East Sussex CCGs: Cancer Performance

A progress update for the East Sussex Health and Overview Scrutiny Committee (HOSC)

September 2019

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1. Background and Introduction

1.1 Further to previous papers produced for HOSC in November 2017, September 2018 and March 2019, this is to provide an update on cancer performance.

1.2 Based on data published over the course of the last two years, a Clinical Commissioning Group Improvement and Assessment Framework (IAF) has been published and this provides an initial baseline rating for six clinical priority areas; one of which is cancer.

1.3 The ratings are broken down by local Clinical Commissioning Groups (CCGs) and published on myNHS showing areas in need of improvement, and also highlighting areas of best practice.

1.4 The headline ratings by CCG of the cancer (Better Care) aspects of the IAF published July 2019 showed that local improvement is needed to maximise outcomes for local people. Eastbourne, Hailsham and Seaford CCG (EHS) was rated "requires improvement" (same as previous year). Hastings and Rother CCG (H&R) rating was "inadequate" (same as previous year). High Weald Lewes Havens CCG (HWLH) rating was "requires improvement" (same as the previous year).

1.5 Table 1 below shows latest performance by IAF cancer target (previous year position in brackets for ease of comparison):

Table 1	**2018/2019 CCG & England average performance by IAF cancer target**			
CCG	Cancers diagnosed at an early stage (62% by 2020)	Suspected cancer urgent referral to having first definitive treatment with 62 days (85%)	One year survival from all cancer (75% by 2020)	Cancer Patient Experience – average score given by patients asked to rate their care on a scale of 1-10 (10 being best)
EHS	49.65% (51.8%)	72.8% (77.1%)	71.8% (71%)	8.8 (8.7)
HR	51.64 (49.3%)	77.19% (71.3%)	70.9% (69.6%)	8.9 (8.7)
HWLH	50.25% (52.1%)	68.09% (76.2%)	73.1% (71.7%)	8.9 (8.6)
England average	52.2% (52.6%*)	82.08% (82.3%*)	72.8% (72.3%*)	8.8** (8.74*)

*Data taken from NHS England IAF reports

** Data from NCPES (2017) used as the basis of the 2018/19 IAF cancer target

1.6 The 62 day target continues to be a challenge however there is an overall improvement in one year survival and cancer patient experience.

1.7 The following sections of this paper provide information on current performance and action being taken to ensure sustainable improvement locally.

Table 2 shows the latest 62 day target performance available:

Table 2: 62 day target performance	
July 2019, 62 day performance Note data is available 2 months in arrears	**Target 85%**
EHS CCG	73.68%
H&R CCG	71.64%
HWLH CCG	80%
East Sussex Healthcare NHS Trust (ESHT)	77.1%
Brighton and Sussex University Hospitals NHS Trust (BSUH)	57.9%
Maidstone and Tunbridge Wells NHS Trust (MTW)	72.2%

1.8 Secondary care diagnosis and treatment for the East Sussex CCGs area is mainly provided by ESHT [host commissioner EHS CCG] with some patients being referred to BSUH [host commissioner Brighton and Hove CCG] and Maidstone and MTW [host commissioner West Kent CCG].

2. Cancer diagnosed at an early stage

2.1 When a patient is diagnosed with cancer, the extent of the cancer is determined by staging and is defined as being at stage 1, 2, 3 or 4. Stage 1 being at an early stage and Stage 4 being advanced cancer. This staging is recorded by secondary care providers. Providers are working to improve the quality and completeness of their data to ensure an accurate picture of all patients diagnosed and the stage at which they are diagnosed.

2.2 There is a range of ways to increase awareness and improve early diagnosis of cancer. Nationally, there are the screening programmes for bowel, cervical and breast cancers and these programmes are offered across the CCGs. Additionally, the national Be Clear on Cancer programme aims to improve early diagnosis of cancer by raising public awareness of signs and symptoms of cancer, and to encourage people to see their GP without delay.

2.3 The CCGs have implemented the June 2015 National Institute for Health and Care Excellence (NICE) guidance for Suspected Cancer: Recognition and Referral (NG12). This is part of delivering earlier diagnosis for cancer patients and hence improved survival. This guideline includes recommendations on the symptoms and signs that warrant investigation and referral for suspected cancer. The (previous) 2005 guidance indicated around 5% of patients referred would actually have a cancer diagnosis. The evidence base has developed since then and the 2015 guidance uses a threshold of 3%. Lowering the threshold for referral does mean an increase in referrals into secondary care for some types of cancer. It should help to improve the number of patients diagnosed earlier – at stages 1 or 2 rather than 3 or 4.

