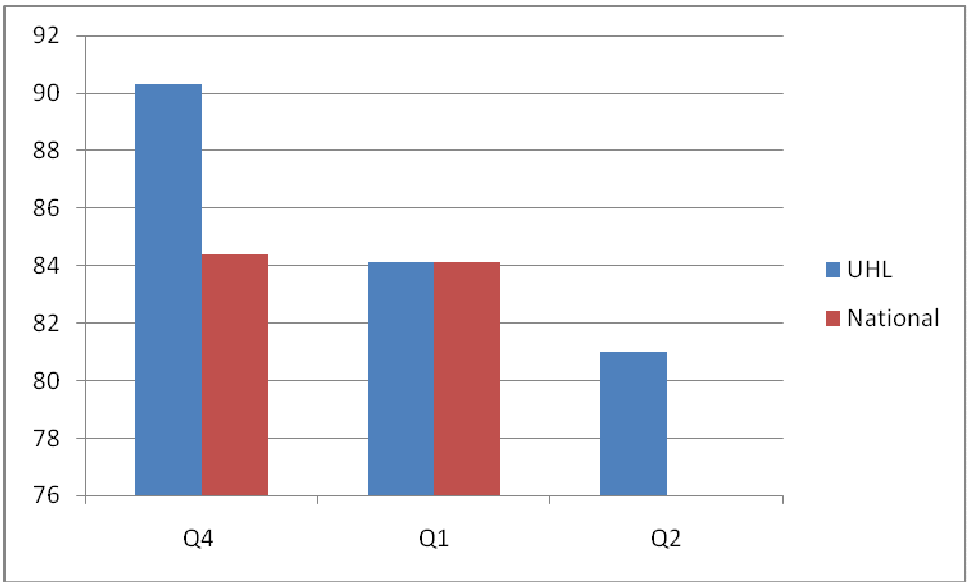
For the purposes of this paper the performance standards referred to are the 2WW urgent referral to appointment standard (93% to be seen within 14 days) and the 62 day urgent referral to treatment standard (85% to commence treatment within 62 days when cancer confirmed in a 2WW referral).

2WW performance for UHL over the last 3 quarters has been as follows;

Target	2013/14 Q4	2014/15 Q1	2014/15 Q2
93%	95.5%	92.2%	90.6% *

**Subject to final validation*

62 day performance over the same time reporting periods is set out in the graph below, with UHL benchmarked against national performance.



Target 85%, Q2 data for UHL subject to validation, Q2 National data not yet reported

A hallmark of the deterioration in 62 day performance is that pathways have been elongated relatively little. As an illustration of this, if a week was shaved off each patient pathway for those who breached the standard, performance in Q2 would have been met for Q2.

4.0 Results of the 2013/14 National Cancer Experience Survey for UHL

This annual survey comprehensively covers the cancer patient's experience of their journey from referral through diagnosis, staging, treatment and discharge through 70 questions.

UHL has seen a significant improvement in its results compared with the 2012/13 survey. In a marked "right shift" the scores for the overwhelming majority of these

domains have improved. As a result UHL is now “in the red” (lowest 20% of trusts) for 13 of the 70 domains, compared with 33 for the previous year. UHL is “in the green” for 2 domains (upper 20% of trusts) compared with none the year before.

A work programme is in progress, covering trust level and individual tumour site level actions as appropriate. This is coordinated by the Cancer Centre Lead Nurse. Central to a further stepwise improvement will be the establishment of a user group.

It is noted that performance and patient experience go hand in hand in so far as a timely service at a time of inevitable stress inevitably improves experience. Of particular interest is the improvement in the experience reported in relation to diagnostic imaging elements of pathways.

5.0 Analysis of the cause of deterioration in performance

A clear understanding of the internal and external factors responsible for the deterioration in performance is a pre-requisite to implementing an effective and sustainable recovery plan.

5.1 External factors

Referral rates

Increased rates of 2WW referral without an increase in the numbers of cancers diagnosed from these referrals effectively means that more resource is required per cancer diagnosed.

In detail;

The overall rates of new cancers treated at UHL have remained unchanged between months 1 to 5 of 2014/15 and the corresponding period in 2013/14 (captured under the 31 day first treatment target). The number of new cancers diagnosed as a result of 2WW referral during the same period is also unchanged (the 62 day target).

By comparison there has been a substantial increase in the rate of 2WW referrals – 11.7% higher in 2014/15 than 2013/14, which in itself comes on a background of a 14.6% increase in 2WW referrals in 2013/14 over the preceding year.

This equates to an additional 209 referrals per month with no additional yield in terms of cancer diagnosis.

This trust level data is summarised below:

	M1-5 2013/14	M1-5 2014/15	Change
2WW referrals(patients/month)	1,784	1,993	+11.7%
62 Day new cancers(Patients/month)	192	189	-1.5%
Conversion rate	8.9%	8.0%	-10%

The breakdown of this data by tumour site demonstrates that although this pattern is repeated throughout all the high volume 2WW referral sites (over 100 referrals per month) the predominant impact has come from increased referrals to Breast under 2WW.

