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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY
REPORT TO THE TRUST HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 28 MAY 2012

Subject:	Cancer Service Improvement
Supporting Director:	Kirsten Major, Director of Service Development
Author:	The Cancer Executive: Dr David Hughes, Trust Cancer Lead Clinician Dr P Fisher , Deputy Trust Cancer Lead Clinician Mrs G Guest, Cancer Services Director Mr D Roberts, Clinical Informatics Lead Mr M Salt, Trust Cancer Lead Nurse Ms H Williams, Trust Cancer Services Manager
Status[1]	

PURPOSE OF THE REPORT:

To provide an account of the activity within the key areas of cancer services for the year 2011/12

- Progress during 2011/12
- Recommendations and actions to be implemented
- Current and anticipated issues
- Future plans

KEY POINTS:

The Cancer Executive is responsible for:

- Providing high level specialist management and leadership to the overall provision of cancer services within STHFT
- Managing all aspects of the delivery of 'Improving Outcomes: A Strategy for Cancer, January 2011' within the Trust
- Monitoring and directing cancer services to achieve national quality standards
- Contributing proactively to the wider North Trent Cancer Network (NTCN)

Key initiatives

- Going Further with Cancer Waits (GFCW)
- Cancer Peer Review
- Improving Outcome Guidance (IOG)
- Service Improvement, including Survivorship
- External Quality Inspections
- Implementation of recommendations in 'Improving Outcomes: A Strategy for Cancer January 2011'
- Compliance with the contractual obligation to supply monthly electronic submission of the full Cancer Registry Dataset from April 2011
- Submission of the Cancer Outcomes and Services Dataset from January 2013

IMPLICATIONS[2]

Achieve Clinical Excellence	• The results of reviews of cancer services indicate that, on the whole, services meet/exceed the quality standards required. There are some areas for improvement
Be Patient Focused	• Cancer waiting time targets are achieved. • Peer review measures include patient focus elements e.g. key workers, patient information etc
Engaged Staff	• Cancer services are delivered by multidisciplinary teams. These teams have developed through a process of evolution and teamwork from staff across different directorates. This has, required and continues to require a high level of staff engagement

	• Development opportunities are provided by the Peer review process

LINKS WITH CQC ESSENTIAL STANDARDS OF QUALITY AND SAFETY:

Outcome	4 – Care and welfare of people who use services 16 – Assessing and monitoring the quality of service provision

RECOMMENDATION(S):

Members are asked to:

- Note the continued progress in the development of cancer services in line with the expectations of 'Improving Outcomes: A Strategy for Cancer January 2011'
- Support the need for additional resources or changes in practice identified as necessary for compliance with GFCW, Cancer Peer Review measures, IOG, the capture of Cancer Registry and Tumour specific national audit data

APPROVAL PROCESS

Meeting	Presented	Approved	Date

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the three pillars (aims) of the STH Corporate Strategy 2008-2012

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

CANCER SERVICE IMPROVEMENT REPORT 2011/12

GOING FURTHER WITH CANCER WAITS (GFCW)

Compliance with all of the Cancer Waiting Times target thresholds has been achieved during 2011/12.

- All figures expressed in %
- Red figures denote those that have not met the threshold

Target	Compliance threshold		Q1	Q2	Q3	Q4
2WW referral GP	93		94	94	96	97
Breast symptoms 2WW referral (cancer not suspected)	93		95	98	98	95
31 Day first treatment	96		98	98	98	98
62 Day first treatment GP referred	85		88	92	93	91
62 day first treatment Consultant referred	TBC		95	91	97	97
31 day Subsequent treatment Radiotherapy (Active 31.12.2010)	94		97	98	99	99
31 day Subsequent treatment Anti cancer drug	98		99	100	100	100
31 day Subsequent treatment Surgery	94		97	95	97	98
62 day Screening to treatment	90		92	91	96	96

Cancer Waiting Times Performance during 2011/12

The performance of Sheffield Teaching Hospitals NHS Foundation Trust (STH) against Cancer Waiting Times (CWT) performance thresholds in the past has been satisfactory, with no persistent failure to achieve any single target threshold since the introduction of the Going Further on Cancer Waits performance framework. However, problems were encountered in the latter two quarters of 2010/11 that necessitated more proactive management of CWT performance being adopted in 2011/12, as detailed below.

