| | | | |
|---|---|---|---|
| **Meeting Date** | **27 October 2020** | **Agenda Item** | **2.2** |
| **Report Title** | **Cancer Performance** | | |
| **Report Author** | Melanie Simmons, Cancer Quality & Standards Manager | | |
| **Report Sponsor** | Jan Worthing, Service Director, Singleton & NPTH | | |
| **Presented by** | Jan Worthing, Service Director, Singleton & NPTH | | |
| **Freedom of Information** | Choose an item. | | |
| **Purpose of the Report** | To provide a summary of Health Boards Cancer Performance for August 2020 and the key issues impacting on cancer pathway delivery and performance. | | |
| **Key Issues** | • Demand is now outstripping our reduced COVID capacity levels in 1st wait, diagnostics, theatres and oncology treatment options.<br>• Based on modelling scenarios we will need to get back to delivering our pre covid activity levels in all areas of Cancer Pathway in order to maintain current performance<br>• Based on backlog position and increasing demand we anticipate current backlog is going to increase before it is able to improve based on the 8-12wk lag in activity we saw due to the pandemic. | | |
| **Specific Action Required** ***(please choose one only)*** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | ☒ | ☐ | ☐ | ☐ |
| **Recommendations** | Members are asked to:<br>• **NOTE the cancer performance position and the ongoing actions taken to support its recovery and Improvement.** | | | |

## CANCER PERFORMANCE

### 1. INTRODUCTION

The report below describes activity and performance to date, performance and progress against the Single Cancer Pathway, and outlines the particular risks going forward along with the actions we are taking to maintain and improve cancer essential services during the COVID-19 pandemic.

### 2. BACKGROUND

The Health Board continues to manage the recovery of Cancer Services in line with National Framework for the Recovery of Cancer Services.

It is anticipated that there will be a growing demand for Cancer Services and the Health Board is working and engaging with the Cancer Network and the Delivery Unit around Capacity and Demand Planning and have been since start of the pandemic.

**Patient and Staff Safety**

In line with National Guidance, we have a robust plan in place to offer Covid test for all patients starting Oncological and Haematological treatments and for those going for Surgery. The Health Board will continue with its process in line with Recovery framework to ensure the safety of patients and staff as part of their cancer journey during this pandemic.

The COVID-19 pandemic continues to affect all aspects of the Cancer Pathway and MDT function. Cancer MDTs have had to have the confidence to be able to make the best decisions for their patients when options have been limited, in the full knowledge that the outcomes may fall significantly short of optimal.

Cancer essential services have continued to be provided however;

- There continues to be an increase in diagnostic services with endoscopy and colonoscopy now available.
- Radiotherapy and chemotherapy availability continues but with reduced capacity.
- There is surgical activity for all tumour sites, although this remains reduced.
- There will be an anticipated increase in surgical procedures undertaken as more theatre time is utilised.

**USC Referrals**

| Oct -19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1532 | 1209 | 1065 | 1484 | 1371 | 843 | 409 | 737 | 1101 | 1192 | 1135 |

Table above shows referrals have started to come back to the levels they were pre-covid.

Cancer Performance waiting times reporting have been relaxed since the start of the COVID pandemic. However, data is submitted to the Wales Cancer Network weekly. The purpose of this information is to provide NHS Wales and Welsh Government with assurance that services are equitable. The use of this information can inform capacity and demand, as well as understanding the harm in the system. It is not used for performance monitoring; but can aid services in delivering a regional approach to cancer where identified and needed.

WG have indicated that when reporting recommences (possibly January 2021) it will be against the Single Cancer Pathway only, however a target has not been set for this pathway to date, suggestions of an unadjusted target of 80% have been muted. A WG workshop was held on the 12th August to discuss the use/application of suspensions and future breach reporting. A consultation paper proposing the discontinuation of suspensions and individual breach reporting had been shared by WG for comments and the Health Board has responded to this.

