NHS
Peninsula Cancer Alliance

Phase 3 Recovery Planning
v3.2, 6 October 2020

1. Summary

	Phase 3 Requirement	Peninsula Cancer Alliance Outcomes
A1.1	Suspected cancer referrals to at least pre-pandemic levels.	***As part of overall communications with public, specific messages about cancer, both attending GPs with concerning symptoms and attending hospital appointments.*** ***Specific work with Primary Care Networks to support return to normal levels of referral for lung cancer*** ***Providers should include plan for a return to normal levels of referral for all tumour sites.***
A1.2	Sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres.	***Providers should plan to have no more than 2 weeks from test request to test result.*** ***Providers should plan for pathology reports to be available within 5 working days for diagnostics pathways. Including molecular testing.*** ***Providers booking cancer diagnostics test at more than 2 weeks should seek mutual support and shared waiting list***
A1.3	Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.	***Providers should plan to have no more than 2 weeks from test request to test result.*** ***Providers booking cancer diagnostics test at more than 2 weeks should seek mutual support and shared waiting list***
A1.4	Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.	***Cancer treatments should be scheduled within 31 days of a decision to treat, including cancer surgery deemed priority 3, so as to meeting 31 day Cancer Waiting Times Standards*** ***Providers who are booking treatments at more than 31 days should seek mutual support and shared waiting list***

A1.5	Specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.	***Specific work with Primary Care Networks to support return to normal levels of referral for lung cancer***
A1.6	Fully restarting all cancer screening programmes.	***Providers should include additional screening activity and subsequent cancer referrals in their capacity plans.*** **Bowel screening** Dependent on colonoscopy (see A1.3) and histopathology (see A1.2) **Cervical Screening** **Breast Screening**
A1.7	Reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.	Providers should agree a recovery actions plan to achieve 1. All four 31 Day standards 2. Feb 20 62 Day performance[1] 3. PTL for 63-103 days of no more than 4% of backlog 4. PTL for 104 day plus of no more than 4% of backlog
		Implement specific pathways changes that support recovery

Community hospital and independent sector services should be used to support delivering objectives A1.2, A1.3, A1.4, A1.7

[1] This will mean some tumour sites will need to achieve much higher than 85% performance against the 62 day standards, as set out in Alliance Tumour Standards

2. Introduction

Providers in the Alliance have come together to provide mutual support throughout the Covid pandemic. Phase 3 Covid recovery planning sets out the expectation for a return to near normal activity and performance against cancer waiting times. This document sets out the expectation for each provider on the scheduling of treatment, diagnostics and pathology reporting. Providers should work with their STP and the Alliance where meeting these expatiations is not currently possible.

This means that cancer services in the Peninsula will continue to have priority access to diagnostics and treatment capacity. Providers that are unable to plan for the above should specify the services and seek mutual support and shared waiting list with other providers. This will be coordinated though the two Alliance Treatment Prioritisation Hubs. This will include mutual support from other providers and additional services commissioned outside of the acute providers (including independent sector, NHS Nightingale or NHS Community Hospitals).

Providers should have contingency plans to continue to deliver these standards during the winter, future COVID waves and with the planned restart of NHS Screening programmes. Providers are working with the Cancer Alliance to implement revised pathways as agreed within the Peninsula Cancer Alliance.

3. Suspected cancer referrals

Urgent cancer referrals have generally returned to least pre-pandemic levels but with some exceptions, notably lung cancer. The Alliance will commission:
As part of overall communications with public, specific messages about cancer, both attending GPs with concerning symptoms and attending hospital appointments.

Specific work with Primary Care Networks to support return to normal levels of referral for lung cancer.

Providers should include plan for a return to normal levels of referral for all tumour sites.

The Cancer Alliance will work with Primary Care Networks with the most challenges for Early Diagnosis which will address pre-existing inequalities and support recovery in particular in these PCNs. Referral rates have recovered well in the Alliance with the exception of lung cancer. The PCN support work will include specific work to identify patients with lung cancer symptoms. The Alliance is also supporting wider engagement with the PCNs to enable them to address the cancer DES. Specific actions through the CRUK facilitators are being undertaken to address lung cancer, include identification of ‘at risk’ patients in GP registers.

a. Support for Patients

Part of supporting patient to have confidence in using services will be clarity around the testing of staff and patients and clear guidance on shielding and self-isolation before appointments.
STP should agree consistent approaches to testing of staff and patients and clear guidance on shielding and self-isolation before appointments.

b. Health inequalities

- The Alliance’s Patient & Public involvement Lead is supporting through Ethnic Minority joint project with Macmillan
    - RDS Pulse Survey
    - RDS Annual Survey

The Alliance is supporting, through the new Cancer DES the sharing of experiences of successful engagement and community-focused projects to improve screening uptake.

See also Section 3

4. Screening

S7a Cancer Screening recovery – Devon, Public Health Commissioning Team

S7a Cancer Screening recovery – |

Providers should include additional screening activity and subsequent cancer referrals in their capacity plans.

5. Treatment Priority

The *Specialty guides for patient management during the coronavirus pandemic* sets out levels of priority of treatment during Covid-19. For cancer surgery this sets out timescales for treatment

Cancer Surgery

Priority	Timescale
1a	Within 24 hours to save life
1b	within 72 hours
2	Elective surgery within 4 weeks (28 days)
3	Within 12 weeks (84 days)

This guidance also specifies 6 levels of priority for systemic anti-cancer therapy (SACT) and 5 levels for radiotherapy but does not provider timescales.