	M1-5 2013/14	M1-5 2014/15	Change
Breast			
2WW referrals(patients/month)	360	537	+49.1%
62 Day new cancers(Patients/month)	32	35	+9%
Conversion rate	8.9%	6.5%	-2.4%
Gynaecology			
2WW referrals(patients/month)	171	206	+20.5%
62 Day new cancers(Patients/month)	7	11.4	+62.8%
Conversion rate	4.1%	5.5%	+1.4%
Head and Neck			
2WW referrals(patients/month)	140	154	+10%
62 Day new cancers(Patients/month)	7.4	5.6	-24.3%
Conversion rate	5.3%	3.6%	-1.7%
Colorectal			
2WW referrals(patients/month)	184	206	+12%
62 Day new cancers(Patients/month)	11.4	12	+5.3%
Conversion rate	6.2%	5.8%	-0.3%
Skin			
2WW referrals(patients/month)	271	308	+13.6%
62 Day new cancers(Patients/month)	23.8	26	+9.2%
Conversion rate	8.7%	8.4%	-0.3%
Gastro-oesophaegeal			
2WW referrals(patients/month)	140	154	+28%
62 Day new cancers(Patients/month)	13	13	0%
Conversion rate	9.3%	7.3%	-2.0%
Urology			
2WW referrals(patients/month)	192	191	-0.5%
62 Day new cancers(Patients/month)	31	26	-16.1%
Conversion rate	16.1%	13.6%	-2.5%

The National context in which the UHL performance should be considered is informative. Comparative data is currently only available for Q1 of 2014/15. 2WW performance nationally has fallen from 95.5% to 93.5% with referrals increased 18% over the same quarter in 2013/14. The conversion rate to a diagnosis of cancer had reduced from 9.5% to 8.5%. 62 day performance nationally deteriorated from 86.9% to 84.1% from Q1 2013/14 to Q1 2014/15.

There is a clear National drive led by government and cancer charities to promote cancer symptom awareness and early referral under 2WW for cancer exclusion. The rationale for this is that this drive will result in earlier diagnosis and therefore better outcomes. The tendency for late presentation and therefore more advanced stage at time of diagnosis is the key factor in the residual “gap” in terms of outcomes in cancer care between the UK and the rest of Europe.

The increase in 2WW demand therefore is likely to represent a sustained trend.

Tertiary referrals

As a large tertiary centre UHL receives a large number of referrals from other acute providers for specialist treatment. Inevitably these tend to be the more complex cases with a higher inherent risk of delays to pathways. UHL receives a substantial number of these referrals, often very close to or after their 62 day breach date, and this has a detrimental impact on trust level performance. However this has not abruptly changed, and therefore does not account for the deterioration in performance.

It is noteworthy that in support of the trust's strategic direction further developing as a provider of specialised cancer care robust and slick processes between providers will need to be in place.

Key examples include the introduction of robotic cancer surgery and centralisation in Leicester of specialised cancer multidisciplinary teams.

Oncology services

The Oncology service at Northampton General Hospital, also providing a service to Kettering, has experienced substantial challenges in recruiting and retaining clinical staff. In the interests of providing safe and high quality services to patients and in recognition of the close working relationship with our partners in Northamptonshire, the oncology service in Leicester has diverted significant resource to supporting the delivery of chemotherapy and radiotherapy to Northamptonshire patients. This has been closely monitored and not contributed to the timely delivery of chemotherapy or radiotherapy to UHL patients. A combined South East Midlands Oncology service with a unified management structure for Leicestershire and Northamptonshire patients will provide a sustainable solution to the oncology needs of the populations.

PET-CT imaging

The availability of CT-PET imaging, essential in the diagnostic phase for many patients suitable for radical treatment, has been variable and dependent upon a central contract through NHS England. Issues with capacity, booking and reporting processes and IT have all at various stages significantly delayed patient pathways and adversely affected performance to an extent.

5.2 Internal factors

Integration of services for cancer pathways

The system put in place which delivered 12 months of continuous improvements in cancer performance is still in operation. It is noteworthy that the representation provided by the services and CMGs provided for the weekly CAB meetings has drifted from General Manager/Service Manager to Service Manager/Operational

Manager and in general the empowerment to actively intervene in delayed pathways appears diminished in association with this.

Support for diagnostic and treatment phases of pathways

Imaging and histopathology provide timely and responsive services in support of the diagnostic phases of patient journeys. Theatre capacity and access to Oncology is adequate to support the delivery of timely treatments for cancer patients. It is therefore acknowledged that delivering cancer performance is within the gift of the CMGs and services which host individual tumour sites.

CMG administrative structure

The transformational work done with imaging to deliver rapid and responsive support of cancer pathways was underpinned by embedded structural change and detailed SOPs dedicated to cancer. Imaging performance for cancer pathways has remained consistently high.