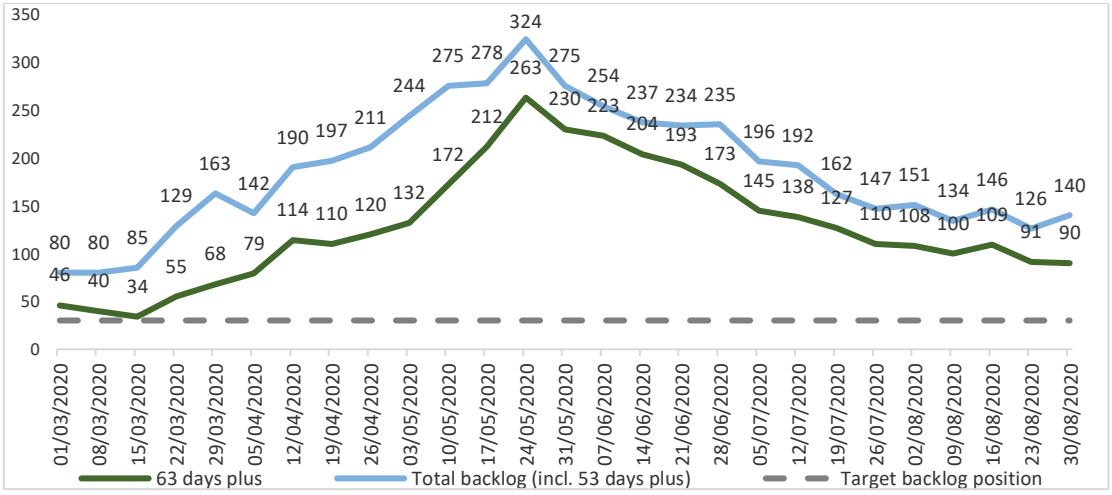
## August 2020 Performance

| **USC performance – 91% (10 breaches) – 106 patients treated** | |
|---|---|
| Lower Gastrointestinal | 4 |
| Urological | 3 |
| Upper Gastrointestinal | 2 |
| Haematological | 1 |

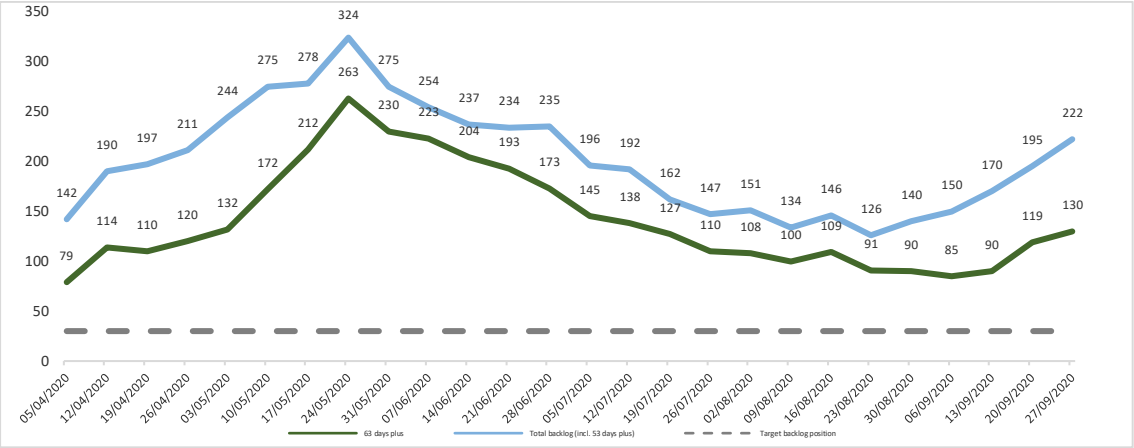
| **NUSC performance – 91% (6 breaches) - 66 patients treated.** | |
|---|---|
| Urological | 3 |
| Head & Neck | 1 |
| Lower Gastrointestinal | 1 |
| Gynaecological | 1 |

**USC Backlog* position** (*Backlog defined: All patients with an active wait status waiting 63 days or more. Required to also report 53-62 days).

