**Agenda item:** 9.2, Public  
**Date:** 31 July 2013

**Title:** 62-day Cancer Performance and Action Plan

**Prepared by:** Dr Christian Hamilton, Divisional Manager CWH & Cancer Services

**Presented by:** Em Wilkinson-Brice, Chief Nurse/Executive Director of Service Delivery

**Responsible Executive:** Em Wilkinson-Brice, Chief Nurse/Executive Director of Service Delivery

**Summary:** The paper provides a summary and analysis of the Trust’s performance against the cancer waiting times standards and the three consecutive quarter failure of the 62-day treatment standard along with the actions taken to bring the Trust back into compliance.

**Actions required:** The Board of Directors is asked to:
- Endorse the report.
- Endorse and approve the Trust wide cancer action plan.
- Approve the submission of this report to Monitor as part of the Q1 compliance submission.

<table>
<thead>
<tr>
<th>Status (*)</th>
<th>Decision</th>
<th>Approval</th>
<th>Discussion</th>
<th>Information</th>
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**History:** Cancer waiting times performance is considered by the Board of Directors in monthly integrated performance report and Board performance exception reports.

**Link to strategy/Assurance framework:** Cancer waiting times performance is an identified risk on the Trust’s Board Assurance Framework (BAF) C(iv).

### Monitoring Information

Please specify CQC standard numbers and tick ✓ other boxes as appropriate

<table>
<thead>
<tr>
<th>Care Quality Commission Standards</th>
<th>Outcomes</th>
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<td>Monitor</td>
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<td>Service Development Strategy</td>
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<td>Local Delivery Plan</td>
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Equality, diversity, human rights implications assessed

Other *(please specify)*
1. Purpose of the Paper
The Trust has breached the 62-day urgent GP referral to first treatment cancer standard for three successive quarters (Q3 12/13 – Q1 13/14) and as a consequence is at risk of being judged to be in regulatory breach of its licence. The purpose of this paper is to provide assurance to the Board of Directors that:

- The risk of failure of cancer targets was identified in October 2012 and action initiated to review all aspects of performance.
- Performance against the 62-day cancer standard has been comprehensively analysed and this is fully understood by the Trust Management Team and Board assurance can be taken from the actions and measures that have been put in place.
- The root causes of the three quarter failure of the 62-day standard are well understood and robust mitigating actions have been taken to ensure sustainable delivery in the future.
- The action plan to return the Trust to compliance has been externally reviewed by the Intensive Support Team (IST) who has confirmed it is robust.
- There is an ongoing programme of improvement work which will ensure sustainable delivery of all of the cancer standards as well as other improvements in efficiency and patient care.
- The operational infrastructure is in place to support the delivery of the plan.
- The performance management infrastructure and accountability has been strengthened.
- The performance monitoring mechanisms and patient tracking processes have been significantly improved.
- Trust wide engagement with the cancer agenda at all levels has improved and the general understanding of cancer performance targets within the wider management team is fully embedded.
- Patients have not been exposed to additional clinical risk as a consequence of the failure to achieve cancer performance targets.

2. Background
The Board of Directors will be aware that between April 2011 and October 2012 the Trust had consistently achieved all of the cancer waiting times standards on a quarterly basis (see Table 1 below). In October 2012 the Chief Nurse/Executive Director of Service Delivery commissioned the Cancer Services Directorate to undertake a high level review of cancer pathways as part of a systematic review of all time based performance targets. At this time there were no obvious signs that continued achievement of the cancer performance standards was at risk.

In the November Board report non-achievement of the 62-day standard in October was reported along with the prediction that the quarterly performance was at risk as a result. This ultimately led to the first quarterly failure of this standard since Q4 of 2010/11. The November Board report also detailed the completion of the internal review which had been commissioned (See Appendix A Internal Review Report).
The margin for achieving the 62 day cancer target was identified as reducing and in January 2013 following confirmation of the Q3 2012/13 failure of the 62-day standard, the Chief Nurse/Executive Director of Service Delivery commissioned an external review of cancer waiting times performance from the Intensive Support Team (IST). The recommendations contained within the IST report (Appendix B) were incorporated with the recommendations from the internal review and a rigorous and robust Trust wide cancer action plan (Appendix C) created. This was reported to the Board of Directors together with the monitoring arrangements of performance against the action plan.

In February 2013 it was reported to the Board of Directors that the January performance across a number of the standards had deteriorated significantly. In Q4 2012/13 four cancer targets were not achieved on a quarterly basis. Two prime reasons for the multiple failures were identified:

- The first related to an administration error identified within the Plastic Surgery Department. Immediate action was taken to deal with the resulting backlog of patients requiring treatment. No patients came to any harm as a consequence of the delay; however there was a significant impact on the number of breaches of the 31-day subsequent surgical treatment target as a result. The failure and subsequent action was reported to the Board and Council of Governors.
- The second related to the introduction of robotic surgery for prostate cancer patients which attracted additional patients to the Trust, many of whom a significant proportion of their 62-day allocation had already expired. Delays with individual robotic prostate patients were found to count against multiple cancer standards, particularly the 31 and 62-day standards.

The Board of Directors will recall that a discussion took place regarding the possible restriction of robotic surgical referrals and it decided that referrals of all appropriate patients, irrespective of the number of days through their pathway, should continue to

### Table 1 – Cancer waiting times performance April 2011 – June 2013

<table>
<thead>
<tr>
<th>Target</th>
<th>Q1 11/12</th>
<th>Q2 11/12</th>
<th>Q3 11/12</th>
<th>Q4 11/12</th>
<th>Q1 12/13</th>
<th>Q2 12/13</th>
<th>Q3 12/13</th>
<th>Q4 12/13</th>
<th>Q1 13/14</th>
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<tr>
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<td>93%</td>
<td>93</td>
<td>112</td>
<td>121</td>
<td>76</td>
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<tr>
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<td>131</td>
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<td>110</td>
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<tr>
<td>First Treatment: All Cancers Breaches</td>
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<td>12</td>
<td>2</td>
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<td>122</td>
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<tr>
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<tr>
<td>First Treatment: Consultant to Imaging or Service Referral Breaches</td>
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<td>29.5</td>
<td>42.0</td>
<td>42.0</td>
<td>42.0</td>
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<tr>
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be accepted despite the negative impact this has on waiting times performance because the treatment provided is best practice care and in the patient's best interest.

Progress reports against the cancer action plan have been provided to the Board of Directors on a monthly basis and were supplemented by a workshop in May 2013 to ensure the Board of Directors had a full understanding of the cancer targets and the actions taken to ensure patients were not exposed to clinical risk as a consequence of the cancer standards non-compliance. In addition the performance against the cancer targets was reported to the Council of Governors at their February 2013 and April 2013 meetings. A seminar workshop similar to that provided to the Board of Directors was held for Governors in July 2013. The Council of Governors endorsed the Board’s decision to continue to accept all patient referrals irrespective of the number of days they are through their pathway.

The IST continues to support the implementation of the Trust’s cancer performance plan for one day per month. Feedback following the IST’s most recent follow up visit in May 2013 was that the IST was pleased that the majority of recommendations made from the diagnostic visit had now been completed.

3.0 Analysis

3.1 Cancer Waiting Times Standards

The Trust’s cancer performance is monitored across a range of eight cancer standards each of which is monitored externally on a quarterly basis. These targets fall into three broad categories of two week waits (2ww), 31-day treatments and 62-day treatments (see Table 1 above for a full list of the standards and their targets).

3.1.1 Multiple Targets

The Board of Directors will recall from the workshop session provided to them by the Cancer Services Directorate Management Team at the May 2013 Board meeting that the make up of the cancer standards, and the way in which they overlap, is particularly complicated. The diagram below taken from that workshop outlines how a single patient can potentially be on multiple pathways and can affect performance of several of the cancer standards.
3.1.2 Aggregated Performance
Each cancer standard is the aggregated position of all of the relevant tumour sites for that target. For the 62-day standard some tumour sites have generally short patient pathways (i.e. Breast) while others such as Lower GI and Urology have more complex and generally longer pathways. The target tolerance is designed to take these differences into account when aggregated.

3.1.3 Small Numbers
For the majority of the standards, the numerator and denominator values are constituted from very low numbers of patients and this means that very small changes can significantly affect performance and variation from month to month is high at individual tumour site level.

3.1.4 Pausing the Clock
Unlike other waiting time targets patient choice to defer or delay treatment for personal/social or a clinical decision to delay the diagnostic phase in the best interest of the patient, do not enable the clock recording the patients journey to be paused. Holiday periods are a particular issue when capacity is naturally reduced and patients’ availability is limited. In response to this, Directorates create additional appointment and operating capacity where possible in the weeks prior and immediately after holiday periods to provide more choice for patients. However within a 14 day period there is very little time within which to create additional capacity and no guarantee that patients will accept the dates provided.

3.1.5 Inter-Provider Transfers (IPTs)
The Royal Devon and Exeter NHS Foundation Trust (RD&E) accepts inter-provider transfers of cancer patients who require specialist treatment available at the Trust. In doing so the cancer waiting times clock which is started in the initial referring Trust continues until the patient is treated at the RD&E. Any
breach of the cancer standards is shared (0.5 breach each) between the referring provider and the treating provider.

3.2 Key Issues Affecting Performance
The detailed analysis of performance undertaken has identified there are a number of key issues which have significantly affected the Trust's performance across a range of the cancer waiting times standards. This section summarises these issues and also highlights the key actions taken to date to resolve or mitigate them.

3.2.1 Robotic Prostate Surgery
The single biggest impact on the Trust's 62-day performance has been the introduction of robotic surgery for the treatment of prostate cancer.

The Board of Directors approved the purchase of a DaVinci robot in October 2012 and the Trust appointed a robotically trained Urology consultant in January 2013. Within the robotics business case it was anticipated that patients who had previously travelled to Bristol for their surgery and that would now be treated in Exeter would have a small negative impact on waiting times performance as any waiting time breaches that were previously shared with Bristol, would now be entirely attributed to the RD&E. What was not fully anticipated was the impact of patients referred from neighbouring Trusts such as North Devon and Torbay, many of whom are referred at a point where they are very close to, or beyond their 62-day breach date. The Trust is currently undertaking a Post Project Evaluation (PPE) of the introduction of robotic prostate surgery which is due for completion in September 2013 so that lessons can be learnt for future service developments.

The result of the introduction of robotic surgery for prostate patients was that the average number of Urology breaches increased from an average of 4 per month to an average of 10 per month. The impact of this in percentage terms for an average month is an overall deterioration of 5.7%.

The graph below shows the impact this has had on the Trust's 62-day performance.
The impact of robotic prostate surgery was also significant on the 31-day standard where the average number of breaches increased from 1.5 per month to 6 per month. The impact of this in percentage terms for an average month is an overall deterioration of 2.2% and was a major factor in the failure of this standard in Q4 of 2012/13.

Despite the impact on cancer waiting times performance the Board of Directors has continued to support the introduction of robotic prostate surgery because of the strong clinical evidence and improved patient experience and clinical outcomes. The Board of Directors is also supportive of continuing to accept patients from neighbouring Trusts to provide a best practice local treatment option for these patients.

### 3.2.2 Urology Actions
The whole Urology team has fully engaged with this important performance issue and has worked extremely hard to mitigate the impact of robotic surgery.

Key actions taken to date:
- Development of a new scheduling spreadsheet specifically for robotic prostate patients which is managed daily to ensure capacity is created to deal with the demand.
- Introduction of a weekly Patient Target List (PTL) meeting consisting of the Clinical Service Manager (CSM), MDT coordinator, Cancer Nurse Specialist (CNS), lead secretary and lead consultant to proactively manage every cancer patient, pulling them through their pathway as quickly as possible.
- Introduction of three session robotic operating lists to increase capacity to deal with the backlog.
- Creation of a nurse-led one stop TRUS biopsy service, increasing capacity and shortening the pathway at the very beginning.
3.2.3 Plastic Surgery Administration
In January 2013 a problem with administrative delays and a backlog of patients waiting to go on the waiting list within the Plastic Surgery department was identified. An urgent review was undertaken and all of the delayed patients were contacted within a matter of days and given dates for surgery. Unfortunately this resulted in multiple plastic surgery patients breaching their 31-day subsequent surgery target dates which contributed to the failure of this standard for Q4 2012/13.

A root cause analysis of the administrative issue was undertaken by the Lead Nurse for Cancer and the final report and recommendations provided to the Deputy Chief Nurse for review and development of an action plan. All of the resulting delays have now been resolved and this is no longer an issue in terms of cancer waiting time performance. No patients were exposed to increased clinical risk as a consequence of the delays.