Quarter 1 (Q1)

The risk of receiving a red rating from Monitor at the end of Q1 arose if **either** of the 62 day (GP referral or Screening referral) thresholds was not achieved in Q1.

These two standards together form a single target and attract a weighting of 1.0. Monitor may apply a red risk governance override if the target is breached for three successive quarters.

Performance in STH fell below the required level in the screening standard in quarter three. 2010/11. The GP referral standard was below the required level in quarter four 2010/11.

Cancer Summits (CEO and Director of Service Development meetings with lead clinicians and senior managers) commenced in May 2011 and the resulting action plan to improve performance against the 62 day cancer targets resulted in achievement of the compliance thresholds for quarter 1. Detailed analysis identified the main areas of performance risk with STH and also revealed that a substantial proportion of 62 day GP and screening breaches occurred in patients referred from other hospitals.

Quarter 2 (Q2)

Risk relating to performance against the 62 day screening referral to treatment standard continued. The pathway of each screening patient continues to be monitored closely.

It became apparent, half way through the quarter, that there was also a significant risk to the achievement of the 31 day subsequent (surgery) treatment standard and a risk to the achievement of the 31 day first treatment standard, almost entirely resulting from capacity constraints in Urology. An action plan to improve Urology performance in providing surgical treatments was implemented and resulted in achievement of the compliance threshold for both the first and subsequent (surgery) treatment standards for Q2.

Compliance with all the thresholds for Q2 was achieved.

Quarter 3

The day of Industrial action (30 Nov) resulted in some challenges to delivery of cancer pathways. Considerable efforts and forward planning resulted in no increase in the number of breaches.

Because of the performance challenges during 2010/11 and the problems experienced during quarters 1 and 2, an external review of Cancer Waiting Times systems and processes was commissioned and completed in the autumn.

Work to implement the recommendations from the external review of cancer services continues, but these can be categorised into five overarching themes:

- Development of clear roles and lines of accountability in the virtual cancer management structure
- Ensuring all staff are adequately trained and equipped for their roles
- Reviewing the effectiveness of Multidisciplinary Team working
- Developing an “information architecture” for cancer services
- Developing a performance management framework for the delivery of CWT targets

Compliance with all the thresholds for Q3 was achieved.

Quarter 4

Performance in Q4 was adversely affected by patient choice over Christmas, as is normal, although there has not been a significant activity backlog being carried forward from Q3 into Q4.

Compliance with all thresholds has been achieved in Q4.

Summary

Following CWT performance challenges during 2010/11, there has been proactive performance management of CWT performance and cancer pathways during 2011/12 which has resulted in the achievement of all CWT performance thresholds in all four quarters of this year. This is the first time that STH has achieved all of the targets in every quarter in a year. This is the result of considerable work across the whole organisation. Following an external review of CWT performance management within the trust, work to develop a more robust system of CWT performance management that will assure future good performance is underway.

Potential risks to future performance:

- Bowel awareness campaign. National campaign from end January. The capacity plan for increasing out patient and endoscopy capacity has been successful in accommodating the increase (40%) in referrals
- Other awareness campaigns – Lung and Breast expected. Capacity plans will be developed to accommodate predicted increases in activity
- Continuing work with DGH's on shared breaches, particularly late referrals

PEER REVIEW

The Cancer Peer Review process is the national quality assurance programme for cancer services. It can consist of either a visit by external Cancer Peer Review inspectors or a self-assessment by the MDT sometimes followed by an Internal Validation process by the Trust and External Verification by the Cancer Peer Review Zonal Team. During a visit or a self-assessment, each MDT is assessed for compliance against a series of measures that are specific to that MDT. The results of a visit are recorded as a percentage of compliance against the measures plus a written record of any problems that are found during the inspection. Depending on their seriousness, these problems are classified as concerns, serious concerns or immediate risks. The results of an External Verification are recorded as a RAG (Red, Amber, Green) rating. The results from the external assessments are set out below.