This remains the main concern, the graph below shows position at end of August 2020



More recently based on the end Sept position we have seen a steady increase week on week in the backlog position




Increased capacity within the diagnostic and surgical services in the last couple of months has resulted in a decreasing number of patients in backlog. However, demand is now outstripping our reduced COVID capacity levels. Of the 222 noted in above graph 63% (142) are in diagnostic phase of their pathway and 17% (33) are in treatment stage

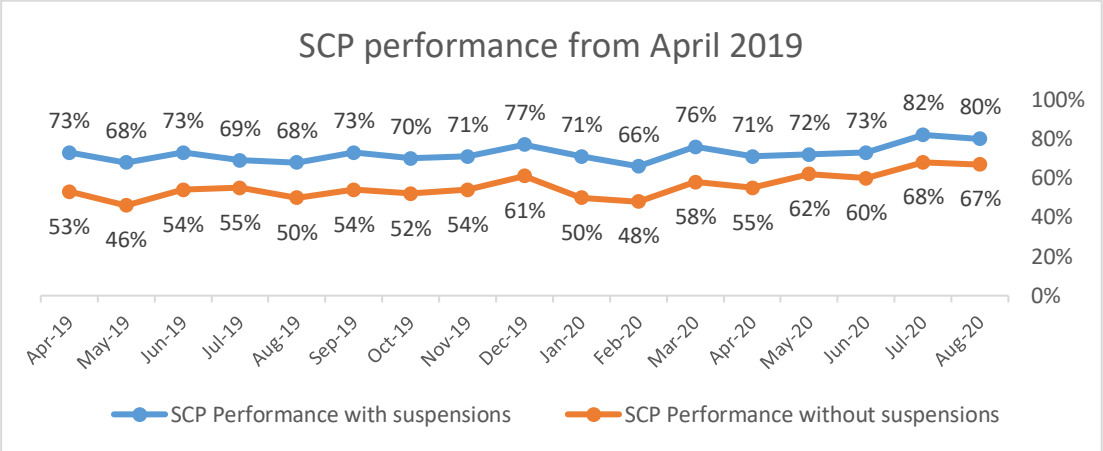
The Table below shows the graph data split by Tumour site, this demonstrates the 76% of the backlog sits within UGI/LGI/Other and Urology. In addition Gynaecology is recently started to raise concerns.

| Tumour Site | 53 - 62 days | | 63 > days | |
|---|---|---|---|---|
| | Number reported | +/- | Number reported | +/- |
| Breast | 1 | 1 | 0 | 0 |
| Gynaecological | 9 | 8 | 3 | 0 |
| Haematological | 0 | 0 | 0 | 0 |
| Head and Neck | 6 | 3 | 9 | 3 |
| Lower GI | 30 | 5 | 39 | 1 |
| Lung | 3 | 1 | 3 | 0 |
| Other | 6 | -2 | 17 | 6 |
| Skin | 10 | 1 | 5 | 2 |
| Upper GI | 22 | 3 | 35 | -1 |
| Urological | 6 | -4 | 19 | 0 |
| **Grand Total** | **92** | **16** | **130** | **11** |

Based on modelling scenarios we will need to return to delivering our pre covid activity levels in all areas of Cancer Pathway in order to maintain current performance.

We anticipate our current backlog is going to increase before it is able to improve, this is based on the 8-12wk lag in activity we saw due to the pandemic. In addition, this will only improve if our activity levels specifically within diagnostics and Treatments stages increase significantly.