2.4 Educational events are held to raise awareness in the signs and symptoms of cancer among GPs. Consultants from different specialties present and engage with primary care teams to

raise awareness and improve communication and engagement between GPs and the multi-disciplinary teams. There are events across all three CCGs during September 2019.

2.5 Further to this, in order to address significant health inequalities, the Healthy Hastings and Rother (HHR) Programme, which aims to address health inequalities by improving the health and wellbeing of people in the most disadvantaged communities and reducing the life-expectancy gap between the most affluent and most deprived communities, continues.

2.6 Cancer is one of the main causes of premature death and a key contributor to inequalities in life expectancy in Hastings and Rother. Cancer incidence and prevalence rates are both significantly higher than England, with colorectal and lung cancers in particular showing worse outcomes. As part of the HHR, a Cancer Quality Improvement Programme has to date completed three projects:

- Cancer Research UK (CRUK) were commissioned during 2018 to provide GP practices with individualised support to improve cancer performance, especially early diagnosis and treatment rates. The results of this work included 20 GP Practices (95%) now having Cancer Action Plans. This completed in 2018. Additionally, as of September 2019, CRUK is providing a facilitator to work with East Sussex CCGs, to continue this work with an initial focus on EHS GP practices.

- A "Community Approaches to Promoting Early Awareness of Cancer" project was delivered by Unique Improvements aimed at promote public awareness of symptoms and the need for early presentation. The approach taken was building on community assets, recruiting, training and supporting teams of local volunteers to take action in their own communities. The project ended in September 2018 and by completion its achievements included: -

  - 769 volunteer hours;
  - 5,846 brief cancer conversations with residents;
  - 1,200 people had a follow up conversation specifically around cancer;
  - The proportion of volunteers who knew 'a great deal' or 'a lot' rose from 33% to 73% at the end of the project and 90% said their increased knowledge would be useful for talking to family and friends in the future and 86% said they would continue to actively talk to people about cancer.

- A CCG Locally Commissioned Service (LCS) provided by GP Practices, led to more than 14,000 people, who have not previously participated in national cancer screening programmes, being engaged by practices and encouraged to participate. An audit has been undertaken at one practice to determine how many people participated in the cervical screening programme following the contact, where there was a 34% increase in uptake.

2.7 In addition to the local roll out of national programmes, learning from the HHR programme will be shared across to East Sussex CCGs in order to understand where to target additional work as appropriate.

2.8 The Surrey and Sussex Cancer Alliance (SSCA) has funding to support improvement in cancer services. A project manager has been funded whose role is predominantly to focus on awareness and early diagnosis including:

- non-specific but concerning symptoms pathways,
- access to diagnostics, a review of capacity and demand with a gap analysis,
- supporting implementation of timed pathways especially lung,
- increasing the uptake of screening programmes.

2.9 SSCA has approved (September 2019) funding for the following proposals in line with the allocation including:

- An initiative to increase uptake of screening following learning from the H&R CCG LCS as previously mentioned. This will focus on EHS CCG based on the outcomes of the work carried out in H&R CCG. This will be developed working with Primary Care Networks.
- ESHT lung rapid diagnosis matron who will input to promote care coordination from the first investigation to diagnosis and beyond at the pre-diagnosis stages of the pathway and support implementation of the national timed pathway.
- ESHT Upper gastrointestinal (UGI) triage nurse who will work within the UGI Nursing team to develop and improve the UGI cancer pathway and enable the organisation to deliver the optimal timed pathway for the service which will result in an earlier detection of cancer for patients.
- ESHT Faster diagnosis trackers to support achieving the new faster diagnosis standard (FDS) 28 day target. This will be based on the Royal Bournemouth FDS pilot site and ESHT experience to date that one of the challenges is the tracking and discharge of patients without a malignant diagnosis by day 28 in the pathway.
- BSUH Divisional Level Patient Navigators to ensure patients are actively navigated along the care pathway.
- BSUH Upper GI and Lower GI Telephone Assessment Pathway nurses to prioritise and facilitate straight to test (STT) endoscopy procedures through 30 minute telephone assessment clinics undertaking full clinical assessment and review to enable more than 80% patients to access STT.

3. Cancer Waiting Times

3.1 The NHS constitutional (maximum) waiting time targets for suspected (and diagnosed) cancer patients include:-

- Two week wait from urgent GP referral to first appointment (2WW).
- Two week wait from general breast symptoms (where cancer is not initially suspected) GP referral to first appointment.