June 2011 - Peer review visits

No immediate risks were identified.

A single serious concern was identified.

Compliance rates
Head and Neck 77.8%
HPB (Pancreatic) 72.7%
Specialist Urology 90.7%
Thyroid 71.1%

Serious Concern
There is no named palliative care core team member on the HPB Team. There are effective links in place, should a referral to the palliative care team be required, but the majority of the patients do require palliative care/treatment or advice from the outset. The Zonal Team was pleased with the Trust response to this concern and satisfied that, pending implementation of the permanent solution (palliative care core team member to attend HPB MDT from end of October 2011), existing links would be maintained.

January 2012 - External Verification (EV) of Internal Validation (IV)

No immediate risks were identified.

Outcomes:
RAG-rated as Red (External Verification disagreed with the Internal Validation report or identified a significant issue with the content)

- Teenage and Young Adult (TYA)

The Zonal Team identified a significant issue - gaps in relation to social worker, allied health professionals and youth worker/activity co-ordinator. All of these must be included in the core membership of the MDT, requiring physical attendance and cover for absence. The Trust's Internal Validation had not considered this to be a concern as patients do benefit from contact with these specialists as and when required throughout their care pathway. The Trust felt that the care of patients is not compromised as a result of these specialists not being listed as core members of the MDT. The TYA service will be subjected to a Peer Review visit in June 2012.

RAG-rated as Amber: (External Verification agreed with Internal Validation with exceptions)

- Chemotherapy WPH - Terms of reference to be revised to include training and competence
- Chemotherapy Intrathecal - Documentation to be revised to identify a single overall lead trainer
- Gynaecology – Confirmation required that the action point from the patient experience survey has been implemented

These are minor issues and only require that documented evidence be amended to reflect actual practice. This will be corrected in the evidence for the next round of peer review (Self assessment in 2012/13).

RAG-rated as Green (External Verification agreed with Internal Validation)

- Chemotherapy RHH
- Chemotherapy Pharmacy
- Testicular

Two Issues Common to the majority of MDTs

- Non compliance with requirements for level 2 practitioners for psychological support. These measures are new in this peer review round and the requirements are very difficult to achieve. Cancer teams are in the early stages of working towards compliance but it is likely that achieving compliance will be problematic for some time.

- Insufficient numbers of MDT core members have attended the recognised course for Advanced Communication Skills Training. Applications are now prioritised at Trust level against a national shortage of training places.

Action plans

Action plans to improve compliance with the Peer Review measures form part of the Trust's strategic service development plans and the work programmes of the appropriate cancer site services. The Cancer Executive is responsible for monitoring the implementation of the action plans.

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Schedule for Peer Review 2012/13

Those MDT's which have been selected, by the Zonal team, for Peer Review visits in 2012:

TYA
Acute Oncology Service (AOS)
Brain/CNS
Sarcoma

The other cancer MDTs will be subject to either self assessment only or self assessment followed by internal validation and external verification.

<u>Summary</u>

There are no outstanding Immediate Risks or Serious Concerns from the peer review visits of June 2011.

The outstanding red RAG rating resulting from the External Verification of the TYA service will be reviewed during the peer review visit to the service in June 2012. as the Trust's Internal Validation had not considered this to be a concern and felt that the care of patients is not compromised.

The overall performance against the peer review standards has been excellent and compares favourably with other similar providers

CANCER SCREENING SERVICES

Breast Screening

The age extension to breast screening was successfully implemented in the trust in May 2011. A review of breast screening services, including commissioning intentions, remains under review within the Network.