3.3 Additional Improvement Work
In addition to the actions detailed above to deal with the key performance issues, Appendix D details additional work undertaken to deliver improved and sustained compliance against the cancer standards.

3.4 Patient Safety Assessment
Patient safety and clinical benefit has been at the centre of the Trust’s approach to the management of the cancer target performance. Performance breaches have been risk assessed. The Clinical Director for cancer services has reviewed patient care to ensure that the longer waits had not diminished the chances of treatments being effective. No incidences have been found of patients being delayed to the detriment of their clinical outcome. The continuing scrutiny of all patient records where a breach has occurred will assist this assurance process as will the continuous monitoring of all patients’ progress on treatment pathways by the treating teams. The corporate and regulatory risks associated with failure of the cancer targets is registered on the Board Assurance Framework.
4. Current Performance
Actions taken to date have impacted positively on performance as detailed in Table 2.

Table 2. Cancer Waiting Times Performance Dec 2012 – June 2013

<table>
<thead>
<tr>
<th>42 Day</th>
<th>All Cancer Two Week Wait</th>
<th>Breaches</th>
<th>Total</th>
<th>Breaches</th>
<th>Total</th>
<th>Breaches</th>
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<tr>
<td></td>
<td>93%</td>
<td>71</td>
<td>800</td>
<td>77</td>
<td>886</td>
<td>61</td>
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<table>
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<th>Breaches</th>
<th>Total</th>
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<th>Breaches</th>
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At the time of writing this report the Trust has achieved seven out of the eight standards in June including achievement of the 62-day standard for the first time in six months. 62-day performance has improved by over 10% on the previous month. It should be noted that the final upload of June data to Open Exeter has not yet happened and this can result in small changes in the numbers as other providers upload their breaches.

4.1 Assurance of Sustained Compliance of the 62-Day Standard
Early signs suggest the actions taken to address the underlying drivers of failure are effective. The target has been achieved in June 2013; the first month to achieve for six months. Not all patients who will require treatment within 62 days during Q2 will have been referred yet, so robustness of any future performance forecast is constrained by a significant element of “known unknown”. For these reasons the Board cannot be given assurance of sustained compliance with the 62-day standard for Q2 2013/14. Whilst there is increasing confidence based on the actions taken to date, it would be unwise to predict when sustained compliance will be achieved on the back of one month’s improved performance. Assurance will be more robustly predictable through Q2 as more performance data becomes available.

5. Resource/legal/financial/reputation implications
This section details any resource, legal, financial or reputation implications that will apply following the failure of any of the cancer standards.

5.1 Regulatory Compliance
Non-achievement of the following cancer waiting times standards in any quarter are scored as follows:

- 14 day urgent GP referral and/or 14 day symptomatic breast, 0.5 points
- 31 day first definitive treatment, 0.5 points
• 31 day second or subsequent treatment (surgery) and/or 31 day second or subsequent treatment (drug treatments) and/or 31 day second or subsequent treatment (radiotherapy), 1 point
• 62 days first definitive treatment for GP urgent referral and/or 62 days first definite treatment for referrals from NHS Cancer Screening Services, 1 point

These scores along with non-achievement scores for other Monitor Compliance Framework indicators are added together and used to produce a the Governance Risk Rating as follows.

For a score of:
• < 1.0, the risk rating is Green
• ≥ 1.0 and < 2.0, the risk rating is Amber/Green
• ≥ 2.0 and < 4.0, the risk rating is Amber/Red
• ≥ 4.0 the risk rating is Red
• In the event that a 1 point target is failed for three consecutive quarters an override risk rating of Red will be applied.

The Trust has failed the 62-day target for 3 consecutive quarters and the Board has declared Red for the Q1 2013/14 Governance Risk Rating Submission to Monitor. Monitor will review this declaration within the terms of the Compliance Framework 2013/14 and consider whether to override the red rating or commence an investigation.

5.2 Financial Penalties
The financial contract penalty for the non-achievement of any of the following cancer waiting times standards in any quarter (2% of the actual outturn value of the service line revenue).
• 14-day urgent GP referral
• 14-day symptomatic breast
• 62-days first definitive treatment for GP urgent referral,
• 62-days first definite treatment for referrals from NHS Cancer Screening Services
• 62-days first definitive treatment for Consultant Upgrades (from Q2)
• 31-day first definitive treatment
• 31-day second or subsequent treatment (surgery)
• 31-day second or subsequent treatment (drug treatments)
• 31-day second or subsequent treatment (radiotherapy)

It is currently estimated that failure in Q1 of the 62-day GP urgent referral to treatment cancer standard will result in a financial penalty of £9k (subject to commissioner confirmation).

5.3 Patient and Public Confidence (Reputational Risk)
Failure to achieve this target has been discussed in an open and transparent manner with the full presence of the public at Board and Council of Governor meetings. Members of the public present at these meetings have supported the Board’s decision to act in the best interest of patients and accept all patients who would benefit from robotic prostate surgery. Should a formal regulatory investigation be launched this has the potential to generate negative publicity and undermine patient confidence. Key partners, Governors and patient groups are aware of the current situation and the actions the Trust is taking and a robust communications plan will be developed to ensure a fair reflection of the Trusts cancer services is provided.
6. **Link to BAF/Key risks**
Failure of the cancer waiting times standards was approved onto the BAF by the Board of Directors in June 2013 under the strategic objective “maintaining operational service delivery”. The risk also sits on the corporate risk register ID1141. The risk is reviewed monthly by the Divisional Manager and the Head of Governance. The mitigating actions are outlined in the Trust wide cancer action plan and the body of this report.

7. **Summary and Conclusions**
This paper has presented to the Board of Directors specific sections which provide information upon which they can be assured that:

- Recent poor performance against the 62-day cancer standard has been comprehensively analysed and the reason for this is fully understood by the Trust Management Team and Board assurance can be taken from the actions and measures that have been put in place.
- The root causes of the three quarter failure of the 62-day standard are well understood and that robust mitigating actions have been taken to ensure sustainable delivery in the future.
- Patients have not been exposed to additional clinical risk as a consequence of the failure to achieve cancer performance targets.
- The action plan to return the Trust to compliance has been externally reviewed by the Intensive Support Team who has confirmed it is robust.
- There is an ongoing programme of improvement work which will ensure sustainable delivery of all of the cancer standards as well as other improvements in efficiency and patient care.
- The operational infrastructure is in place to support the delivery of the plan.
- The performance management infrastructure and accountability has been strengthened.
- The performance monitoring mechanisms and patient tracking processes have been significantly improved.
- Trust wide engagement with the cancer agenda at all levels has improved and the general understanding of the cancer waiting times standards within the wider management team is fully embedded.
- The target has been achieved in June 2013 the first month to achieve for six months. The early signs are positive for Q2 however the Board cannot be given assurance of sustained compliance with the 62-day standard for Q2 2013/14.

8. **Proposals**
- The Board of Directors endorse the report.
- The Board of Directors endorse and approve the Trust wide cancer action plan.
- The Board of Directors approve the submission of this report to Monitor as part of the Q1 compliance submission.
List of Appendices

Appendix A – Internal Review of Cancer Pathways
Appendix B – Intensive Support Team Cancer Diagnostic Review
Appendix C – Trust Wide Cancer Action Plan
Appendix D – Additional Improvement Work
Appendix E – Cancer Performance Dashboard
Appendix F – Diagnostics Action Plan
1. **Introduction**

This paper provides a high level review of cancer patient pathways at the Royal Devon and Exeter (RD&E) from the perspective of the Cancer Services Directorate. It has been requested due to the corporate risk of failing cancer waiting times targets and the difficulties encountered in delivering a robust monitoring and assurance framework. The primary aim of this report is to highlight the elements of the patient pathway that regularly experience pressure and that contribute to delays in the patient pathway and to provide some options and recommendations for improving flow, efficiency and, where possible, quality.

2. **Background**

The RD&E has consistently achieved a high quality service for the majority of cancer patients with excellent outcomes and high levels of patient satisfaction. The Trust provides specialist centre services over a number of tumour sites with pathway and governance responsibility, which is challenging for the Cancer Services Directorate to manage across multiple Directorates within the Trust as well as with external organisations/Trusts.

More recently the ability to sustain this has been a challenge and is most noticeable in the 62 day cancer pathway where there is a risk of failing the target on a monthly, and more worryingly, a quarterly basis. A considerable amount of additional admin and management time is spent retrospectively validating and correcting data errors which is time that would be better spent proactively managing patients through to treatment as quickly as possible and/or redesigning pathways.

Developments in cancer treatments as well as National initiatives and natural disease growth are starting to outstrip capacity despite the Trust continuously striving to improve cancer pathway efficiency and productivity.

3. **Starting a Cancer Pathway**

Patients can enter onto a suspected cancer pathway through a number of routes:

- Routine GP referral
- GP 2 week wait (2ww) referral for suspected cancer
- National screening programmes (Breast, Bowel, Respiratory etc)
- Consultant to consultant referral (incidental discovery of cancer)
- Inter-provider transfer from another Trust
- Emergency admissions

The Trust receives over 10,000 2 week wait referrals each year of which fewer than 1500 are found to have cancer. It should also be noted that these account for only half of all the cancers that are diagnosed each year.

Cancer and non-cancer referrals mostly come through the Choose and Book (C&B) system although paper based and fax systems still exist in specialties. Whilst the C&B system is used for the referrals the appointments are mostly made here via the 2 week wait office. Capacity for slots is variable across the various specialties such that not all appointments are able to be booked online through the C&B system. Urgent 2ww referrals not booked through C&B are currently faxed through to the 2ww office. If there are no slots available then additional capacity is created to accommodate the demand. Following a recent incident of lost faxes, the Directorate is currently trying to move away from using a fax system and on to an NHS e-mail
system, but this relies on each GP practice having an e-mail address that they look at on a daily basis.

For this system to work efficiently through C&B there would either need to be sufficient 2ww slots available on C&B to eliminate the need for a fax or e-mail based backup, or consultants will need to review C&B referrals on a daily basis to effectively triage and direct them to the most appropriate clinic/diagnostic appointment as has been introduced successfully in the lower GI cancer pathway.

All cancer referrals are registered on the cancer waiting times (CWT) tracker when they come through the 2ww booking office and start a 62 day cancer clock. Real-time tracking information is critical to providing the visibility of where patients are within their pathway such that patients can be pulled through the system effectively and blockages or delays dealt with expeditiously.

Recommendations:
- Create sufficient 2ww slot capacity in all specialties to eliminate the need for an alternative referral route outside of C&B.
- Integrate the tracking system into normal booking systems to eliminate data entry issues and reduce duplicate admin workload.
- Use only the C&B system for the management of 2ww referrals but in the interim utilise NHS e-mail to eliminate the use of fax referrals.

Within a complex cancer pathway where breaches can occur by a matter of days, a two week wait for an initial appointment with a specialist can prove to be too long and instantly puts pressure on the remainder of the pathway. Moving elements of the diagnostic phase into primary care would enable the Trust to more appropriately and swiftly direct patients to the right healthcare professional and start treatment more quickly. The very start of the cancer pathways needs to be redesigned in line with an emergency pathway such that access into secondary care is almost instant; changing the concept that two weeks is an acceptable wait when cancer is suspected.

The greatest number of ultimately diagnosed cancers does not come through the 2ww system but are referred to the hospital routinely. This effectively means that prioritisation of 2ww suspected cancer referrals disadvantages routinely referred patients who later go on to be diagnosed with cancer. In the longer term it would not seem unreasonable to move all symptomatic referrals to be seen within two weeks to provide the best possible outcomes for all cancer patients as has been introduced for breast patients. This would require designated specialist time, possibly with diagnostic support, and triage of referrals each working day.

Recommendations:
- Redesign pathways to enable instant access to cancer diagnostics and treatment.
- Reduce routine symptomatic referral times to within two weeks.
- Explore options to expand GP direct access to diagnostics.

On the whole, pathways and processes between the Trust and the National screening programmes work well. However, any new screening modality adds significantly to the Trust’s diagnostic workload without necessarily improving patient outcomes or increasing the number of cancers diagnosed. The biggest pressure comes when there are additional National awareness campaigns such as the recent Bowel Cancer awareness campaign which resulted in a very large increase in demand for endoscopy with no increased pick up rates of cancer. Further awareness
programmes are planned in respiratory and bowel along with an age extension of the bowel cancer screening programme, all of which will put additional pressure on the front door of these services and has the potential to delay the diagnostic phase of genuine cancer patients as well as increasing delays to patients on surveillance of suspected cancer. It is expected that the Government will announce an additional bowel cancer screen with a flexible sigmoidoscopy offered to all at 55 years old. Commissioners will be expected to look at all potential providers to deliver the necessary increase in endoscopy services.

