Board of Directors Meeting in Public

Subject:	Cancer 62 day Backlog Recovery Trajectory	**Date:** May 2021	
Prepared By:	Helen Hendley, Deputy Chief Operating Officer and Lisa Reeve, Head of Elective Care		
Approved By:	Simon Barton, Chief Operating Officer		
Presented By:	Simon Barton, Chief Operating Officer		
Purpose			
To update the Board on the cancer 62 day backlog recovery trajectory in response to the 2021/22 NHSE priorities and planning guidance.		**Approval**	
		Assurance	
		Update	**X**
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X			**X**	
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -	External Reports/Audits	Triangulated internal reports **X**	Reports which refer to only one data source, no triangulation	Negative reports

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	
Patient Impact	**X**
Staff Impact	
Services	**X**
Reputational	

Committees/groups where this item has been presented before

- **SFH Cancer Board, Tuesday 25 May 2021**
- **Elective Steering Group, Thursday 27 May 2021**
- **Execs, Wednesday 2 June 2021**

Executive Summary

In the 2021/22 priorities and operational planning guidance, NHS England (NHSE) set out a key objective: return the number of people waiting for longer than 62 days ("the backlog") to the level observed in February 2020 (for SFH this was 45 patients).
As of 9 May 2021, 93 patients have been waiting for more than 62 days. The tumour sites with the greatest backlogs are lower GI, urology, breast and upper GI.

The recovery plans have been led by tumour sites and set out a range of actions including a review of Covid measures, appointments of staff and streamlining processes through improvement projects.

Whilst a number of mitigations are in place, the key risks to delivery of the trajectory are:

- Diagnostic capacity
- Lower GI as a high volume pathway seeing increased demand
- Reliance on a tertiary provider
- Residual impact of Covid

The Board is asked to:

- Support the backlog reduction trajectory for 21/22 (as a minimum)
- Acknowledge that if referrals continue to increase, routine care is likely to be delayed further.
- Performance against trajectory will be available to Execs via the weekly Elective Care Report.
- Note that a monthly clinically led Cancer Board has been established.

Cancer 62 day Backlog Recovery Trajectory
Trust Board
May 2021

Summary

In the 2021/22 priorities and operational planning guidance, NHS England (NHSE) set out a key objective:

- Return the number of people waiting for longer than 62 days ("the backlog") to the level observed in February 2020 (for SFH this was 45 patients).

The purpose of this paper is to provide an update to the Board on how Sherwood Forest Hospitals (SFH) will achieve this objective.

Current backlog

As of 9 May 2021, 93 patients have been waiting for more than 62 days. The themes can broadly be split in 3 categories:

- Waiting for a test – mainly endoscopy or radiology
- Awaiting the outcome from a diagnostic test, clinic appointment or a plan for next steps
- Awaiting treatment either at SFH or NUH.

The tumour sites with the highest backlogs are lower GI, urology, breast and upper GI.

Monthly trajectory

A high level backlog trajectory for the system has been set for the first 6 months of the year (H1), outlined below.

H1 Trajectory	April	May	June	July	August	September
Nottinghamshire System	284	283	264	242	233	212
Sherwood Forest	101	95	93	85	74	65

Locally, more detailed plans for the year have been set, considering both for the backlog as a whole (including NUH transfers) and SFH only (excluding NUH transfers). Plans have been led by the tumour site teams and incorporate the key risks to pathway complexity, links with NUH and other risks.

ach tumour site plan considers carefully how teams will recover without having a negative impact on workforce. For some, this will mean the addition of team members and for others, a review of measures put in place as a result of Covid or streamlining historical processes.

SFH trajectory including NUH transfers

Tumour site	Starting position - actual	Current month trajectory	In-month actual	Future months trajectory									
	April	May	09-May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Breast	11	8	9	7	6	6	6	6	6	6	4	3	3
Lung	5	5	4	4	4	3	2	2	2	2	2	2	2
Haematology	3	3	3	3	2	2	2	2	2	2	2	2	2
UGI	9	10	13	9	8	7	5	5	5	5	5	5	5
LGI	39	36	41	34	30	27	27	22	22	27	22	18	14
Skin	4	4	4	4	3	3	2	2	2	2	2	2	2

Gynaecology	6	3	11	3	2	2	4	4	4	4	4	4	4
Urology	20	19	14	17	15	12	10	10	10	10	10	10	10
Head & Neck	4	6	3	5	4	4	3	3	3	3	3	3	3
Grand Total	**101**	**95**	**93**	**85**	**74**	**65**	**61**	**56**	**56**	**61**	**54**	**49**	**45**