## Single Cancer Pathway




## August 2020 position / tumour site:

| | In target with suspensions | Total treated | % |
|---|---|---|---|
| Head and neck | 3 | 4 | 75% |
| Upper GI | 8 | 11 | 73% |
| Lower GI | 16 | 23 | 70% |
| Lung | 19 | 25 | 76% |
| Sarcoma | 1 | 1 | 100% |
| Skin (exc BCC) | 36 | 36 | 100% |
| Brain/CNS | 2 | 2 | 100% |
| Breast | 18 | 18 | 100% |
| Gynaecological | 7 | 8 | 88% |
| Urological | 10 | 19 | 53% |
| Haematological | 13 | 20 | 65% |
| Acute leukaemia | 3 | 3 | 100% |
| Children's | 0 | 0 | % |
| Other | 1 | 2 | 50% |

Due to nature of cancer targets and the fact it is percentage figure of treated cancer activity that month makes it challenging to demonstrate what would be required to

achieve an improved performance this is the same for both SCP performance and the traditional USC and NUSC targets.

Further work to understand what we can do within the optimal pathways to improve waiting times regardless of the performance measure is ongoing.

## 3. GOVERNANCE AND RISK ISSUES

Performance remains a significant risk until sustainable solutions are in place across the pathways and the backlog position is addressed. Areas of main concern are below-

### a) Endoscopy

The demand for endoscopy has been increasing at pace both locally and nationally for some time. Unprecedented pressures on hospital services and workforce because of the Covid-19 pandemic has further challenged the Endoscopy service. The COVID-19 pandemic has severely curtailed the practice of endoscopy (as an exemplar for outpatient diagnostic procedures) and restart and recovery processes will be influenced by the need to protect patients and staff from disease transmission

Pre COVID the total number of procedures undertaken was circa 230 per week. This activity was through a combination of HB funded sessions and Insourcing activity. During COVID, the activity decreased to between 5 and 20 procedures a week with emergency inpatient cases only being undertaken. From June onwards the teams were actively restoring sessions with an increase week on week in terms of activity undertaken. On week commencing the 14th September 114 procedures were undertaken.

The Service have been working on a Recovery plan, for all Endoscopy services and aligned with the National Endoscopy Programme. Phase 2 in the plan includes the following priorities-

- To clear the USC Backlog and ensure ongoing capacity to match USC Demand. **Backlog of 184 cases** and ongoing new demand of 80 referrals per week.
- To ensure capacity available to manage the Inpatient demand within 24 hours of referral.
- To review urgent cases on the current waiting list and assess risk within the Cohort of patients and agree on plan for each case. This could be needs Endoscopy, FIT Test, CT Colon.

The numbers of USC patients in the backlog continue to increase and it is proposed that the following actions are taken to clear the backlog and provide a sustainable capacity base to manage this cohort of patients.

1. Maximise use of available funded nursing capacity using agreed job planned Endoscopy sessions.

2. Maximise use of available funded nursing capacity with WLI Backfill payments. Currently we have capacity that is funded from a nursing perspective with limited Endoscopist sessions to support. Action taken to increase capacity from September –December 2020 would see a complete reduction in the backlog and support on going new referrals to be managed in a timely way.

3. The above coupled with the increase of Straight to Test by November 2020 should create enough capacity to manage backlog and new demand.

### b) Urology

Performance has significantly reduced in this specialty to an average of 69% this financial year, as a direct impact of Covid and the reduced capacity associated with this. Unprecedented pressures on hospital services and workforce as a direct consequence of the Covid-19 pandemic has challenged the Urology Department in its ability to meet the demands on the service. The table below shows the weekly clinic capacity for the Urology cancer pathways has reduced.

| **Service** | **Pre-Covid Slots** | **Current Slots** | **Additional Information** |
|---|---|---|---|
| Prostate Biopsy | 21 | 16 | Service suspended in April, and recommenced in June and capacity was reduced to 8 per week |
| Haematuria | 28 | 24 | Capacity reduced to 12 during April and May resulting in a significant backlog |
| Prostate Clinics | 60 | 12 | The majority of patients are undergoing initial telephone consultation as well as follow-up consultation |
| General Clinics | 180 | 50 | Face to face clinics for all priorities |

Theatre allocation has reduced from nine all day theatre lists (6.5 at Morriston/2.5 at Neath Port Talbot Hospital) pre-Covid. In the current climate, we are allocated between two and three lists per week, giving a reduction in capacity of at least six all day theatre lists. Patients are being tightly managed via a priority list with the most

clinically urgent being allocated to available sessions by the clinicians (including non-cancer procedures).