Some cancer referrals such as colorectal are triaged by consultants and go “direct to test”. With other cancer pathways such as sarcoma, patients are planned to be first sent to radiography for diagnostic imagery prior to being seen by a consultant. This will create an additional workload for radiology and dedicated capacity for cancer patients is not currently ring-fenced such that delays can occur if routine activity is already fully booked. Carving out small amounts of ring fenced slots is inefficient and can lead to wasted capacity so a much larger cohort of patients is required to make this practical.

Recommendations:
- Plan additional diagnostic capacity well in advance of go live dates for awareness campaigns.
- Prioritise cancer referral triage and diagnostic capacity above routine elective workload.
- Ring fence diagnostic capacity for cancer patients including the reporting of the diagnostic test results.
- Provide daily consultant grading/triage of cancer and non-cancer referrals in all specialties.

Other than through a 2ww referral, cancer pathways are started as soon as a cancer is suspected or diagnosed through any other route. At the point that a consultant suspects a patient may have cancer he/she can upgrade the patient and start a new 62 day upgrade pathway. At present this is often not recorded or registered on the cancer tracker and results in suspected cancer patients not being prioritised through the system as quickly as they should and also results in an under recording of 62 day upgrade pathways. Currently the 62 day upgrade pathway is not reported to Monitor but this is likely to change in the future so presents a risk as it is not regularly achieving this target due to pathway delays and low denominator numbers.

Recommendations:
- Integrate cancer tracking into normal working practice so that upgrades can easily be picked up and recorded at source.
- Education of all clinical staff as to the process for upgrading a patient when cancer is suspected.

4. 2ww Booking Office
The role and process of the 2ww booking office is complex and time-consuming mainly due to the current systems and processes relating to the number of 2ww referrals coming in from GP practices by fax, sometimes in duplicate or triplicate. All referrals are added to the relevant pending list on the Patient Administration System (PAS) and added to the cancer tracker. Different hospital sites have different pending lists which further complicates the process. Each speciality has different clinic codes and booking rules for 2ww patients. There is a further complexity for patients referred to the upper and lower GI tumour sites in that referrals initially come in to the 2ww booking office and are subsequently sent to Endoscopy who triage the
referral; those patients who require an appointment are then sent back to the 2ww office to make the booking. Those patients who require a colonoscopy or gastroscopy are booked by Endoscopy who then let the 2ww booking office know the date of the diagnostic procedure to update the cancer tracker and stop the 2ww clock. The lack of outpatient capacity in a number of specialties results in booking staff constantly having to chase the clinical Directorates for additional slots. The delay in getting appointments made first time result in additional phone calls from GP practices requesting an update on patients’ appointments which further adds to the workload of the booking staff. Once an appointment is made the 2ww office informs the GP practice of the date of the appointment by fax.

Accommodation for the existing 2ww booking office staff is currently an issue as they are housed in a cramped environment in Noy Scott House which makes management of the service difficult for the Directorate as it is physically distant to the management team. There are also issues around cover for annual and sick leave with only one member of staff currently with the expertise to manage the whole process.

Recommendations:

- Relocate 2ww booking staff within oncology/haematology to enable better cross cover working and provide additional expertise.
- Endoscopy department to make 2ww appointments directly and add patients to the cancer tracker rather than sending them back to the 2ww office.

Inter-provider transfers (IPT) are initiated by Trusts referring patients to the RD&E for treatment. The Cancer IPT forms are in addition to any RTT IPT forms as they contain more detailed information e.g. clock start, decision to treat and breach dates. This information is vital for completing the cancer tracker and should be added and updated in a timely way. The RD&E also complete an IPT form when referring patients to other Trusts for treatment. It is also the responsibility of the treating Trust to complete the treatment details and date of treatment so that the referring Trust can update records and predict any shared breaches. There is a standard IPT form in use which has been agreed by the Peninsular Cancer Network. The forms are sent by e-mail between MDT co-ordinators who are responsible for updating the cancer tracker and also for returning treatment information to referring Trusts in order for those Trusts to complete their data entry. Trusts share 62 day breaches where a patient has not been treated within the required timescale. Problems can occur when an IPT form hasn’t been received and the Trust is only made aware of a shared breach when the referring Trust uploads their information on to Open Exeter. This issue is likely to get worse as the Trust extends the range of specialist services it provides for a wider geography of patients.

5. Cancer Waiting Times (CWT) Tracker and Cancer Register

Information relating to the audit and tracking of patients with suspected and diagnosed cancer is currently managed on two separate systems; Dendrite and the CWT tracker, the latter of which was developed and is maintained by the RD&E’s Application Development Team.

Both systems take demographic information from the Trust’s PAS but are otherwise very much reliant on manual data entry from Cancer Audit Facilitators, MDT Co-ordinators, Clinical Nurse Specialists, IM&T staff and Medical Secretaries in order to capture cancer registry information for national audits and to gather patient tracking information used to manage cancer patient pathways and waiting times. Using two separate systems to collect this vital information is inefficient, time consuming and unwieldy and the variety of staff groups involved in collecting the required data often
do so retrospectively. Running two unlinked systems is inefficient and data entry involves significant repetition. Use of multiple systems also increases risk of data transcription errors or omissions as staff believe they have updated information but it has not linked to the relevant system. Timeliness of data entry and data quality needs to be improved in order to help mitigate the risk that the Trust will miss national waiting time targets.

Recent admin staffing shortages especially within the surgical Directorates has led to delays in cancer patient pathways. These delays are often only visible after the event as the cancer tracker is updated subsequent to the delay occurring as admin backlogs are cleared. The introduction of MDT coordinators for each cancer site has made a significant difference and this will continue to improve as they become fully embedded in their roles but a large proportion of the process is still reliant on medical secretaries.

Managing cancer pathways is currently a resource intensive activity, with staff required to access and update cancer tracking and audit systems whilst logging in and out of PAS and Pathology/Radiology systems to view the full spectrum of clinical and administrative information held for each patient. Integrating radiology or pathology results into the existing cancer audit and tracking systems is not currently feasible. Results are held as unique records and do not relate to specific pathways or patient events. As the Trust implements further elements of the integrated Electronic Patient Record (EPR) information across the record will become accessible and more efficient to manage and the cancer waiting times tracker and cancer register data need to be integrated into that system.

The existing cancer register hosted on the Dendrite system has outgrown its usefulness in its current format. Demands for increased data in terms of quantity and complexity have not been matched with system development. Data requirements have grown due to a number of national initiatives with the development of revised and expanded datasets, drive to improve data completeness for cancer staging, expanded national tumour specific audits and regional reporting requirements. Risk assessment has highlighted that the Trust is vulnerable to failing to meet its cancer data reporting responsibilities. This risk is currently mitigated by a considerable amount of manual data collection and data validation.

Steps have been taken to improve this situation. Vacancies in the cancer audit team have been filled and there has been an expansion in the number of whole time equivalent posts. The audit team is also utilising the Dendrite tool to revise databases to meet new reporting requirements due to be introduced in January 2013. Further development of the cancer register would help to increase the efficiency of this work by linking registers and providing a more useful tool for data collection in the MDT meeting. This would streamline processes and reduce the risk of multiple data sources.

It would also be advantageous for Clinical Nurse Specialists and other healthcare professionals to have the facility to electronically record within the single cancer information system:

- Patient contact information (valuable for their workload analysis)
- Patient interactions
- Relevant social information (such as carers contact details)
- Clinical information relevant to National cancer audit projects
The introduction of a single system for recording cancer data and to meet CWT reporting requirements would bring a much needed improvement in efficiency and in the accuracy of data collection. This would bolster the success of cancer tracking by incorporating reporting requirements into a clinical data system.

**Recommendations:**
- Procure a single designated system which would collect data on all patients to facilitate the patient pathway tracking and fulfil the cancer register information requirements.

6. **Cancer Waiting Times Performance Monitoring**

The current timetable for production of cancer waiting times figures for the Board report is generally three weeks after the month end. Collation of the number of breaches and percentage compliance takes place within the first ten days after the month end. The reports by which breaches are provided are from the CWT tracker and produced by the Cancer Services IM&T analyst. These reports are sent out on the 1st of each month to the Directorate leads who validate the information and report back to the CSM for Cancer Services as to whether the breaches are correct. Sometimes the information on the CWT tracker has not been updated therefore what appears in the report to be a breach may not actually be correct and vice versa. A more detailed validation is then carried out by the Cancer Services Directorate for patients with complex pathways and any queries over clock starts and stops are resolved. This involves the Clinical Director for Cancer Services along with the Cancer Services DM, CSM and ASM to combine knowledge of the CWT guidance with clinical expertise. Sign off is then required from the relevant treating specialty Directorate.

Central reporting to Monitor of cancer waiting times is via a system called Open Exeter. The number of breaches (numerator) and cancers treated (denominator) is uploaded by IM&T approximately 6 weeks after the month end. The information is again taken from the CWT tracker at the time of the upload. Due to this system being 'live' and changes being made at any point in time, the number of breaches can change from when the figures were reported to the Board. It is usually at this point that further validation is required from the Cancer Services Directorate to corroborate the position.

All of this extensive validation is a huge drain on management resources that could be significantly reduced if all aspects of the patient pathway were recorded correctly in real time. Ownership of the patient pathway and any potential breaches within the treating specialty Directorates is variable as the majority of monitoring and responsibility is currently with the Cancer Services Directorate.

**Recommendations:**
- Set specialty specific stretch targets and trajectories to drive improvement and ownership of cancer waiting times targets within treating specialty Directorates.
- Integrate cancer PTL information and discussion into the weekly RTT PTL meetings.

7. **Multidisciplinary Team (MDT) Discussion**

The appointment of dedicated MDT coordinator support has significantly improved the functionality of the MDTs over the last few months and will continue to add more value as the knowledge and understanding of the team develops further.
Appendix A

Several of the MDTs are done through a video conference with another hospital such as Torbay or North Devon and some MDTs videoconference with more than one hospital simultaneously. This provides an efficient mechanism for as many clinical professionals as possible to discuss cases across a wide geography which is proven to add value to patient care and clinical outcomes. The video conferencing equipment is obviously essential to this process but the Trust has continued to have serious IT and equipment issues with the current videoconferencing systems.

As and when the equipment fails, considerable time is spent by the Cancer Services management team trying to fix the problem without any dedicated audiovisual technical support. The MDT room is used by many disciplines outside of Cancer Services and often the equipment is misused or mishandled resulting in malfunction, the cost and chaos this causes has an impact on the affected MDTs, on the delivery of cancer services and on our reputation with outside organisations who we provide specialist MDT support to.

Recent failure of the equipment has meant that many MDTs have had to be rearranged or moved to another room where there is the necessary equipment. This is extremely disruptive and has on occasions caused delays in patients' treatment. All of the videoconferencing systems within the Trust were purchased over a period of time by different teams and are from different companies which also add to the problem when they fail as each company has different support/maintenance contracts and response times.

Delays to patient pathways can occur if all of the core team members are not consistently available. Provision of cover for holidays and sickness is also an issue for certain core members of an MDT due to the sub-specialist nature of the work and is made more complicated with multi-trust MDTs.

Having reliable and robust videoconferencing facilities to communicate with partner organisation has great potential to make much more efficient use of all staff time and save money. If the Trust is to work more closely with any organisation a single support service for both ends would possibly save on costs and increase reliability. All Trusts have teams working to provide robust cancer governance. This Trust has a good reputation for this and potential savings could be made by sharing and rationalising how governance is delivered across our partner organisations.

Recommendations:

- **Over time, replace all of the videoconferencing equipment with one technology provider.**
- **Explore options of joining forces with other Trusts who share our MDTs both in terms of V/C equipment but also the Governance arrangements for MDTs.**
- **Explore the recent developments in video technology alongside new internet based telephony system.**
- **Appoint an on site IT Audio/Visual support technician to maintain all videoconferencing equipment. This service could be shared with organisations.**

8. **Diagnostics**

The provision of adequate diagnostic support with access to appointments and specialist opinion is critical to the smooth expedient flow of patients through their cancer pathway. Retrospective analysis of cancer breaches has identified a significant number are as a result of delays in the diagnostic phase of the pathway.
Appendix A

The Diagnostics Directorate provides a high quality efficient diagnostic service to support a full range of medical and surgical disciplines. This includes processing, scanning, analysing, diagnosing, monitoring, reporting, performing biopsies and supporting cancer staging on a daily basis. The histopathologists and radiologists prepare for and attend numerous weekly MDTs to discuss diagnosis and advise on patient management.