- 31 days from diagnosis (date of decision to treat) to first treatment (start date) (31 day).
- 31 days for subsequent treatments for new cases of primary and recurrent cancer where an anti-cancer drug regimen or surgery is the chosen treatment modality.
- 31 days for all subsequent treatments for new cases of primary and recurrent cancer where radiotherapy is the chosen treatment modality.

- 62 days from urgent GP referral to first treatment (start date) (62 day).
- 62 days from a cancer screening service to first treatment.
- 62 days from a consultant's decision to upgrade the urgency of a patient they suspect to have cancer to first treatment.

- 28 days from suspected cancer referral to diagnosis (shadow monitoring from April 2019 mandated April 2020).

3.2 The Sussex Cancer Board is now in place to support working across the system and providing the SSCA with a single point of coordination for engagement. The 2019/20 work plan includes delivering and sustaining the Cancer Waiting Times Standards as one of its top priorities.

3.3 Challenges to compliance include a number of interconnected reasons such as limited capacity as a result of workforce challenges, limited diagnostic capacity and complex pathways. There are actions to improve this and these are detailed in the Trust specific actions following.

3.4 There has also been an increase in 2WW suspected cancer referrals. There are a number of reasons for this including the implementation of NG12, lowering the threshold for referral, and various initiatives to raise awareness of signs and symptoms of cancer. However, bearing in mind issues such as diagnostic capacity and workforce, it is a challenge for provider Trusts to substantially increase their capacity to meet the growing demand. The increases from 2017/18 to 2018/19 were:

- EHS CCG: 14.2%
- HR CCG: 5.3%
- HWLH: 14.3%

- BSUH: 5.88%
- ESHT: 10.07%
- MTW: 17.47%

2019/20 activity shows the trend of increasing referrals is continuing. There are a number of initiatives to help to address the growing demand including primary care education to ensure appropriate referrals, Trusts are carrying out demand and capacity reviews and workforce planning. Further details are noted in the Trust specific sections below (sections 4, 5 and 6).

3.5 All patients who breach the 62 day standard and wait over 104 days are subject to a Clinical harm review process. All 104 day breaches are returned to the multi disciplinary team meetings for clinical harm discussion once their first treatment has occurred in line with national guidance. The anonymized details are shared with CCGs. To date, no harm due to 104 day breaches has been identified.

4. ESHT Cancer waiting times performance and progress

4.1 ESHT is now predominantly meeting the NHS constitutional cancer waiting times targets with the exception of the 62 days from urgent referral to treatment – see table 3 below

showing ESHT 2WW, 31 day and 62 day targets over the last year. There are plans in place to improve performance.

4.2 ESHT Cancer Waiting times' performance is shown in Table 3 below:

Table 3	**ESHT Cancer Waiting times' performance (%)**												
Target	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 18	Feb 18	March 19	April 19	May 19	June 19	July 19
2WW (93%)	96	91	83.7	96.8	96.5	96	93.8	96.3	96.4	96.4	94.9	94.7	94.6
31 day (96%)	95.7	90.7	90.4	91.2	92.7	96.7	98.6	98.4	96.1	96.1	96.7	94	97.4
62 day (85%)	73.4	68	59.7	66.3	69.8	80.7	72.9	80.3	75.5	81.6	77.1	73.1	77.4

4.3 The CCGs issued ESHT with a Contract Performance Notice in June 2018 with regard to the fact that they were not achieving 62 day target. ESHT produced a Cancer Recovery Plan which provides good assurance regarding targeted action to improve. This is regularly reviewed and the CCGs continue to work proactively with ESHT to ensure the actions in the plans continue to secure improvement and ensure sustainability of cancer services delivery. Actions include:

- Reviewing specialty pathways to ensure timing to support faster diagnosis and treatment and adoption of the recently produced national timed pathways for urology; lung and lower and upper gastrointestinal.
- Reviewing the breast cancer pathway to ensure full implementation of one-stop clinics and most appropriate follow up pathways.
- Implementation (February 2019) of new colorectal suspected cancer pathway incorporating FIT (faecal immunochemical test) and straight to test (endoscopy). Patients are being diagnosed and treated much earlier with some patients receiving treatment within 30 days.
- Implementation (June 2019) of a new Urology Investigation Suite enabling a one stop clinic incorporating diagnostics. This should take at least two weeks off the pathway. 62 day performance for urology in July was 85.7% - a 3.6% improvement on May.
- Implementation of straight to test for patients on a lung suspected cancer pathway.
- Continued review of trigger points used on patient tracking lists (PTLs) to ensure the patient pathway is pro-actively managed.
- Order Comms (an electronic requesting system) for radiology, is already rolled out to all GPs in the CCGs, and is progressing for roll out within ESHT during 2019.
- A comprehensive demand and capacity review for each specialty across the whole pathway.