As cancer performance is in the gift of the host CMGs to deliver for each cancer type, the CMGs were asked to produce recovery plans in June based on their analysis of patient level detail for patients who had breached the 62 day standard, with the brief of returning cancer performance to the level reported in Q4 2013/14 by the end of Q2 of 2014/15. These recovery plans have not resulted in improved performance to date.

Parallel priorities

It is likely that parallel priorities are detracting from cancer performance. It is not suggested that this is in any way due to conscious displacement of cancer activity, but rather due to the apparent lack of effective dedicated cancer administrative structure and processes within CMGs and services.

Clinical engagement

Clinical engagement with the delivery of high quality and timely cancer care remains high, in the face of the current operational delivery challenges.

6.0 Recovery Plan

1) Embedding dedicated cancer pathway procedures within CMGs;
    a. The model of the Imaging in Cancer transformation is used as the basis for the trust wide approach, as the work on structure and process required for this in 2013/14 was extensive and detailed, and currently stands out as an area of high performance for cancer.
    b. The CMG level cancer SOPs to cover internal structure, processes escalation procedures and Internal monitoring.
    c. The internal standards required for elements of pathways are;

i. Daily review of 2WW capacity available to meet peak daily referral demand.
ii. Internal diagnostic or staging procedures – endoscopy, biopsies, diagnostic surgical procedures – all patients to be offered procedure within 7 days of request.
iii. Treatments;
    a) Minor surgical treatments, within 14 days of decision to treat.
    b) Major surgical treatments, to be offered treatment within 3 weeks of decision to treat.
    c) Oncology – chemotherapy – to start within 2 weeks
    d) Oncology – radical radiotherapy – within 3 weeks
    e) Oncology – palliative radiotherapy – within 10 days
    f) ITAPS – pre-assessment within 3 working days of referral
    g) ITAPS - high risk anaesthetic assessment within 7 days

2) Representation at the weekly Cancer Action Board by all services required to support cancer care at service manager level.

3) CMGs and services to anticipate and provide capacity for a further annual growth in 2WW referrals at 20% per annum, and respond proactively to national cancer awareness campaigns.

4) A clinically lead review of cancer pathways is underway.

5) Working together with the CCGs, a clinically led review of cancer performance, focussing on 2WW referral criteria and practice.

6) In order to make sustainable performance for some of our most complex cancer cases possible, the trust is investing in an on-site PET-CT scanning facility with control of capacity and process to support pathways in the long term.

The prompt implementation of these actions will return cancer performance to standard by December 2014.

7.0 Mitigation of Clinical Risk (in light of current performance)

As highlighted above in the overview of performance, the elongation of cancer pathways has been relatively modest. It is reasonable to surmise that there is highly unlikely to be increased clinical risk associated with the deterioration in performance. Nevertheless measures to monitor and mitigate risk for patients with lengthy cancer pathways were put in place during the period of high performance, and these remain in place now;

- ***From day 34-39 on a 62 day pathway***

All 62 day pathway patients who reach day 34 without a confirmed treatment date within breach are discussed at a PTL meeting between the relevant service manager and the relevant Cancer Centre tracker to review the case and management plan.

- ***From day 40-62 on a 62 cancer pathway***

All patients within 3 weeks of breach date and without a treatment start date scheduled before breach date are discussed at the Cancer Action Board to identify and address avoidable delays in pathways. These patients are identified to the MDT lead clinician for the type of cancer and to the consultant responsible for the patient to highlight the risk of delayed treatment and offer support in dealing with any obstacles to care.

- ***From day 63-99 on a 62 day cancer pathway***

These patients are discussed first at the weekly Cancer Action Board and their care is prioritised over patients who have not yet breached, accepting the adverse impact this has on performance.

- ***From day 100 onwards***

All 100 day plus breach patients are referred directly for weekly review by the MDT lead clinician for the relevant cancer type, and discussed fortnightly in the formal setting of the MDT meeting. The purpose of this is to expedite management where possible, and obtain a clinical assessment of any potential harm caused to the patient by the delay. “Harm reports” are returned to the cancer centre, and any cases of potential harm are discussed at Cancer Board. To date no cases of actual or likely harm have been reported due to treatment delay.

These mitigations have been discussed at length during a “Deep Dive” review of Cancer Centre governance at UHL by our commissioners, and deemed appropriately rigorous.

8.0 Conclusions

UHL has demonstrated that it is capable of delivering high quality, timely cancer care reflected in recent high performance and improved patient experience.

The system for the integration of cancer pathways underpinning performance remains in place. Diagnostic services and treatment capacity are not rate limiting.

Overhaul of internal processes within CMGs will restore UHL to a high performing cancer centre by December 2014.

9.0 Recommendations/Actions

- This report to be noted

- Support is sought for the multi-faceted approach suggested for sustainable recovery in Cancer Performance (as set out in point 6)
- Assurance is derived from the actions to mitigate risk as set out in section 7.0