Supporting and managing cancer related referrals and specimens is challenging. The current pathology information system is unable to provide user friendly audit or SLR functions for laboratories like histopathology. Turnaround times and on-going treatment and care can be hampered by specimen delivery delays and paper results not being delivered directly back to the requestor. Patients on a 62 day pathway are not always flagged to the laboratories as urgent. Urgent “orange card” referrals to Radiology for suspected or newly diagnosed cancer cases on 31/62 pathways have increased by over 100% in the last year. Proposed changes to the sarcoma pathway from April 2013 whereby patients will be sent directly to Radiology first, including redirected imaging from Torbay will increase the workload further. Routine musculoskeletal (MSK) and CT waiting times are increasing through new work and greater demand for 7 day turnaround times while also being asked to ‘ring fence’ appointments for cancer referrals. An increase in more complex options for treatment, volume and complexity of work while ensuring continued delivery of safe high quality reports in the short timeframe for MDT review is ever more challenging.

Manual analysis by the MDT coordinators and the Cancer Services Directorate is required to understand where diagnostic delays have happened. Newer pathology and radiology systems have the capacity to flag all cancer diagnostic test results to the MDTs directly and instantly which will reduce the reliance on waiting for paper reports to be seen and actioned.

Cellular Pathology
This diagnostic histopathology service provides support to the full range of medical and surgical disciplines. There is weekly attendance at twelve cancer MDT meetings to discuss diagnosis and advice on patient management. This includes teleconferencing to partner DGHs. There is a key partnership with adjacent Molecular Genetics department to support diagnostics in oncology and haematology patients.

The department supports haematology bone marrow biopsy reporting as well as providing an on-site urgent frozen section reporting service to support a wide range of surgical departments, including availability at weekends and bank holidays. Diagnostic cytology supports the full range of medical and surgical disciplines. This includes biomedical scientist’s attendance at endoscopy lists (EBUS and pancreatic EUS). The cervical screening service is provided by a high quality laboratory with the latest HPV testing technology.

Blood Sciences
The Blood Sciences department provides an extensive range of diagnostic tests including:

- FBC results for Haemato Oncology inpatients analysed and reported early morning (results before 9am) to allow assessment for blood product requirements and FBC results for Haemato Oncology outpatients and daycase provided on site immediately
- FBC results for other oncology patients performed daily pre-chemo therapy and radiotherapy, results available within in 1 hour
Coagulation required for some chemo patients
Proteins for Haematology patients
Flowcytometry is used for Haematology diagnosis and monitoring
Flowcytometry is essential for monitoring patients for stem cell transplants and product QC
Bone marrows are mainly required for haematology and diagnosis
Stem cell processing for high dose chemo therapy support for haematology patients

The highest users of blood products are oncology patients and most oncology patients on treatment require renal function, liver function and bone profiles on a daily basis. Diagnosis of several cancers is aided by tumour markers and drug levels are monitored in the department to avoid toxicity levels.

Recommendations:
- Procurement of a new pathology information system with the ability to provide audit, SLR information and histology reports electronically.
- Process review of sample delivery and results to requester to highlight delays and streamline current working practices.
- Routinely flag all patients on a 62 day pathway as “urgent” for Histopathology.
- Review the increase in orange card referrals and encourage the use of order communications to ensure timely and appropriate “urgent” referrals are received by Radiology.
- Support business case for a 4th MSK consultant.
- Improved CWT reports showing patient level pathway delays relating to potential or actual diagnostic delays that can feed into the weekly Diagnostic PTL meetings.

9. Cancer Treatments
Once diagnosed, cancer can be treated in a multitude of ways with many permutations and combinations that cross multiple departments and include:
- Radiotherapy/Brachytherapy
- Surgical/Medical Treatments
- Chemotherapy
- Palliative Care
- Other drug therapies (ie hormone therapy)

Radiotherapy
Radiotherapy treatment options have increased exponentially over the last 10 years with new modalities being developed all the time to enhance patient outcomes. Often the result of these new treatment options is an increase in complexity to plan the patients and in treatment time or treatment frequency resulting in capacity pressure for the associated departments. There are currently 3 linear accelerators (Linacs) in operation at the RD&E with plans for a 4th in the next 18 months.

Growth in radiotherapy capacity has been modelled locally and nationally and is predicted to grow by 4% by 2014. Modelling via the Malthus capacity and demand tool confirms that 3.5 Linacs are needed to deliver the required radiotherapy activity in 2013 and that 4 will be needed by 2014.

So far this year, activity is already 4% up on plan with 6507 fractions (472 courses) of Linac activity being delivered in Q2 compared to 5791 (413 courses) in the same quarter of last year. This year, radiotherapy activity has been moved to a block
contract ahead of new mandated PbR tariffs being released for 2013/14 which will provide both risk and opportunity in equal measure. This will be done in a staged way to mitigate risk to both providers and commissioners but is expected to better remunerate for complex planning treatments such as with Intensity Modulated Radiotherapy (IMRT) and Image Guided Radiotherapy (IGRT).

Both IMRT and IGRT have been introduced in line with National guidance and commissioning expectations. These techniques take significantly longer to plan and deliver than conventional treatments. However, the rate of implementation of these treatments has been slow and the Trust is currently unable to meet the target set by the National Radiotherapy Advisory Group (NRAG). Blockages include insufficient Consultant Oncologist time for complex planning, a lack of computer processing power and the need for the Physics team to do lengthy patient specific Quality Assurance (QA) checks which have to be done outside of normal clinical time. Commissioners will have rising targets of proportion of treatments which should be delivered in these ways. They should also attract an enhance tariff to reflect the complexity and time required to deliver.

The National Cancer Action Team (NCAT) has launched a Radiotherapy Innovation Fund which is aimed at supporting delivery of IMRT and achievement of a 24% reverse planned IMRT treatment target from April 2013. Tim Cooper has been asked to meet each Radiotherapy Service Manager to discuss what support would be helpful. He will attend with members from clinical teams already delivering at, or near to, appropriate levels of IMRT delivery in the hope of providing practical solutions as well as reviewing the Trust’s bid for investment.

Current the Radiotherapy Department is challenged in its ability to start radiotherapy treatment courses within the waiting time targets due to a treatment capacity shortfall. Continuing with the implementation of IMRT and IGRT and also introducing 4D adaptive radiotherapy is adding further pressure to the system and takes up more treatment time that could be used to deliver a greater number of patient treatments.

Recommendations:

- Provide a comprehensive bid to NCAT for additional resources relating to IMRT circa £250k. The Trust will need to support this bid with additional revenue resources to achieve the target of 24% from April 2013.
- Commence a period of extended day working in order to increase capacity. This will help to meet waiting time targets whilst at the same time meeting new commitments to the IMRT expansion programme.
- Move medical physics routine maintenance and quality control (QC) work on the Linacs outside of core working hours. This was originally funded within the business case for the 3rd Linac but is no longer on the scoreboard and will require a new CRIC.
- Move to an 8:00 am handover of the Linacs from medical physics to enable an additional 30 minutes per day per machine of treatment time.
- A quick decision needs to be made by the SCG on the location of the 4th Linac so that service delivery plans can be made.

Brachytherapy

The expansion of brachytherapy treatments continues to create capacity pressures and challenges in its delivery. The Trust is required to:

- Provide Prostate Interstitial Brachytherapy in conjunction with Urology such that the number of patients planned for is maintained (80 pa).
Appendix A

- Provide Image Guided Brachytherapy for cervical cancer according to Clinical guidelines.
- Provide brachytherapy for all other patient groups as referred in line with peer review and clinical guidelines.
- Maintain all waiting time targets for Brachytherapy.

For prostate interstitial brachytherapy there is a risk of cancer breaches as there are only 2 sessions per week which does not always prove sufficient. These patients will always have a course of hormones first but this is sometimes already complete when the patient is referred to an oncologist. Pathway improvements are being worked on with other referral teams in Torbay, Truro and Taunton to speed things up and avoid waste and duplication.

**Recommendations:**
- Approve brachytherapy business case when presented at next Exec group meeting.
- Continue to work with neighbouring Trusts to improve the pathway for Brachytherapy patients.

**Radiotherapy Staffing**

The Radiotherapy Department has experienced significant staffing shortages this year due to long term sickness and an inability to recruit into senior posts. Locum use has been required to cover the shortfall while recruitment has been progressed. The department is now fully established but the increased demand is still causing pressure on overtime payments. Tight budget management has prevented this from creating an overspend so far this year but will not be manageable going forward if demand continues at the same rate.

There is insufficient protected radiotherapy planning time in the Clinical Oncologists job plans. This is especially critical for the new complex treatments such as IMRT where planning time has increased hugely. Treatment delays and breaches have occurred as a result of delays in getting the planning completed in a timely way. Some of this pressure will be eased with the appointment of a new part time clinical oncologist in January but there are competing demands on oncologist time. The Trust’s job planning exercise is already highlighting a degree of unremunerated overworking by the existing clinical oncologists in an attempt to keep up with demand. There is a considerable risk here of a cost pressure on medical staff budgets if all consultant activity was fully remunerated in addition to the investment that is required to deal with growth. The planned provision of an acute oncology service will also require additional consultant time commitment, which is currently being modelled.

Radiotherapy Physics staff have also been under recruited which has prevented the possible move of routine planned maintenance and quality control of linear accelerators outside normal clinical time.

**Recommendations:**
- Consolidate future predicted income growth now in order to resource radiotherapy and clinical oncology time in the most cost effective way and to deal with the demand which is above plan.
- Review SLAs with Torbay and N.Devon to appropriately remunerate the Trust for activity undertaken on their behalf and ensure PAs within Oncologist job plans are funded correctly.
• Explore options with neighbouring Trust such as Taunton about combining clinical oncologist resources and cover arrangements in single operator tumour sites such as Head and Neck.

Accommodation
The lack of clinical and office space continues to be challenging. Outpatient clinic space has been maximised and the release of an additional clinic room has been achieved by a reshuffle opportunity presented by the CT simulator extension. Office accommodation is very cramped with some consultants working in converted cupboards and others sharing cramped space with their secretaries. Location of office accommodation in the vicinity of the clinical areas is crucial to the efficient and effective delivery of care and supervision that this co-location provides.

The reduction in space in the chemotherapy day case suite (Cherrybrook) has had a knock on effect in the outpatient clinic area resulting in a large number of patient complaints and negative feedback.

Recommendations:
• Plan replacement of Cherrybrook with expanded facility and additional office capacity.
• Extend the working day and week to maximise utilisation of clinical space.
• Further move low risk infusion work to community and/or primary care setting (although this might negatively impact on income).
• Scope the feasibility of creating an RD&E homecare provider model.
• Review room utilisation and allocation between Oncology and Medical Physics departments to maximise usage.

Chemotherapy
Inpatient adult chemotherapy is provided for in Yeo and Yarty wards while daycase activity is delivered in Cherrybrook and Yarty Daycase. Chemotherapy growth and the use of supportive medicines in this cohort of patients continue to increase and are predicted to do so for the next ten years. Previous disease sites that were not treated with, or chemotherapy was limited for, such as Prostate, Lung and Upper GI have now all been expanded with many drugs that can now be accessed due to NICE recommendations and the Cancer Drug Fund.

Currently the RD&E is the highest user in the South West of the Cancer Drug Fund and quite often the drugs being requested are new and experimental in many cases, and by the nature of this are complex in their delivery requirements.

To maintain inpatient capacity across Cancer Services all chemotherapy regimens where appropriate have been transferred to the daycase units. However, concurrent treatment with both chemotherapy and radiotherapy is increasing the pressure on space especially with the loss of the end of bay of Cherrybrook, as many of these patients are in the unit for the day therefore reducing the chair capacity for other patients. The loss of the end bay on Cherrybrook also means that on a day to day basis it is very difficult to flex the workload within the department as was previously possible. Many of the patients requiring daycase treatment are very frail, ill and do require to be able to lie down. On top of this, the department also manages its own emergency admissions which do have an impact when the beds are reduced.

Recommendations:
• Use of homecare delivery of chemotherapy where appropriate, pilot starting with Herceptin November 2012.
Appendix A

- Review of supportive therapies being delivered closer to home December 2012
- Development of an Advanced Nurse Practitioner (ANP) in oncology to mirror that in Haematology
- Development of AOS to potentially reduce length of stay

Haematology
Although haematology daycase activity is increasing, the department have developed nursing roles to support this increase in activity and overall the Haematology pathway redesign work continues to enable the absorption of additional workload at minimal extra cost.

Surgical & Medical Treatment
The RD&E provides surgical and medical treatment of colorectal, upper GI, breast, urology, skin, lung, head and neck/thyroid, sarcoma and gynaecology cancers. Surgical capacity for cancer treatment is generally protected from the bed pressures within the hospital especially evident through the winter. However, while the capacity may be protected the quality of service provided on the surgical wards is affected by winter pressures and was evident in the Cancer Patient Feedback survey this year which showed a drop in patient satisfaction related mainly to ward care and courtesy of ward staff.