SFH trajectory excluding NUH transfers

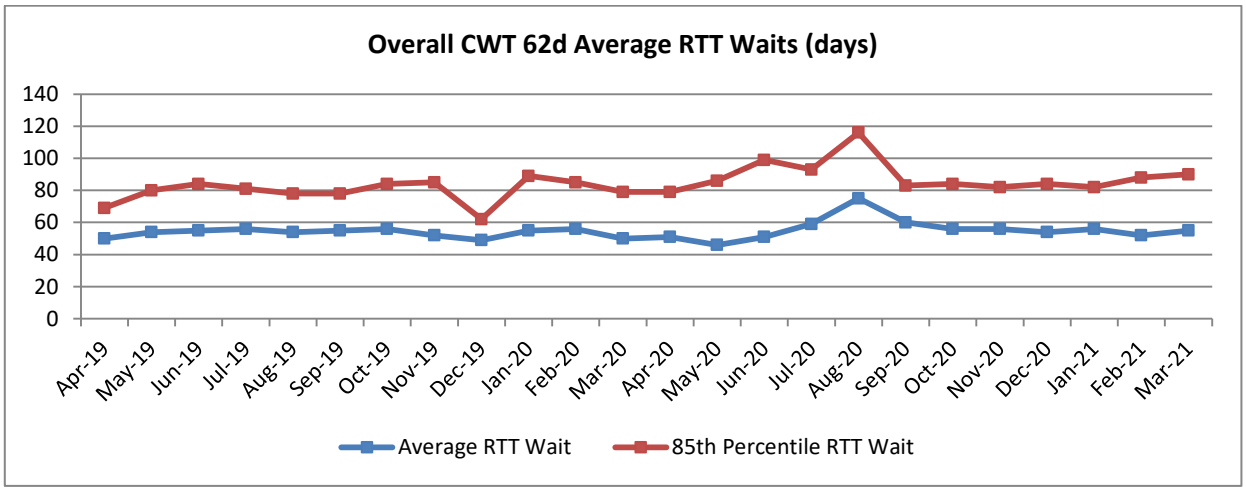
All Tumour sites	**Starting position - actual**	**Current month trajectory**	**In-month actual**	**Future months trajectory**									
Grand Total	**64**	**5**	**71**	**62**	**54**	**48**	**45**	**41**	**41**	**45**	**40**	**36**	**33**

Actions in place:

- **Lower GI** – dedicated central project resource is supporting the team to streamline processes, focussing on straight to test and faster diagnosis. Some initial changes have already been implemented and from July, an additional band 3 support role will relieve nursing and clinical teams, speed up the pathway and allow colleagues to work at the top of their skill.
- **Urology** – the service have recently introduced template biopsies under local anaesthetic instead of general and this will aid in a more rapid offer of diagnostics. A new consultant also joins in June to support the team.
- **Breast** – as of May, all patients will proceed straight to triple assessment, reducing the wait by up to 7 days. GP engagement continues to encourage appropriate referrals to the symptomatic and pain services. Work is on-going to understand radiology and pathology waits.
- **Upper GI** – the divisional team have commenced an improvement project which specifically focusses on distinguishing UGI from HPB. Dedicated 2ww clinics aligned to each pathway will be introduced and staging laparoscopies will start at King's Mill Hospital at the end of May, reducing the reliance on NUH.
- **Gynaecology** – as a suggested tumour site which could be facilitated through a Rapid Diagnostic Centre model, support is in place to identify opportunities and be an early adopter.
- **Lung** – the service has recruited an additional consultant as part of the Targeted Lung Health Check programme. The rollout of this phased with clear gateways to manage risk and maintain capacity.
- **Head and Neck** –project support is in place, a one-stop neck lump clinic was launched in early May with the impact expected in July. In addition, a locum Consultant joined in April and a Clinical Nurse Specialist in May, both of which are expected to aid triage and facilitate the one stop clinic.
- **Skin** – following recruitment and the introduction of Basal Cell Skin Cancer (BCC) pathways, the service will have an improved triage process reducing the wait to first seen.

Key areas of risk

All services are focussed on resolving delays for our longest waiters as a priority and specifically those waiting 104 days and over. Lower GI, breast, skin and gynaecology face challenges with their 85th percentile waits, the actions set out above are expected to improve the overall position.



	Outline	Mitigations
Risk 1 - demand	• Since submission of the trajectory to NHSE in April, referrals have continued to increase to 12% and the most challenged services are those who have also typically seen the greatest rise in demand: lower GI at 28%, breast at 22% and upper GI at 15%.	• 2ww audit to take place at a tumour site level in July. • As part of the lower GI improvement programme a review of the referral criteria is being undertaken.
Risk 2 – diagnostic capacity	• The most significant challenges are in CT and endoscopy; both having also seen increased demand. Waits of 4-6 weeks are currently seen in CT colonoscopy, a key test for lower GI.	• SFH has been successful in its bid as part of the national accelerator programme which will support both of the above services. Work has begun to establish this at pace.
Risk 3 – lower GI	• The trajectory relies on all services to deliver but given the volume of cancer care that sits within lower GI and the current backlog position, significant improvement is required in this pathway.	• Regular project management meetings and KPI tracking is in place to mitigate risk and identify any sign that plans are 'off track'.
Risk 4 – a number of pathways are dependent on NUH pathways and capacity	• Oncology capacity – a hard to recruit to service. • Urology robotic treatment capacity. • Staging laparoscopies - Covid prevented SFH launching this in 2020.	• Weekly calls are in place with NUH around oncology both in considering mitigations and understanding the impact on lower GI, breast and lung. • Staging laparoscopies are expected to be in place by June 2021, introducing weekly capacity.
Risk 5 - residual impact of Covid	• Patients have chosen to wait for their care at all stages of the pathway pending their 1st and 2nd vaccines. Another wave could alter behaviour again. • Clinical teams are observing that patient fitness has deteriorated during the pandemic due to lack of mobility and disruption of usual routines of self-care which leads to delayed procedures and repeat tests.	• SFH continues to communicate with patients about the importance of attending for their care. • Work is on-going with pre-op to consider alternative processes for managing this aspect of care.

62 day performance

Whilst the planning guidance did not specifically ask for a 62 day performance trajectory, the Trust will continue to manage and report performance against the 85% standard on a monthly basis. On average 62 day performance for 20/21 was 68%, through the enactment of this plan the average performance is expected to be 76% for 21/22. The assumptions underpinning this include an assessment of increased referrals at 10%, increased treatments (8% conversion rate) and maintaining breaches at current levels.

Support required

The Board is asked to:

- Support the backlog reduction trajectory for 21/22 (as a minimum)
- Acknowledge that if referrals continue to increase, routine care is likely to be delayed further.
- Performance against trajectory will be available to Execs via the weekly Elective Care Report.
- Note that a monthly clinically led Cancer Board has been established