One all day weekly list at Neath Port Talbot will commence at the beginning of November. However, only day case work is permitted, which will allow for small bladder tumours (less than 1cm), orchidectomies and some day case diagnostic procedures.

Radiotherapy for Urology is severely stretched and waiting times for treatment can be 6-8wks from decision reached to proceed with treatment.

The service has been working on recovery as outlined below:

- Non face to face activity is being undertaken wherever clinically appropriate as a first contact for prostate referrals – an average of 70 referrals per month
- Haematuria investigations as a USC are undertaken in line with NICE guidance, ie patients over the age of 45 with visible haematuria – an average of 57 referrals per month
- General USC referrals are allocated to the next available appropriate hot clinic (dependent on sub-specialty) – an average of 29 referrals per month
- The service have secured an additional alternate week theatre list in Cardiff to undertake the robotic prostatectomies, which commenced on 14th September reducing our backlog to five patients awaiting a date for surgery
- Additional theatre allocation is still required in order to address the backlog of 33 USC/NUSC patients already listed for procedures, as well as the additional recurrence patients. However, clinicians continue to clinically prioritise cases
- Consultants have requested additional weekend work to address the backlog. However, specialist staffing hubs limit the possibility of this

### c) LGI & UGI

Prior to COVID clinics undertaken were 4 sessions for rectal bleeding, eight for colorectal and 9.5 for UGI. WLI clinics were relied on to support capacity previously. During COVID, Straight to Test Implementation plan developed and FIT testing has been implemented to reduce need for outpatient attendance allowing consultants to undertake telephone consultations with patients to explain results/future investigations.

Both tumours sites are being significantly affected by Endoscopy capacity issue, which are big further compounded by theatre capacity severely limited by staff shortages (vacancies/sick/shielding) and the need to follow labour intensive COVID-19 SOPs. Patients are prioritised by clinical need.

**As part of the Recovery, a huge range of actions to improve performance has been implemented by services, some of which are noted below.**

**Diagnostics**

- Extended days on all three sites for outpatient CT and at weekends at Morriston.
- Mobile van in place to support with MRI backlog.
- CT Colonograms being performed on all three sites.
- Successful appointment of Gastroenterology Consultant in Singleton to commence in November 2020
- Endoscopy Nursing Establishment all fully recruited into funded establishment and additional 3wte RGN's funded to support the implementation of GI Bleed Rota.
- Endoscopy Recovery Plan developed and aligned with NEP (National Endoscopy Board) plan
- Development of training plan and agreed scheduled training sessions
- Fast track Nurse Endoscopist training is going well.
- The restoration of endoscopy rooms and redeployment of specialist staff to their endoscopy units post COVID
- The Service has implemented the use of the NEP deferred patient spreadsheet to record all tracking and booking of deferred procedures, surveillance, screening, non-urgent symptomatic patients and USC patients.
- SBUHB have implemented FIT in USC groups of deferred patients as an interim arrangement for managing prioritisation of deferred procedures.

**Theatres**

- In line with all surgical specialties, all patients are being added to the HB waiting list being held centrally. Theatre capacity is being allocated in accordance with the date they were added to the list and the overall numbers per specialty, with no consideration given to the SAFF target date or breach position.
- Thoracic theatre capacity to be restored to pre-covid levels from week commencing 12th October 2020 (2 lists per week- 3 sessions)
- Further pilot to be undertaken week commencing 21st September 2020 for two weeks with daily pleural clinics.
- Head and Neck changes in Clinical Practice for appropriate patients - Undertaking some diagnostics (pre-covid undertaken in Theatres) in an Outpatient setting. New diagnostic scope purchased to increase further outpatient diagnostic capacity – awaiting delivery.

**Outpatients:**

- Within all specialties, USC patients are being virtually reviewed and assessed via Attend Anywhere and maximum USC Face to face clinic capacity is being reinstated through phase 2 of the outpatient recovery plan.