General capacity pressure, both for outpatient and theatre slots, does routinely result in a number of cancer breaches for certain cancer tumour sites. Common areas of pressure are Gastroenterology (Endoscopy), Colorectal Surgery, Dermatology and Urology. Super sub-specialisation in some of these tumour sites also adds a level of complexity and an inability to effectively cover leave or sickness/absence.

End of Life Care
Due to the End of Life National Strategy which was written in 2008 there has been an increase in awareness of the end of life care provision within the acute sector and achieving the preferred place of care. The RD&E currently have a pilot Discharge Palliative Care Team working within the organisation which will be evaluated at the end of the twelve month period (April 2013) to hopefully secure funding for the future.

The overall aim is to reduce active patients dying in the acute hospital by 10%. This target will be difficult to achieve as there are no current levels to benchmark against however the aim is to be ensure that the Trust provide the preferred place of care to 70% of its patients.

ADASTRA is an electronic register for the care of these patients which is currently being rolled out at the RD&E. It is expected to enhance the pathway across the healthcare communities and improve communication and therefore reduce, where appropriate, acute admissions.

10. Partner Organisations
The Trust currently provides a range of cancer pathways and treatments in partnership with the following Trusts:
- North Devon Healthcare NHS Trust (Barnstable)
- South Devon Healthcare NHS Trust (Torbay)
- Taunton & Somerset NHS Foundation Trust (Taunton)
- Yeovil District Hospital NHS Foundation Trust (Yeovil)
- Dorset (Dorchester)
Appendix A

- Plymouth Hospitals Trust (Derriford)
- Cornwall & Isle of Scily Hospitals Trust (Truro)
- United Hospitals Bristol

The flow of patients between different hospitals adds an additional complexity to a cancer pathway. Issues that regularly arise when dealing with pathways between Trusts include:
- Lack of transfer information and IPT forms
- Uncertainty of cancer clock status
- Delays in transfer of notes, referral letters and other admin processes
- Differences in interpretation of the cancer guidelines which can result in breaches being mis-appropriated

Capacity issues in other Trusts such as Torbay are often expected to be filled by the RD&E i.e with Oncologist. This is especially an issue at present as Torbay has lost one of their Oncology Consultant’s yet the RD&E provide their service and Clinical Lead (Dr Bliss) but are not directly consulted about how they staff the Department at present. This provision of cover can compromise the RD&E’s ability to deliver the required levels of activity and care for its own patients and puts an extra burden on to the clinical staff involved.

11. Charitable Organisations
The Trust has excellent relationships with a number of third sector organisations including ELF, FORCE and Macmillan. Maintaining these relationships has led to a significant amount of additional funding and resource that has provided additional quality and efficiency to our cancer services and should not be underestimated. We score very highly in our Cancer Patient Survey results for the support these organisation give to them.

12. Peer Review
The intended outcomes of the National Cancer Peer Review (NCPR) programme are to:
- Confirm the quality of cancer services
- Allow speedy identification of shortcomings
- Publish reports that provide accessible public information about cancer services
- Provide timely information for local and specialised commissioners
- Validate information available to other stakeholders

The NCPR Programme is an integral part of the “Improving Outcomes - A Strategy for Cancer” published in January 2011. It supports quality assurance of cancer services and enables quality improvement. The Manual for Cancer services is used to support the NCPR process. This incorporates recommendations from NICE Improving Outcomes Guidance for Cancer Services as well as more recent guideline documents and quality standards. All teams are required to undertake an annual self assessment of compliance against such standards.

Fourteen teams completed a self assessment exercise against cancer standards this year. Nine teams demonstrated an improvement in the reported level of compliance, four teams maintained their level of compliance and one team demonstrated a decreased level of compliance. In addition, four of the self assessments were subject to an internal validation exercise whereby self assessments were reviewed by an internal panel to provide assurance of a robust process. The validation
Appendix A

exercise confirmed the outcomes of the self assessment exercises for the four teams involved.

Teams identified thirty concerns across fourteen different topics. The validation process noted a further three concerns. One serious concern was noted via the validation process. This related to the availability of radiology cover for Skin MDT meetings.

Recommendations

- **Diagnostics Directorate to work with Cancer Services and Skin MDT to address serious concern relating to lack of named radiology cover at MDT meetings**
- **Directorates hosting individual MDTs to be given the responsibility for completing work plans and achieving compliance with cancer standards. Updates to be provided via Quarterly Review**

13. Summary

Cancer patient pathways touch on almost every service and department in the hospital and require an intense amount of communication and coordination in order for patients to move seamlessly and effortlessly between healthcare professionals, admin teams, diagnostic providers and support services. They are very much the embodiment of a service that is centred on the patient but with this comes a challenging set of issues which require whole system and whole organisational alignment to make continuous improvement possible.
### 13. Summary of Recommendations

<table>
<thead>
<tr>
<th>Subject</th>
<th>Recommendation</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Booking</td>
<td>Create enough 2ww slot capacity in all specialties to eliminate the need for an alternative referral route outside of C&amp;B.</td>
<td>Directorates requested to produce plans.</td>
</tr>
<tr>
<td></td>
<td>Integrate the tracking system into normal booking systems to eliminate data entry issues and reduce duplicate admin workload.</td>
<td>Exploration of upgrading existing cancer database with a view to piloting in colorectal.</td>
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<tr>
<td></td>
<td>Use only the C&amp;B system for the management of 2ww referrals but in the interim utilise NHS e-mail to eliminate the use of fax referrals.</td>
<td>Agreement to implement NHS-email system with DART.</td>
</tr>
<tr>
<td></td>
<td>Relocate 2ww booking staff within oncology/haematology to enable better cross cover working and provide additional expertise.</td>
<td>Currently exploring accommodation options.</td>
</tr>
<tr>
<td></td>
<td>Endoscopy department to make 2ww appointments directly and add patients to the cancer tracker rather than sending them back to 2ww office.</td>
<td>Discussions with Medicine required.</td>
</tr>
<tr>
<td></td>
<td>Redesign pathways to enable instant access to cancer diagnostics and treatment.</td>
<td>Further discussions with Diagnostic Directorate required.</td>
</tr>
<tr>
<td></td>
<td>Reduce routine symptomatic referral times to within two weeks.</td>
<td>Discussions with relevant specialties/Directorates required.</td>
</tr>
<tr>
<td></td>
<td>Explore options to expand GP direct access to Diagnostics.</td>
<td>Further discussions with Diagnostic Directorate required.</td>
</tr>
<tr>
<td>Capacity</td>
<td>Plan additional diagnostic capacity well in advance of go live dates for awareness campaigns.</td>
<td>Consideration as part of Upper/Lower GI pathway work.</td>
</tr>
<tr>
<td></td>
<td>Reduce waiting times for urgent cancer referrals to within one week and reduce routine referral times to two weeks.</td>
<td>Further discussions with Directorates required.</td>
</tr>
<tr>
<td></td>
<td>Prioritise cancer referral triage and diagnostic capacity above routine elective workload and ring fence diagnostic capacity for cancer patients including the reporting of the diagnostic test results.</td>
<td>Further discussions with Directorates required.</td>
</tr>
<tr>
<td></td>
<td>Redesign pathways to enable instant access to cancer diagnostics and treatment.</td>
<td>Colorectal and urology pathway work to be extended to include other tumour sites.</td>
</tr>
<tr>
<td></td>
<td>Provide daily consultant grading/triage of cancer and non-cancer referrals in all specialties.</td>
<td>Part of access policy implementation.</td>
</tr>
<tr>
<td>Cancer Tracking</td>
<td>Integrate the cancer tracking into normal working practice such that upgrades can easily be picked up and recorded at source.</td>
<td>Exploration of upgrading existing cancer database with a view to piloting in colorectal.</td>
</tr>
<tr>
<td></td>
<td>Education of all clinical staff as to the process for upgrading a patient when cancer is suspected.</td>
<td>Discussion at tumour site leads meetings.</td>
</tr>
<tr>
<td></td>
<td>Procure a single designated system which would collect data on all patients to facilitate the patient pathway tracking and fulfil the cancer register information requirements.</td>
<td>Exploration of upgrading existing cancer database with a view to piloting in colorectal.</td>
</tr>
<tr>
<td>Performance Monitoring</td>
<td>Set specialty specific stretch targets and trajectories to promote importance and ownership of cancer waiting times targets within cancer sites.</td>
<td>Further discussion required with R Blackwell and Directorates.</td>
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<td>------------------------</td>
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<tr>
<td>MDTs</td>
<td>Over time, replace all of the videoconferencing equipment with one provider.</td>
<td>Further discussion with IM&amp;T required.</td>
</tr>
<tr>
<td></td>
<td>Explore options of joining forces with other Trusts who share our MDTs both in terms of V/C equipment but also the Governance arrangements for MDTs.</td>
<td>Include as part of partnership working project.</td>
</tr>
<tr>
<td></td>
<td>Explore the recent developments in video technology alongside new internet based telephony system.</td>
<td>Further discussion with IM&amp;T required.</td>
</tr>
<tr>
<td></td>
<td>Appoint an on site IT Audio/Visual support technician to maintain all videoconferencing equipment. This service could be shared with organisations.</td>
<td>IT Department to resubmit business case.</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Procurement of a new pathology information system with the ability to provide audit, SLR information and histology reports electronically.</td>
<td>Diagnostics Directorate to pursue procurement.</td>
</tr>
<tr>
<td></td>
<td>Process review of sample delivery and results to requester to highlight delays and streamline current working practices.</td>
<td>Further discussion with Diagnostics Directorate required.</td>
</tr>
<tr>
<td></td>
<td>Routinely flag all patients on a 62 day pathway as “urgent” for Histopathology</td>
<td>Further discussion with Diagnostics Directorate required.</td>
</tr>
<tr>
<td></td>
<td>Review the increase in orange card referrals and encourage the use of order communications to ensure timely and appropriate “urgent” referrals are received by Radiology.</td>
<td>Further discussion with Diagnostics Directorate required.</td>
</tr>
<tr>
<td></td>
<td>Ring fence diagnostic capacity for cancer patients including the reporting of the diagnostic test results.</td>
<td>Further discussion with Diagnostics Directorate required.</td>
</tr>
<tr>
<td></td>
<td>Support business case for a 4th MSK consultant</td>
<td>Exec Director approval required.</td>
</tr>
<tr>
<td></td>
<td>Improved CWT reports showing patient level pathway delays relating to potential or actual diagnostic delays that can feed into the weekly Diagnostic PTL meetings.</td>
<td>Include as part of the ongoing cancer tracking work between Cancer Services and IM&amp;T.</td>
</tr>
<tr>
<td>Radiotherapy/Oncology</td>
<td>Provide a comprehensive bid to NCAT for additional resources relating to IMRT circa £250k. The Trust will need to support this bid with additional revenue resources to achieve the target of 24% from April 2013.</td>
<td>Bid currently being worked up by Cancer Services.</td>
</tr>
<tr>
<td></td>
<td>Commence a period of extended day working in order to increase capacity. This will help to meet waiting time targets whilst at the same time meeting our commitments to the IMRT programme.</td>
<td>Oncology Department to assess viability.</td>
</tr>
<tr>
<td></td>
<td>Move medical physics routine maintenance and quality control (QC) work on the Linacs outside of core working hours. This was originally funded within the business case for the 3rd Linac but is no longer on the scoreboard.</td>
<td>Further discussions between Oncology and Medical Physics required.</td>
</tr>
<tr>
<td></td>
<td>Move to an 8:00 am handover of the Linacs from</td>
<td>Further discussions</td>
</tr>
<tr>
<td>Appendix A</td>
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<td>---------------------------------</td>
<td>-------------------------------------------------</td>
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<tr>
<td>medical physics to enable an additional 30 minutes per day per machine of treatment time.</td>
<td>between Oncology and Medical Physics required.</td>
<td></td>
</tr>
<tr>
<td>A quick decision needs to be made on the location of the 4th Linac so that service delivery plans can be made.</td>
<td>Further discussion with Trust and SCG required.</td>
<td></td>
</tr>
<tr>
<td>Review SLAs with Torbay and N.Devon to appropriately remunerate the Trust for activity undertaken on their behalf and ensure PAs within Oncologist job plans are funded correctly.</td>
<td>Business/commercial team to review.</td>
<td></td>
</tr>
<tr>
<td>Consolidate future predicted income growth now in order to resource radiotherapy and clinical oncology time in the most cost effective way and to deal with the demand which is above plan.</td>
<td>SLR case to be made.</td>
<td></td>
</tr>
<tr>
<td>Explore options with neighbouring Trust such as Taunton about combining clinical oncologist resources and cover arrangements in single operator tumour sites such as Head and Neck.</td>
<td>Part of future options with Taunton.</td>
<td></td>
</tr>
<tr>
<td>Brachytherapy</td>
<td>Approve Brachytherapy business case when presented at next Exec Group meeting.</td>
<td></td>
</tr>
<tr>
<td>Accommodation</td>
<td>Exec approval required.</td>
<td></td>
</tr>
<tr>
<td>Plan replacement of Cherrybrook with expanded facility and additional office capacity OR expand the working day and week to maximise clinical space.</td>
<td>Part of capital estates strategy.</td>
<td></td>
</tr>
<tr>
<td>Further move low risk infusion work to community and/or primary care setting although this will negatively impact on income.</td>
<td>C2C project.</td>
<td></td>
</tr>
<tr>
<td>Scope the feasibility of creating an RD&amp;E homecare provider model.</td>
<td>New business opportunity.</td>
<td></td>
</tr>
<tr>
<td>Review room utilisation and allocation between Oncology and Medical Physics department to maximise usage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Use of homecare delivery of chemotherapy where appropriate, pilot starting with Herceptin November 2012.</td>
<td></td>
</tr>
<tr>
<td>Review of supportive therapies being delivered closer to home December 2012</td>
<td>C2C project.</td>
<td></td>
</tr>
<tr>
<td>Development of an ANP in Oncology to mirror that in Haematology.</td>
<td>Internal development to be tested.</td>
<td></td>
</tr>
<tr>
<td>Development of AOS to potentially reduce length of stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Review</td>
<td>Diagnostics Directorate to work with Cancer Services and Skin MDT to address serious concern relating to lack of named radiology cover at MDT meetings.</td>
<td></td>
</tr>
<tr>
<td>Integrate cancer PTL information and discussion into the weekly RTT PTL meetings.</td>
<td>Discussions already started.</td>
<td></td>
</tr>
<tr>
<td>Directorates hosting individual MDTs to be given the responsibility for completing work plans and achieving compliance with cancer standards. Updates to be provided via Quarterly Review</td>
<td>To become part of new performance management framework.</td>
<td></td>
</tr>
</tbody>
</table>
1. Introduction