Quality Assurance (QA) of the Breast Screening Service
A QA inspection of the Breast Screening Service was completed in October 2010. The majority of actions required to improve services have been completed. The few actions outstanding are being implemented. There are no serious concerns. The next QA visit is scheduled for October 2012.

Bowel screening
This relatively new service (2007) was praised by the QA Visitors (April 2011) who were impressed at the energy, time and effort that had gone into the setting up the programme and felt that what had been put in place was exemplary. The service is led by a clinician who is clearly passionate about the programme and is supported by a strong team of like-minded clinicians, management and staff who have patient safety and quality at the heart of their work.

Quality Assurance (QA) of the Bowel Screening Service
A QA inspection of the Bowel Screening Service was completed in April 2011. The majority of actions required to improve services have been completed. The few actions outstanding are being implemented. There are no serious concerns. As the QA system for the Bowel Screening Programme is in its infancy a date for the next QA visit has to yet been scheduled.

Cervical screening
Since January 2012 testing for high risk HPV (Human Papilloma Virus) has been provided on site (previously Mancheter). This has resulted in improved turnaround times and the colposcopy service continuing to achieve its targets.

Quality Assurance (QA) of the Cervical Screening Service
A QA inspection of the Cervical Screening Service was completed in June 2010. A few minor actions remain outstanding from the action plan. There are no serious concerns. The next QA visit is scheduled for February 2013. The service last received CPA accreditation in May 2010. There are no outstanding non conformities. The next CPA accreditation is scheduled for May 2012.

NATIONAL SPECIALISED SERVICES

Choriocarcinoma service (gestational trophoblastic disease)
A very early bid was made, in 2011, to the national commissioners to extend this service to include treatment for very rare ovarian germ cell tumours. A response is still awaited.

SERVICE IMPROVEMENTS

TYA (Teenage and Young Adults) Late Effects Service
TYA patients completing their oncology follow-up are referred on to the late effects service. Access to Psychological services for patients once they have reached their 25th birthday is now available. However, access to social care for patients beyond their 25th birthday continues to be a challenge. A business case is to be developed for discussion with service providers of social care.
A comprehensive screening service for patients with Fanconi Anaemia, a rare genetic condition that predisposes an individual to malignancies, has now been adopted in the adult late effects clinic.

Recall of patients who received autologous stem cell and high dose chemotherapy treated since the mid 90's is to be undertaken in 2012/13.

Work on a patient DVD regarding late effects information for TYA patients continues in earnest. Much of the filming is complete and editing in process. Completion of filming is due imminently and it is hoped to launch the DVD in the summer of 2012.

CANCER DATA

The increasing importance of robust cancer data management

Underlying most of the service improvement initiatives is a need for good quality data. The contractual obligation to submit the national Cancer Registry data set has forced a review of the way cancer data are managed within STH. A need has been identified to consolidate, where possible, the collection of cancer related data. This has been achieved by extending the system currently in use for the collection of GFCW target data. This extended system centres around MDTs; supporting the MDT meeting process and providing the facility to capture elements of the Cancer Registry dataset discussed at these meetings. This work also supports the collection of tumour specific audit data. The work provides a structured information system ready to support the collection of the anticipated Cancer Outcomes and Services dataset which will be contracted for delivery from January 2013.

The work to amend the information system to manage the collection and submission of GFCW target data and support the collection of Cancer Registry minimum dataset, has not been formalised in a project and has not received any additional external resource. Prioritisation and development of cancer-related informatics projects is being carried out through the new project management framework being implemented by the Interim Director of IM&T. This includes a project to assess new software for inter-trust information transfer being carried out in collaboration with the Barnsley and Rotherham hospital trusts.