**Radiotherapy**

- Local concessions forms to allow for changes in procedure including PPE, changes in fractionation (shorter treatment times, minimise patient time in department and maximise available treatment capacity), safe patient flow through the department, remote consent and other changes in practise.
- We continue to provide radiotherapy services, with 75% capacity protected (compared to prior to the pandemic). We have 3 Linacs treating non-COVID patients and 1 running for COVID. Patients awaiting radiotherapy are subject to revised clinical assessment to test relative risk in the context of COVID and where necessary alternative management plans are enacted.
- Almost all follow-up appointments, and an increasing number of routine new patient appointments, are telephone/VC. Patients are still seen in person as necessary.
- Working up a case for Radiotherapy Recovery using capacity from Breast changes, paper when to Rest and Recovery on 02.09.20, as is being included in our Qtr3/Qtr4 operational plan.
- Covid Screening in place for all Radical Lung RT patients in SWWCC

**SACT**

- Covid-19 screening tool has been developed to assess all patients prior to admission onto the oncology ward in addition to measuring temperature and oxygen levels.
- A Covid 19 risk assessment tool is used prior to attendance to chemotherapy day unit and on attendance all patients and staff are screened at the entrance with a temperature check and asked to use alcohol hand gel and offered face masks.
- Working on SACT Covid Recovery Plan to mitigate loss of capacity and to be able to respond to anticipated surge in demand with the ongoing recovery of surgery and screening. The SACT optimisation project around low risk injectables has commenced, work programme is now 8wks plan to get something to Reset & Recovery by mid Oct 2020. This remains the plan.
- Week commencing 20th September, monitoring data showed 83% capacity (Target 85% due to complex planning and safety issues).
- Covid Screening now in place in both SBUHB and HDD UHB we are now routinely testing all patients attending SACT units for treatment prior to each cycle of treatment.

## 4. FINANCIAL IMPLICATIONS

No recommendations are specifically made within this report requiring Board approval.

## 5. RECOMMENDATION

The Committee are asked to note the Cancer performance position and the ongoing actions taken to support its recovery

| Governance and Assurance | | |
|---|---|---|
| **Link to Enabling Objectives** ***(please choose)*** | **Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities** | |
| | Partnerships for Improving Health and Wellbeing | ☒ |
| | Co-Production and Health Literacy | ☐ |
| | Digitally Enabled Health and Wellbeing | ☐ |
| | **Deliver better care through excellent health and care services achieving the outcomes that matter most to people** | |
| | Best Value Outcomes and High Quality Care | ☒ |
| | Partnerships for Care | ☐ |
| | Excellent Staff | ☐ |
| | Digitally Enabled Care | ☐ |
| | Outstanding Research, Innovation, Education and Learning | ☐ |
| **Health and Care Standards** | | |
| ***(please choose)*** | Staying Healthy | ☒ |
| | Safe Care | ☒ |
| | Effective Care | ☒ |
| | Dignified Care | ☒ |
| | Timely Care | ☒ |
| | Individual Care | ☒ |
| | Staff and Resources | ☒ |
| **Quality, Safety and Patient Experience** | | |
| Timely access for cancer patients improves outcomes | | |
| **Financial Implications** | | |
| Nil identified outside of agreed WLI's | | |
| **Legal Implications (including equality and diversity assessment)** | | |
| Not applicable | | |
| **Staffing Implications** | | |
| Shortages of staff due to vacancies/ sickness/shielding does impact on access for cancer patients. | | |
| **Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)** | | |
| ○ **Long Term** - Public Health and cancer survival outcomes.<br>○ **Prevention** – Acting earlier will ensure better cancer survival<br>○ **Integration** – Cancer impacts everyone and so improvements in Cancer Pathways and outcomes will have positive impact on well- being.<br>○ **Collaboration** - Collaborative working.<br>○ **Involvement** – Optimal Cancer Pathways ensure patient-centred care. | | |
| **Report History** | N/A | |
| **Appendices** | Nil | |