1.1. Reasons for engagement

The IST was invited to visit Royal Devon and Exeter NHS Foundation Trust (RD&E) following a request from the Trust. The IST is currently supporting the Trust in relation to RTT 18 Weeks and it was felt that the Trust would benefit from having a similar review of its cancer services.

The aim of the visit was to undertake a diagnostic review of the Trust's cancer service, its approach to managing patient pathways and look at ways to imbed and sustain delivery of the cancer targets. This review was to include an assessment of the resilience and stability of the Trust's cancer systems, processes and policies, an evaluation of the organisation's responsiveness to delivering timely cancer services; and to make recommendations for improvement where appropriate.

The report that follows is a summary of the IST cancer diagnostic visit that summarises the themes and issues that came out of the meetings that were conducted throughout the visit. Recommendations to take forward are included within each section.

This report follows on from the informal presentation that was given at the end of the visit.

1.2. Current performance

This table shows the organisation's 62 day cancer waiting times performance (area of most concern) by month from December 2011 – November 2012, as uploaded by RD&E to Open Exeter:

In 2011/12, the Trust achieved each of the cancer standards consistently every quarter. However, this year, the Trust failed the 62 day cancer standard for Q3 and has concerns around Q4 performance.

The cancer service stated that they have consistently achieved high levels of patient satisfaction with particular positives noted as the input from the clinical team (in the top 10
Appendix B

last year). The National Cancer Patient Survey highlighted a potential issue with nursing levels on the in-patient ward and a requirement for additional pathway information.

1.3. Specific concerns

During the briefing meeting with the deputy chief operating officer and cancer management team at the start of the IST’s visit, the key areas of concern were highlighted as the following:

- Organisational ownership of the cancer targets
- Sustainability of the cancer targets
- Ability of the organisation to share good practice across tumour sites
- Reliance on individuals to micromanage pathway performance
- Lack of visibility of cancer pathway management with respect to IT.

The IST noted that the 2 day diagnostic agenda was limited in its clinical input and would suggest that further work be undertaken to ensure the input and engagement of these teams in order to drive improvements. The Trust will be holding a cancer ‘summit’ at the end of March in order to engage and educate clinical and managerial staff on cancer pathways however the agenda was not confirmed at the time of our visit.

2. Leadership and management

The Trust does not appear to have a written cancer strategy that includes the specific aims and future direction for the service. The Trust expressed a desire to build closer links with Taunton and Somerset NHS Trust. Commissioning structures are becoming clearer, and there are good personal links with the Trust and commissioners however the cancer management team are not always directly involved with commissioning discussions relating to and impacting on cancer services. The abolishment of the cancer networks has made this more difficult and the Trust will be looking to form relationships with the new commissioners as specialist commissioning structures become clear.

A variety of examples were expressed to the IST that highlighted a lack of formal processes across Directorates. While business cases and new developments that impact cancer services are usually highlighted to the cancer services Directorate and their involvement gained, there is no robust process by which this is guaranteed. On occasions the finer detail of new developments have been missed and later found to cause problems in support Directorates as it was not fully discussed or communicated throughout the planning stage. This also highlights the limited collaborative approach e.g. the increase of outpatient demand in endoscopy.

2.1. Trust cancer management team

In line with good practice, there is a named executive lead for cancer (the Chief Nurse/Executive Director of Service Delivery), a named Trust clinical lead for cancer (who is a gynaec-oncologist), a lead cancer manager (Divisional manager - Child & Women's Health and Cancer Service), a Clinical Services Manager for cancer and a lead cancer nurse (who is the lead nurse for chemotherapy).

The Trust has reacted to underperformance on the 62 day pathway by ‘shining a light’ on cancer (rather than proactively managing concerned compliance). The cancer team hoped that the priority of cancer will be maintained within the organisation to ensure that more challenging areas are tackled to deliver sustained results for patients. The Executive support of the Cancer Summit provides evidence of
Recommendations:
- Maintain focus on cancer delivery to embed and sustain changes.
- Give clarity on the lines of accountability from Executive Director level down through the Trust.
- Empower the cancer team to make changes that affect all aspects of the pathway.
- Improve collaborative working across services e.g. development of pathways, planning for awareness campaigns, additional resource for WLI clinics etc.
- Give clarity of the role and function of the cancer team and the positioning of the team within the organisation.

3. Cancer Structure

The IST heard positive feedback from the cancer team in relation to the increased priority that cancer currently had however, did not feel that this was necessarily matched with an understanding and awareness of cancer across all Directorates and the wider local health community.

The Trust does not yet have documented cancer pathways with clearly defined event milestones and trigger points for internal pathways nor for cross providers (inter provider transfers). This means that pathways on the whole are being managed by what staff feel should be happening rather than an agreed timed pathway with a clear SLA and standards for each of the diagnostic areas.

Clinicians are required to implement “last minute” fixes (e.g. overbook, re-arrange patients on a list etc.) to get patients seen within 62 days.

Below the Clinical Services Manager (CSM) are a peer review/governance lead and the administration service managers responsible for the MDT co-ordinators (amongst other responsibilities). The cancer services administration manager has an extremely wide remit with overall responsibility for a team of approximately 50 individuals, ten of whom report directly to her. As such, she feels that she has insufficient time for service improvement work. The Trust's MDT co-ordinators have a remit to support the monitoring, tracking and timely progression of cancer patients along their cancer pathway. The team covers the functions of:

- MDT meeting preparation and actioning of outcomes
- Covering the MDTs of absent colleagues
- Cancer patient tracking (for GP, inter-provider and upgraded referrals)

The IST has concerns around the functioning of the team and how their ways of working (time management in relation to balancing time for tracking with MDT preparation/attendance time) impact on cancer waiting times. The team consists of both experienced and new individuals and the Trust has split the MDT co-ordinators into two teams that are able to support each other and share knowledge and understanding around the cancer agenda. The IST understands that these two teams vary in both experience and ability to cross cover.

Through discussions with MDT co-ordinators and members of the cancer audit team that have an impact on the pathway management of cancer patients, each tumour site has a different way of working. Some co-ordinators spend the majority of their time preparing for the MDT, and have limited time to track patients, whilst other members have strong links with the CNS, medical secretaries and the audit team and have the ability and/or time to
appropriately track. The current system relies on all of the individuals mentioned above
taking ownership for their specific part of the pathway; however medical secretaries are
unclear of their responsibilities. Where responsibility for the patient is unclear and they are
not being tracked in real time, there are obvious weaknesses.

Macmillan is sponsoring a pathway co-ordinator post for 2 years which the Trust hopes to
use to support pathway development and management. However it will be important to
ensure that this does not add further confusion to roles and responsibilities in relation to
managing the cancer pathway.

Recommendations:
- Agree the roles and responsibilities for MDT co-ordinators, medical
  secretaries and cancer audit staff in terms of their physical input and
  responsibilities to the patients’ cancer pathways.
- Agree a set a standard operating procedures for MDT co-ordinators to ensure
  that each provides and fulfils the same responsibilities across their tumour site.

4. Reporting and Governance

4.1. Accountability

Cancer performance and quality is reviewed at an Executive level at the quarterly review
meetings held with each Directorate. There is a monthly Senior Operational Group (SOG),
chaired by the Executive lead for cancer and attended by the Divisional managers, where
cancer may be discussed, and a weekly access meeting where performance can be
challenged with Clinical Service Managers (cancer is the new focus). There are bi-monthly
clinician to clinician meetings, and cancer clinical lead meetings are held on a monthly basis.
Individuals at all levels were unclear as to who had operational accountability for the delivery
of the cancer targets.

The IST noted that weekly cancer tumour site PTL meetings varied in structure, core
attendance, process and effectiveness, and are not embedded like ‘core’ elective PTL
meetings across the rest of the organisation. The delivery of patient pathways is heavily
reliant on the individual knowledge and experience of the MDT co-ordinator and the working
relationship with the relevant CNS to ‘pull’ the patient through their pathway. This way of
working needs to be advocated across all tumour groups.

Recommendations:
- Meeting structures relating to cancer performance need to be more effective
  from quarterly review to local weekly PTL meetings
- Review co-location and joint working opportunities between MDTCs and
  clinical teams

5. Patient access and choice

All 2WW referrals are received in to the 2WW booking office and due to recent changes are
now mainly via Choose and Book (except Upper and lower GI due to the straight to test
triage process). The 2WW office is manned from 8:30am to 4:30pm every week day with
limited cover for leave should the booking clerk be absent (for 3 days). As soon as the
referrals are received they are entered onto the cancer tracker system. The 2WW booking
clerk sited challenges with overnight delays in newly created outpatient slots appearing on
Choose and Book. The issues relate to last minute appointments that may be taken up by
other PAS users (seeing the slots first) prior to the slots appearing on Choose and Book. Where a patient goes straight to diagnostics e.g. MRI or CT it was unclear which consultant had responsibility for the patient. This is an issue when the MDT coordinators search the PTL by consultant rather than tumour site as is the case.

The Trust stated that they receive a high level of inappropriate 2WW referrals however could not fully quantify this in all tumour sites. Dermatology are currently undertaking an audit of 2WW referral appropriateness which is nearly complete and will be shared with primary care to agree an action plan. However, this needs to be repeated in other tumour sites where there is perceived to be a problem.

The Trust have subsequently stated that 2WW capacity and demand analysis has been completed for each specialty and shared with Directorates for inclusion in 13/14 operational planning which includes an analysis of seasonality.

The Trust produces an ASI report that identifies those patients that are not able to have a 1st outpatient slot booked within 2 weeks. It is clear that there are some capacity shortfalls where patients are struggling to be directly booked within 14 days, without intervention to put on additional slots or reassign slots for cancer patients. It is clear that in some tumour sites 1st appointments are being offered on day 13 which does not allow for cancellations should this be unsuitable. If two dates cannot be offered within 14 days it would not be appropriate to record this breach as ‘patient choice’, as this is due to the Trust’s capacity issues. For many tumour sites 14 days will be too long a time to wait given the complex nature of the pathway, the Trust must plan to see patients within 7 days of referral in order to look at sustainably delivering.

Given the apparent capacity shortfall in outpatients, the Trust were unable to quantify the gap between capacity and demand or provide specific long term plans to address the issues raised. The Trust has developed a mechanism to ‘predict’ future demand, but this has not been matched with core funded capacity. Directorates have been asked to map capacity and demand for cancer activity in this year’s Operational Planning.