4.4 As noted above, the 62 day target continues to be a challenge and a number of initiatives are in place to support improvement where this may relate to patient choice. For example, initiatives to help patients understand the importance of their appointments, such as the patient leaflet that GPs and ESHT give to patients who are referred on the suspected cancer 2WW pathway, and the recruitment of a nurse whose role is to contact patients who decline an appointment to talk through and help where possible. Examples of where this has helped include:

- talking more about the reason for the referral and what the patient can expect;
- understanding patients' personal issues so enabling arranging suitable appointments;
- liaising with care homes so that appointments are made when staff can be released to accompany patients;
- arranging transport;
- or simply a phone call the day before an appointment as a reminder.

4.5 Some issues such as workforce are more complex to address such as the shortage nationally of histopathologists, oncologists, radiologists and dermatologists. Filling posts locally to ensure improved performance is a challenge.

4.6 Suspected cancer referrals have increased. With the implementation of NICE guidance NG12 lowering the threshold and various initiatives to raise awareness this is as it should be. Treatments have increased too for example, ESHT is now providing an average of 143 (first) treatments per month (December 2018- May 2019) compared to 115 (first) treatments for the same period the previous year. Capacity work continues to meet this growing demand.

4.7 Diagnostic capacity is a challenge. The SSCA is leading work to develop nationally recommended Rapid Diagnostic Service. Demand and capacity modelling is underway across Sussex. Development of the rapid diagnostic service will be phased over the next 5 years starting with a rapid diagnostic service for concerning but not specific symptoms during 2020.

5. BSUH cancer waiting times performance and progress

5.1 BSUH continues to be challenged with respect to the 2 week wait and 62 day NHS constitutional cancer waiting times targets. Delays in diagnostics continues to be a contributory factor to non-compliance of the 62 day performance standard. Demand and capacity modelling is underway to identify how diagnostics can support the current 62 day pathway and future 28 day faster diagnosis standard.

5.2 Table 4 below shows BSUH waiting times' performance:-

Table 4	**BSUH Cancer Waiting times performance (%)**												
Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 18	Feb 18	Mar 19	April 19	May 19	Jun 19	Jul 19
2WW (93%)	85.6	84.7	80.8	80.7	85.8	89.9	89.3	90.2	87.8	82.3	77.8	88.8	88.1
31 day (96%)	99.2	98.7	97.5	96.7	96.5	99.5	95	96.2	95.3	92.7	91.9	93.2	96.0
62 day (85%)	70.9	71.4	74.1	71.6	75.2	65.7	63.8	60.2	72.9	63.3	63.2	64.1	57.9

The key issues that have led to the BSUH deterioration in performance include:

- Increase in 2 week wait referrals.
- Reduced diagnostic capacity due to staffing and equipment breakdown/damage.
- Workforce challenges.

5.3 The primary focus for the cancer improvement actions is to improve the management of the overall waiting list by:

- Targeted reduction of the overall patient tracking list (PTL) size.
- Reducing waits for patients to be seen on the 2 week wait pathway.
- Reducing the total number of patients waiting over 62 and 104 days.

5.4 Provider and CCG actions to deliver the improvement include:

- Joint transformation plan and alliance funding bids.
- Individual signed-off tumour site recovery plans.
- CT reporting backlog reduced through some outsourcing
- Reduction in the non obstetric ultrasound (NOUS) waiting list by outsourcing some activity.
- Upper GI consultant surgeon vacancy out to advert.
- Lower GI and UGI are utilising any theatre capacity at short notice.
- Daily and weekly escalation and patient level management has been reviewed and enhanced.
- Ongoing exploration of virtual clinics and stratified pathways.
- Implementation of times pathways for lung and colorectal.
- Faster diagnosis standard included in CCGs/BSUH contract with a focus on colorectal, lung, prostate and UGI.
- CCG/BSUH weekly conference calls to monitor progress and performance.
- Early diagnosis project manager, started July, with focus on rapid diagnostics.
- Faecal calprotectin – adoption of York pathways now agreed. This will increase the threshold for Faecal Calprotectin releasing colonoscopy capacity.

5.5 The positive impacts of the improvement plan are not yet reflected in the percentage performance however the improvement in overall waiting list can be seen below with reductions achieved in the total numbers of patients waiting longer than 62 and 104 days.