EXTERNAL QUALITY INSPECTIONS

National Chemotherapy Advisory Group (NCAG)

This report, published in 2009, made recommendations on the provision of chemotherapy and acute oncology services. The term ‘acute oncology’ refers to the management of emergency admissions of patients with cancer or with suspected cancer. These admissions may be due to the initial presentation of the cancer happening as a medical or surgical emergency, acute complications of the disease or its treatment or conventional medical or surgical emergencies occurring in cancer patients.

An Acute Oncology Service has been in place at Weston Park Hospital (WPH) since January 2009 and has had a positive impact on the management of emergency admissions on that site with evidence of reduction in length of stay and admissions avoidance.

One of the major challenges for the Trust will be delivering an Acute Oncology Service to the NGH. An initial pilot started in late 2010 to understand the size and the nature of the service required on the NGH site. A further pilot commenced in April 2011 which enhanced the service provided as well as generating further valuable data.

The need to provide an Acute Oncology Service to each of the 5 cancer units in the Network will also be extremely challenging. A Network Workshop was held in January 2012 to examine alternative models of oncology provision across the network as it is recognised that the current configuration of services makes it difficult to release medical time for Acute Oncology. A pilot with Chesterfield and north Derbyshire Royal Hospital (CNDRH) will commence in May 2012 to understand the implications of a new model of working and to assist in the development of principles that can be applied across the network.

National Radiotherapy Advisory Group (NRAG)

Work continues to understand why rates of radiotherapy delivery in North Trent are lower than predicted according to the size of the population and thus to understand whether there is a need for increased radiotherapy capacity. The department has been a pilot site for the MALTHUS project which provided the opportunity to model radiotherapy demand more accurately. The MALTHUS model was beta tested of behalf of NCAT, resulting in significant changes in the software prior to release. MALTHUS has now been used to model the demand for lung cancer radiotherapy in Sheffield in detail and, reassuringly, showed this to be very similar to the radiotherapy delivered in 2011. Further work is ongoing across a number of tumour site groups to predict future demand and therefore inform the business case for replacement and additional Linear Accelerators.

QART
The externally accredited quality assurance system for radiotherapy. The Radiotherapy department is involved in a continuous process (rolling programme) of 'auditing for improvement' in order to retain accreditation.

North Trent Blood and Marrow Transplant programme

During an interim inspection (October 2011) all aspects of the Sheffield RHH programme were assessed as compliant by the inspector. There are no areas of concern evident from this Interim Audit and so the current accreditation for the STH programme is unaffected. No further action is required.

SUMMARY OF THE MAIN ACHIEVEMENTS

- Compliance with all cancer waiting times thresholds in every quarter in the year.
- Excellent performance against the cancer peer review standards
- Provision of high quality cancer screening services.
- Provision of a comprehensive, patient focused Late Effects Service to long term cancer survivors (older than Teenagers/Young Adults).

SUMMARY OF THE MAIN CHALLENGES

- Implementation of the recommendations from the external review of cancer services.
- Formulating a strategy for STH cancer services that parallels the new trust strategy and takes into account the NHS structural changes resulting from the Health and Social Care Act.
- Sustainability of maintaining the delivery of performance against the cancer wait targets.
- Securing resources required to implement plans associated with meeting Improving Outcomes Guidance and service developments following peer review.
- Maintaining the WPH assessment unit which is fundamental to underpinning the Acute Oncology Service across Sheffield and the Network. Commissioners have not agreed to recurrent funding so the provision of this service remains an additional cost pressure for WPH.
- Extending the STHFT Acute Oncology Service to the Northern Campus and developing a Network wide Acute Oncology Service. If the pilot with CNDRH re oncology models is successful it will be necessary to run the old and new systems in parallel for about 3 years.
- Accurate modelling of radiotherapy demand to inform future plans regarding radiotherapy capacity and/or satellite centres.
- Complying with the National and Trent Cancer Registry MDS.

- The very detailed workload required of an ever increasing number of external inspections and Internal Validation (Peer Review workload in particular).
- Managing the implications of the revised ‘Improving Outcomes: A Strategy for Cancer January 2011’.