The team confirmed that the Trust Access Policy states that if a patient DNAs their appointment or cancels twice, they will be discharged back to primary care. The Trust felt that the DNA policy was being followed however the cancellation policy was not routinely employed. This is in part due to the inability of the local PAS to make cancellations easily visible. The IST has yet to review the access policy and has not looked at its practical application.

Recommendations:
- Move all services to the 2WW Choose and Book System
- Strengthen the staffing structure for the 2WW office (cover and training)
- Comprehensive capacity and demand planning required for 2WW in order to understand the issues and plan appropriately going forward.
- Agree appropriate audit and feedback on inappropriate 2WW referrals
- Review patient access policy and rules application
- Provide appropriate training to ensure standardisation of rules application

6. Data quality, analysis and reports

6.1. Cancer reporting

The Board receive a monthly dashboard of performance statistics that include a traffic light indicator for the cancer targets. The Board have been made aware of the difficulties of
Appendix B

retrospective validation that means that data received is not necessarily a direct reflection of the performance uploaded 25 working days after the month end (e.g. shared breaches). The Board report does not currently have any data quality checks on cancer to assure them that what they are reading is accurate.

Monthly Open Exeter reporting of cancer patients is signed off by the Directorate manager with responsibility for Cancer.

The IST noted the following potential issues with the data reported by the Trust on Open Exeter

- Huge variation in the number of 2WW referrals each month (Table 1)
- Low numbers of patients reported as 2WW breast symptomatic (Table 2)

The Trust felt that the low number of 2WW breast symptomatic referrals was due to the GPs referring through the traditional route of the standard 2WW referral and simply using the incorrect clinic slots as opposed to a low referral rate. The Trust was unclear as to the reasons why the total 2WW referral numbers varied quite so much month on month.

Table 1: Reported 2WW referrals December 2011 to November 2012 (Data Source Open Exeter)

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<tbody>
<tr>
<td>Seen</td>
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<td>823</td>
<td>844</td>
<td>849</td>
<td>840</td>
<td>816</td>
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<td>714</td>
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<td>Breaches</td>
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<td>46</td>
<td>34</td>
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<td>17</td>
<td>38</td>
<td>13</td>
<td>13</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Performance</td>
<td>95.1%</td>
<td>92.7%</td>
<td>94.5%</td>
<td>98.6%</td>
<td>95.8%</td>
<td>97.7%</td>
<td>98.0%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>95.2%</td>
<td>96.1%</td>
<td>95.8%</td>
</tr>
</tbody>
</table>

Table 2: Reported number of 2WW Breast symptoms December 2011 to November 2012 (Data Source Open Exeter)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Seen</td>
<td>35</td>
<td>49</td>
<td>45</td>
<td>69</td>
<td>39</td>
<td>47</td>
<td>30</td>
<td>48</td>
<td>33</td>
<td>39</td>
<td>42</td>
<td>23</td>
</tr>
<tr>
<td>Breaches</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Performance</td>
<td>97.1%</td>
<td>95.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.4%</td>
<td>95.2%</td>
<td>95.7%</td>
</tr>
</tbody>
</table>

Cancer information are currently working on a prospective report looking at 62 day cancer pathways as it is widely accepted that all reports are currently retrospective and do not allow for timely interventions.

The IST noted that the Trust reported low volumes of consultant upgrades given the size of the service. The Trust expressed issues in identifying these patients and with the awareness and communication of this group of patients.

6.2. **Cancer validation and data quality**

The Trust has an electronic patient tracker system (Cancer Waiting Times (CWT) Tracker) which is based on single episode entry of elements of the pathway which linked together allow you to track a patient on a suspected/diagnosed cancer pathway. The system has a one way feed from PAS allowing the transfer of basic demographics however does not communicate with any other hospital system. This inevitably leads to wasted time in seeking out pathway information and means that staffs need to enter the same information on different electronic systems at least twice. The system is quite slow and like all systems
needs staff to be fully trained in its operation in order to use it appropriately. Tracking information is inputted by medical secretaries, MDT co-ordinators, cancer audit staff and Clinical Nurse specialists. These groups represent a large number of people within the Trust and as such the system is open to staff that are not fully trained in its use i.e. medical secretaries and understanding of terms leading to poor data quality and excessive retrospective validation.

Although the CWT tracker system has its challenges, these are no more than any other cancer tracking system, and the Trust should concentrate on ensuring the timely and accurate input of relevant data at this stage as opposed to necessarily purchasing a new system to resolve these tracking issues.

The cancer tracker is used by the MDT co-ordinators to track patients along their pathway but is also used by the cancer audit team to pull specific local and national audit data from. The responsibilities of these two posts in the entering of relevant pathway information has become ‘muddy’ and depending on the experience and time of the MDT co-ordinator for a given tumour site will have a bearing on the level of tracking that can be done.

The CWT Tracker system feeds the cancer PTL which is the report by which cancer patients are tracked. It is imperative that the Trust uses pathway milestones to remove appropriate patients from the PTL at the earliest stage on their pathway so that the focus is on the patients who are suspicious of having cancer.

The Trust has no formally documented and signed up to tumour site specific timed pathways. These pathways must be clinically agreed and then used by the trackers to ‘pull’ the patients along their pathways managing by exception (those that fall outside of the agreed timelines).

Current escalation around cancer patients is not standardised. Relevant service managers will be aware of capacity shortfalls at the outpatient stage and possibly at the inpatient stage, however this is often too late in the pathway to do anything. The Trust stated that they do have an escalation policy however this is not always followed consistently. It is unclear as to the route escalation takes and who has responsibility for the patient i.e. is it up to the cancer Directorate to ensure delivery or the relevant tumour group Clinical Services Manager?

The IST noted that non-GP referrals ie A&E patients, inpatients and community hospital patients are only identified on the MDT agenda and not by any other communication process.

6.3. **Breach analysis**

The Divisional Manager and CSM for Cancer services are required to produce an exception report to the Board for each of the cancer targets that are not achieved, which is presented by the Executive lead for cancer. These reports give specific reasons for patients breaching the standard.

The cancer team are aware of the reasons for breach however; appear to have little influence over dealing with any pathway constraints for breaches. Where capacity (whether outpatient, diagnostic or inpatient) is sighted as an issue and highlighted, there is little evidence of these matters being addressed in the long term.

**Recommendations:**

- Review new prospective cancer reports to ensure they are fit for purpose
- Trust to understand the variation in the number of 2WW referrals
- Employ additional data quality checks to ensure the capture and reporting of all 2WW and Symptomatic Breast referrals.
- Challenge local commissioners to help GPs to complete the appropriate 2WW referral proforma
- Give clarity on roles and responsibilities to both the MDT co-ordinator and cancer audit roles
- Ensure ownership and data quality of cancer pathways are part of the MDT co-ordinators role
- Agree tumour specific timed pathways as a matter of urgency
- Ensure access to the CWT Tracker is limited to those that are appropriately trained to use it
- Agree local reports to support pathway management/escalation by exception
- Review escalation policy and empower the CSM for cancer to ensure its application.

7. Cross Organisation Pathways (IPT)

The Trust confirmed that they are mainly an ‘importer’ for cancer treatments however they do send a small number of referrals out of Trust for treatment. There are no agreed timescales by which patients should be received into the Trust and the degree of ‘work up’ for each pathway that should be complete prior to transfer. There appears to be a reliance on the relationships between individuals at external Trusts and Royal Devon and Exeter cancer team in order to have the correct minimum data set for the patients (and therefore the correct pathway start date). The Trust told the IST that there is a central mailbox for Inter Provider Transfers (IPTs) which is monitored by the MDT co-ordinators and the cancer audit team.

Members of the cancer audit team noted that some patients who were treated at the Trust and originated at another provider do not always have an IPT form and therefore had no start date and may not be counted on Open Exeter.

Recommendations:
- Agree key referral milestones/transfer dates with all Trusts linked on the cancer pathways and provide appropriate escalation routes up to Executive level.
- Provide operational clarity on the expected route of entry for all cancer patients and key contacts on the pathways across Trusts.
- Work with external levers to support required changes (commissioners).

8. Observations and summary of issues raised in meetings with the clinical support teams

The IST met with clinicians and teams from the clinical support services i.e. endoscopy, radiology and pathology. The key issues and themes are summarised below.

8.1. Upper GI

Observation of the Upper GI MDT Meeting

The IST was invited to observe part of the upper GI multi-disciplinary team meeting (MDM). This MDM was highlight by the Trust as good practice. Whilst the IST noted some areas of good practice, in the 25 minutes that the IST was able to observe the meeting, there were a number of areas for improvement noted:
The meeting did not start on time (scheduled to start at 12.30 but started at 12.43)
MEMbers of the MDT arrived late (up to 20 minutes late)
The video-conferencing equipment was not working (the IST was told that this is a regular occurrence). A teleconference line was organised which connected to Plymouth at 12.45
The MDT agenda lacked relevant content – Incomplete fields
The MDT co-ordinator did not engage in duties expected of the role in this type of meeting e.g. to raise issues such as breach dates, ensuring the completion of diagnostic request forms, live recording of outcomes etc.
Of the 8 patients that the MDT discussed which the IST was present:
- For 4 patients, the IST was not able to determine that an outcome was agreed by the group
- 2 patients added to the list in error and were deferred to the following week
- 2 patients seemed to have outcomes that were already pre-decided and there was no additional clinical enquiry or challenge to the decision-making
On the whole, it was not always clear who was responsible for following-up the MDM action for a patient.

8.2. Diagnostics: Endoscopy

The IST noted good practice in this service in relation to the use of nurse endoscopists and pre-assessment for certain cohorts of patients. The team has taken advantage of endoscopy improvement support from NHS Improvement and were recently re-accredited by JAG.

There has been work undertaken in relation to demand and capacity modelling and to identify the size of a backlog in surveillance patients that had built when the service experienced increases in demand following the bowel awareness campaign. Waiting times are consistently no more than two weeks for suspected cancer/urgent patients and six weeks for routine patients, and there is a clear plan to manage the backlog in relation to surveillance patients by the end of March 2013.

The service experiences abuse of the ‘orange card’ (request card identifying a patient is being referred to endoscopy as a suspected cancer) but all referrals are triaged on a daily basis and sub-standard requests are sent back to the referrer for more information and in some cases where patients are referred as routine but in fact should be seen urgently, these referrals may be upgraded.

A telephone or face-to-face pre-assessment takes place for all lower GI endoscopy patients and this has seen a reduction in the DNA rate for this group. However, there is no upper GI endoscopy patient pre-assessment and DNA rates are approximately 10%.

This DNA rate is further compounded by the fact that some upper GI patients will be sent fixed appointments (non-negotiated/unconfirmed) appointments in the post if the booking team is unable to contact the patient by telephone.

There is agreement across the whole of GI for full pooling of referrals across the entire team; however this is severely limited by the use of paper diaries. NHS Improvement has already made a recommendation to the team to implement electronic booking and this is being explored.

Recommendations:
Appendix B

- The endoscopy team to extend pre-assessment to upper GI endoscopy patients
- The endoscopy booking team to implement booking with choice and negotiating appointments for upper GI endoscopy patients as in lower GI endoscopy
- Reiterating the NHS Improvement recommendation: to implement electronic booking and removing the use of paper diaries.

8.3. Diagnostics: Radiology and Histopathology

The IST met jointly with clinical and managerial representatives from radiology and histopathology, key cancer diagnostic support services. Common themes were identified across both services around poor communication from the specialties/tumour sites in relation to additional demand that will lead to increased workload for support services and lack of joined up whole system pathway management e.g. lack of timed pathways with documented and communicated escalation points.

Histopathology

The team reported that the service was functioning well and is not a major source of delay along the cancer pathway. Current turnaround times are three days for biopsies and seven days for excisions. However, increases in workload (often unplanned) have been a challenge to manage; for example, as a result of increases in flexi sigs, new robotic work, and increases in work from lung, head & neck, breast and urology services. There is a temporary flexible arrangement to allow staff to work additional hours to keep on top of the workload and this will be reviewed after one month.

The IST was told that there was never additional funding for diagnostic staffing resource when the MDT meetings were first set up, and as meeting frequency is being increased, they have to say no to requests to increase their attendance at meetings unless the specialties are able to fund the additional staff resource, e.g. lung and head & neck.

It was discussed that the specialties do not have a full awareness of the histopathology prep work that is required prior to an MDT such as the reporting and slide pulling. Often there is duplication of effort, where slides then have to be pulled again, when patients are rolled over from one MDT meeting to the next week’s meeting due the patient either being prematurely added to the agenda or the full information not being available. Although there are agreed cut off dates for patients being added to the MDT agenda, the service often receives requests to add patients on at the last minute.