5.6 BSUH has a comprehensive recovery plan that should ensure compliance with all constitutional cancer standards by December 2019. BSUH is in the process of reviewing this recovery plan with senior management and clinical oversight to ensure not only recovery but sustainability too.

6. MTW cancer waiting times performance and progress

6.1 Table 5 below shows MTW waiting times' performance:-

Table 5	**MTW Cancer Waiting times' performance (%)**												
Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
2WW (93%)	82.3	76.4	78.1	86.5	90.9	88.1	87.6	89.2	88.7	82.7	87.5	81.0	87.1
31 day (96%)	98.0	96.2	95.1	96.2	96.8	97.2	95.9	96.2	96.1	96.5	96.0	96.8	97.7
62 day (85%)	61.5	76.5	40.0	86.4	72.2	69.2	64.0	86.7	82.4	72.6	70.9	73.1	72.2

6.2 MTW have put in place a comprehensive recovery plan to improve performance. The impact has been a gradual and sustainable improvement in performance. Actions include:

- Breast (one-stop clinic capacity): consultant radiologist or Consultant Radiographer, trainee consultant radiographer, mammographers, nurses and radiology diagnostic assistant (RDA).
- Revised Clinical nurse specialist (CNS) team structure to include advanced practice/leadership roles and succession planning junior roles due to current workforce age profile.
- Increased endoscopy capacity.
- Gynaecology additional resource: physicians' associate or triage nurse.
- Gynaecology, testicular, head and neck, sarcoma additional resource: sonographer, RDA/administrative support, ultrasound machine and couch.
- Haematology physician's associate.
- Head and neck: CNS 2 week wait cancer co-ordinator.
- Lower and Upper GI administrative support workers for straight to test pathways.
- Lower and Upper GI and prostate pathway navigators.
- Lower and Upper GI and lung straight to test triage nurses.
- Lower GI additional clinics (consultant, theatre staffing and administration).
- Lung respiratory physiologist, lung function machine and increased support for Assistant General Manager.
- Management support team leaders and cancer performance general manager.
- Radiology: increased MRI and CT capacity – mobile scanner plus reporting or increased staffing establishment locally and roll out of home reporting across radiologists.
- Urology additional clinics (consultant, theatre staffing and administrative), nurses for Urology Investigation Unit and administrative support/typist.

7. One year survival from all cancers

7.1 The England average for one year survival rates from all cancers is 72.3% (2015). This is an increase from 71.6% in 2014.

The 2018/19 CCG IAF shows improvement for the CCGs in one year survival:-

- EHS are at 71.8% (71% previously)
- HR at 70.9% (69.6% previously)
- HWLH at 73.1% (71.7% previously).

8. Patient Satisfaction Survey

8.1 The National Cancer Patient Survey is carried out annually by Quality Health Ltd commissioned by the Department of Health (DoH).

8.2 There have been considerable improvements in recent years and despite some continued challenges, the outcome of the 2017 patient satisfaction survey is positive, with EHS

achieving 8.7, H&R 8.7 and HWLH 8.6 out of 10. There is variation nationally and the average is 8.7.

8.3 ESHT and MTW were rated 8.9 which is above the England average of 8.7. BSUH were 8.6 which is slightly lower than the England average.

9. Conclusion

9.1 There is much positive action in hand to continue to improve the experience and outcomes of people diagnosed with cancer. We will continue to implement actions and monitor cancer performance to ensure improvements across all the targets.

9.2 Focus remains on improving the CCG IAF targets and ensuring we continue to meet the NHS Constitution targets as well as ensuring action to achieve the 62 day target.

9.3 As part of this, we are working within the new Surrey and Sussex Cancer Alliance to support implementation of the cancer related recommendations in the NHS Five Year Forward View and the Department of Health Independent Cancer Taskforce Report: Achieving World-Class Cancer Outcomes 2015. These support improvement in the four cancer targets in the CCG IAF.

9.4 The Sussex Cancer Delivery Board is working with SSCA to delivery system-wide transformational change to work towards compliance with the aims of the Long Term Plan (2019). This will support improvement across cancer services.

9.5 The development of Integrated Care Systems should provide more improvement opportunities. With Primary Care Networks for example, working at scale and sharing ideas and using a shared workforce will be advantageous. This could help awareness and earlier diagnosis through setting up systems to chase screening non-engagers, having leads and processes ensuring suspected cancer referrals are more uniform and complete and training the wider workforce to help recognise potential cancer symptoms.

9.6 Cancer patient experience is high across East Sussex and is expected to continue to improve through the use of health needs assessments and the introduction of personalised care.

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Final