There is no order comms functionality for pathology, although results are accessible via the pathology system. The team highlighted that MDT co-ordinators seem reluctant to access the pathology results system directly to check results or to telephone the lab for results. Paper reports are the norm and they are sent to the referrer via internal post. Some users have complained of delays in this process. To support the cancer tracking process, there is a manually generated weekly report which goes out weekly to the cancer auditors which highlights proven cancer histologies. The aim is to automate this report in due course.

Recommendations:
- The Trust to explore how to appropriately resource growing MDTs and MDT meetings
- The histopathology team to provide education to the MDTs regarding the process for preparation of the MDTs
Appendix B

The Trust to encourage staff to access results directly on the pathology system to reduce wasted time on the patient’s pathway

Radiology

The service has experienced increases in demand across CT and MRI. Although the service is currently able to manage this increased demand at the moment, scheduling is a fine balance. In relation to CT, where demand has doubled and there has been a 20% increase in complex work, the service has extended operations to weekend working. In relation to MRI, the service utilises an MRI van for 12 hours, 4 days a month to keep on top of demand.

There has also been an increase in request for procedures under GA and as there are only two GA sessions per week this is being accommodated but it is a challenge.

Communication from the services about changes in practice that will impact on radiology is poor and the team feel that the formal processes e.g. business planning, business cases are not robust enough to ensure that the service is fully notified, given sufficient time and financial resource or involved in the redesign process. An example given was the lack of communication in relation to the increase in use of CT colonography on the lower GI pathway.

The team highlighted challenges around the abuse of the orange card system and incorrect prioritisation of referrals due to poor knowledge of its purpose. They also raised the issue of delays in receiving the paper requests, (the expectation is that the request card should be physically delivered to the department by the referrer), which gives less time for the patient to be seen without breaching.

Reporting turnarounds are currently one day for inpatients and three days for outpatients. It is rare for reporting to take over seven days and this is monitored regularly. A new timetable and a pooled reporting flexi-working arrangement has been introduced.

The team reported a strong history of service redesign and improvement. They are focused on maintaining the principle of not carving out capacity and reducing the number of queues into the service. Despite requests from the specialties, they have resisted carving out dedicated slots for particular services. The team are working towards having a two week waiting time for routines by the end of March and a one week waiting time for urgent referrals. It is expected that this will lead to less need for the use of the orange card.

Recommendation:

- The Trust to reiterate the responsibilities and expected timescales in relation to submitting radiology request cards

Over-arching diagnostic recommendations:

- The Trust to re-issue communication about the appropriate use of the orange card system
- The Trust to review its formal business planning and business case authorisation processes to build in a clear structure and expectation of full communication and sign-off from all the relevant services in relation to business cases and service developments

9. IST Support
The IST would be pleased to offer support to the Trust in the following areas:
- 2WW capacity and demand
- Supplying evidence of good practice in specific areas
- Reviewing prospective cancer reports and data quality checks
- Support timed pathways
- Support exception reporting against clinically agreed milestones

10. Conclusion

The Trust clearly evidenced areas of good practice during the two day review. These included;

- Clinical and managerial engagement
- Developed nursing roles e.g. urology (TRUS biopsy) and nurse endoscopists
- Achievement of 70% staging performance target
- Choose and Book as single referral route (excl. UGI and LGI)

The 62 day cancer standard is very sensitive to a small number of breaches. For this Trust around 16 breaches could be enough to fail the 85% target in a given month (depending on the number treated). These breaches should only be due to patient choice and clinical complexity reasons and not the inability of the Trust to treat within the given time.

The recommendations within this report are to ensure sustainable delivery of the cancer pathways as part of elective care from which the cancer targets naturally fall. Although the number of recommendations is high (given the number of monthly breaches), it is important to note that the intention is to ensure appropriate pathways for all diagnosed and query cancer patients as well as enabling the staff of the organisation to manage the patients care appropriately.

In summary the key issues to address include;
- Agree cancer strategy as an organisation
- True ownership and accountability of cancer within the Trust
- Empowerment of the cancer team (involved in commissioning and delivering appropriate, and timely pathways)
- Clarity of the MDT co-ordinator, cancer audit roles
- Training and management of medical secretaries (with regards to cancer tracking)
- Appropriate use and accountability of using the CWT Tracker.
- Prospective cancer reports
- Data quality checks
- Continued drive on clinical ownership

*Intensive Support Team – Cancer (NHS IMAS)*
3rd March 2013

**Contacts:**
Appendix D

Additional Improvement Work

1. Two Week Wait (2ww) Capacity and Patient Choice
This section details actions taken to deliver sustainable performance against the 2ww and symptomatic breast targets.

1.1 Commissioner/GP Engagement
On the 11th July 2013 Devon CCG commissioners held an Improving Early Diagnosis of Cancer event at which groups of GPs and tumour site lead consultants met to:

- Follow-up issues raised through significant event audits.
- Have small group dialogue with secondary care colleagues around symptoms, patient presentations and referrals.
- Improve liaison between primary and secondary care.
- Use the afternoon for airing ideas on improving patient ask questions and debate issues relating to cancer referrals and cancer pathways. Over 100 GPs were in attendance.

In addition, the Cancer Services Directorate has worked with commissioners to provide GPs with more up to date guidance on 2ww referral criteria as well as asking them to remind patients that they will need to be available to accept an appointment within the next 14 days.

The joint access policy is currently being reviewed to ensure that it best reflects the latest cancer waiting times guidance.

1.2 Patient Choice
In order to mitigate the impact of patient choice on the achievement of this standard the Cancer Services Directorate has:

- Undertaken a detailed 2ww capacity and demand analysis, providing each tumour site with a forecast of demand enabling them to build the necessary capacity into operational planning and budget setting for the year and providing patients with a wider choice of appointment dates.
- Moved all 2ww appointments onto the “choose and book” system and away from faxing, reducing admin delays and creating a robust audit trail.
- Introduced a new protocol for the 2ww booking staff which ensures all options for alternative appointment dates are explored with the relevant specialty teams within the 14 day target.
- Where necessary, Directorates plan additional 2ww clinics pre and post holiday periods to provide the maximum amount of choice of dates.

2. Patient Tracking and Data Quality
Significant improvements in the effective tracking and monitoring of a patient’s progress along their pathway have been made through the creation of a new 62-day cancer PTL which was later integrated into the cancer performance dashboard. These tools have proven to be the most valuable development for the managerial, administrative and clinical teams in getting real time visibility of where patients are in their pathway. It enables them to act proactively, making interventions to pull them through their pathway more expediently and to escalate issues to the appropriate manager if they are unable to resolve them. These reports form the cornerstone by which the weekly tumour site cancer PTL meetings now work effectively and by which progress is monitored at the cancer performance meeting.
As part of the cancer performance dashboard, a number of new data quality checks have been built in to improve the quality of information on the cancer tracker. Additional information resource has been allocated to validate all open cancer pathways to ensure only active pathways are being tracked. Data queries which cross reference multiple information systems are run each month to ensure all cancer patients are identified and correctly recorded on the cancer tracker. New imaginative training tools have been created to better ensure staff understand, interpret and can remember the cancer waiting times guidance.

3. Strengthened Cancer Performance Structure
Building on the learning taken from managing Referral to Treatment (RTT) targets, a similar performance management and governance structure has been introduced for the monitoring and management of cancer waiting times. The diagram below details the new meeting structures and lines of reporting. This structure has significantly increased the specialty level engagement with the cancer waiting times agenda and clarified lines of responsibility and accountability with regard to cancer performance.

The new patient tracking tools and a performance dashboard enable specialty PTL meetings to work more effectively and proactively in the management of cancer patient pathways. Specialty specific action plans have been created and performance of these is managed through the Divisional performance management structure.
4. Renewed Focus on Cancer

The Trust Executive has prioritised the cancer agenda providing renewed focus and additional support. Work has started on writing a Cancer Strategy for the Trust which will be the blueprint by which cancer care and patient pathways are redesigned and transformed over the next three years.

The Cancer Services Directorate has designed and launched a series of Cancer Summits aimed at revitalising and prioritising the cancer agenda throughout the Trust. These events have brought together all of the individuals involved in cancer care to educate and involve them in shaping the cancer agenda.

The first summit was held on the 27th March 2013 and focused primarily on the cancer waiting times standards and included breakout sessions to discuss MDT working, pathway process standardisation and improvements through best practice. The second summit is planned for the beginning of October 2013 and will cover the topics of the pathway redesign project, the survivorship agenda and development of an acute oncology service.

5. Cancer Pathway Redesign Project

This project started in April 2013 and is a joint two year partnership with Macmillan and is one of the first in the country to focus on redesigning the whole patient pathway. Working with Macmillan has provided national expertise in the development of infrastructure to support the patient which is sustainable and ensures that quality is maintained throughout the pathway.

The primary aim of the project is to work collectively to increase survivorship, actively promoting the health and wellbeing of cancer patients living with, and beyond cancer. With a predicted 100% increase in the number of patients living with cancer over the next two decades, a more sustainable, risk stratified model of patient follow up, needs to be identified, which correlates with the National Cancer Survivorship Initiative (NCSI) and includes self-managed rehabilitation and recovery for each patient in the community and encompasses:

1. Built-in internal standards (quality indicators)
2. Timescales (milestone stages)
3. Roles and responsibilities
4. Patient information (to educate, inform and support)
5. Survivorship care plans

By taking such proactive steps now, the Trust will be more effective in managing future capacity demand while remaining patient focused in the care that is provided. The project focuses on developing a whole system approach which is both cross Directorate and multidisciplinary, with all the relevant internal and external community partners.

The project was started in April 2013 and a phased approach has been taken. Phase One is well underway and includes the first four cancer pathways of Colorectal, Haematology, Urology and Skin. Each phase is expected to take 9-12 months to fully complete and Phase Two will begin towards the end of 2013. Only through this total pathway approach will the long term sustainability of the cancer waiting times standards be achieved.

6. Diagnostic Turnaround Times
Appendix D

Improving diagnostic turnaround has been identified as a key area where improvement would positively impact on cancer pathways and performance of the waiting times standards.

Appendix F details the extensive diagnostics action plan created to deliver improvements in diagnostic turnaround times for Imaging and Pathology.

7. Achieving Sustainable Performance
There are a number of new emerging external factors which are forecast to impact on the Trust’s ability to achieve sustained compliance with the cancer waiting times standards in the near future. Action to anticipate and mitigate the impact of these external factors has commenced.

7.1 Peak in Breast Referrals
Commissioners are currently reporting a significant increase in GP attendances relating to breast conditions and this is generating peaks in 2ww and symptomatic breast referrals. The growth in breast 2ww referrals between 2012/13 Q4 and 2013/14 Q1 was 16.2% and the growth for combined 2ww and symptomatic breast referrals was 9.6% for the same period. No increased demand for breast capacity was forecast or commissioned for in the 2013/14 contract.

The breast team are currently developing plans to deal with these spikes in referrals, creating the necessary appointment capacity. However, due to the very short time between referral peaks and the need for additional capacity there is a high likelihood that the 2ww and symptomatic breast standards will be at risk of failure in July 2013.

7.2 Peak in Skin Referrals
Whilst 2ww referrals for suspected skin cancer are subject to seasonal variations the recent prolonged good weather has resulted in an increase in demand which is above that which was forecast and planned for. The growth in skin referrals between 2012/13 Q4 and 2013/14 Q1 was 33.3% which is partially due to seasonal referral patterns but the growth on the 2012/13 Q1 and 2013/14 is still 27.2%. A 7.6% increase in Dermatology outpatient capacity was commissioned for in the 2013/14 contract which is proving insufficient to cope with the sudden increase in demand. As with the increase in breast referrals above, the skin team have now created additional appointment capacity to deal with the demand but due to the time taken to set up the additional clinics there will be a number of additional 2ww breaches in July.

7.3 Be Clear on Cancer (BCOC) Campaign
The autumn 2013 ‘Blood in Pee’ national campaign will run from 15th October to 20th November and will include TV, press, radio and out of home advertising, such as posters and pharmacy bags. In addition, the campaign will include national, regional and local PR, and some face-to-face events held in public areas such as shopping centres. The campaign will be targeted at both men and women aged over 50, the age group most likely to get cancer. The key message is “If you notice blood in your pee, even if it’s ‘just the once’, tell your doctor”.

The impact on referrals in pilot sites is described in the briefing document and using baseline data on their service such that the Urology department are able to predict the increased capacity needed. The Urology team are
reviewing their capacity and demand gaps and there are plans for an additional one stop haematuria clinic to be created ahead of the campaign.