Phase 3 requires a return to meeting the 31 Day Cancer Waiting Times Standard to treat patients within 31 days of a decision to treat

Cancer treatments should be scheduled within 31 days of a decision to treat, including cancer surgery deemed priority C, so as to meeting the following standards
This was achieved for July 20 for the Alliance for 2123 patients out of 2175 (98%)

		Performance July 20					
Measure	**Std**	NDH	RCH	RDE	TSD	UHP	PCA
31-day wait from decision to treat to first treatment	96%	99%	99%	94%	99%	98%	98%
31-day wait for subsequent anti-cancer drug regimen	98%	100%	100%	99%	100%	100%	100%
31-day wait for subsequent radiotherapy	94%	n/a	100%	99%	100%	85%	95%
31-day wait for subsequent surgery	94%	100%	100%	79%	96%	97%	94%
31-day wait from decision to treatment - All		99%	99%	95%	99%	97%	98%

6. Access to Radiology and Endoscopy

For urgent cancer referrals, Phase 3 requires a reduction in patients waiting for longer than 62 days, with an immediate plan for managing those waiting longer than 104 days. In addition to scheduling treatment within 31 days this will require reducing the waiting times for diagnostic

tests. Pre Covid, providers has local procedures for timely access to diagnostic tests to allow patient to be treated within 62 days. *These varied by tumour pathway but*
Providers should plan to have no more than 2 weeks from test request to test result.

The Adopt and Adapt actions for endoscopy include the dissemination and adoption of the latest guidance for IPC from the BSG. FIT testing, which has been available for 18 months will be used to triage both the backlog and future 2ww referrals for suspected colorectal cancers.

7. Pathology Reporting Times

Reporting times for pathology were a common contributor to cancer waiting times pre-Covid. As activity returns to normal levels or even above normal:
Providers should plan for pathology reports to be available within 5 working days.

8. Cancer Waiting Times

The restoration of diagnostics and surgery capacity (A1.2, A1.3 and A1.4) will be the main way in which Cancer Waiting Times Standards will be met. In addition, **providers should agree a recovery actions plan to achieve**

1. All four 31 Day standards
2. Feb 20 62 Day performance
3. No more than 4% of reported 62 day pathways being 104 days plus
4. PTL for 63-103 days of no more than 4% of backlog
5. PTL for 104 day plus of no more than 4% of backlog

Providers will continue with pro-active harm reviews of those waiting more than 104 days from an urgent GP referral. Any harms identified should have a root cause analysis and will be reported to the trust board. The Alliance has already shown the significant reduction in 104 day waits since 15 March. Providers will continue to reduce 104 days waits – aiming for no more than 4% of the backlog to be over 104 days.

9. Practicalities of mutual support

We recognise that providing mutual support to other providers is difficult. All providers have constrained capacity and patients are often reluctant to accept more distance services, especially if they are being asked to switch mid-pathway from one provider to another. This means that we need to plan for shared support by treatment or diagnostic modality and not wait for individual patients waits to prompt seeking an alternative service.

- **Providers who are booking treatments at more than 31 days should seek mutual support and shared waiting list**
- **Providers booking cancer diagnostics test at more than 2 weeks should seek mutual support and shared waiting list**

10. Workforce

The Alliance is working with Health Education England to support training in a number of areas (nurse endoscopy, reporting radiographers, prostate biopsy). We will also engage a workforce expert to support team to take a more holistic review of their skill mix and potential for development, which then inform longer term training commissions from HEE.

11. Alliance Long Term Plan and Adapt & Adopt

Recovery of cancer will depend on access to services also covered by STP Apart & Adopt plans, specifically CT & MRI, Endoscopy and Theatres. The South West also has a Cancer Apart & Adopt

hackathon on 24 September. This reiterated the priority changes in the Alliance Long Term Plan. Systems are now confirming with providers the timescales and support to implement each specific action. The recovery actions are in Appendix 1.

NHS
Peninsula Cancer Alliance

Appendix 1

South West Cancer Adapt & Adopt
Peninsula Cancer Alliance Actions
Draft v1.1 28 Sep 20

Topic	Lead	Action	Deadline	Connections to other Workstreams
Breast	Alliance	Breast pain service available for all practices for symptomatic breast referrals.	Dec 20	
Colorectal	Alliance	Introduce FIT for all 2 week wait referrals to support triage and management colorectal teams.	Sep 20	
Digital	Sunita Berry	Implement Image sharing and networks reporting	Tbc	A&A CT & MRI
Digital	Tbc	Implement digital histopathology	Tbc	
Digital	Tbc	Implement intelligent order comms both within and into acute providers	Tbc	
Digital	Providers	Put digital remote monitoring systems in place for breast, prostate, colorectal	Mar 21	
Lung - Faster Diagnosis	Providers	Cancer pathway navigators to support Faster Diagnosis (Lung)	Nov 20	
Lung - Faster Diagnosis	Providers	NOLCP Re-introduce reflex CTs for Chest X-rays coded as “CX3 - CT required”.	Sep 20	
Lung - Faster Diagnosis	STP	NOLCP CT same day as chest x-ray Or Outpatient appointment same day as CT	Tbc	A&A CT & MRI CT Capacity CT and x-ray reporting capacity, including hot reporting
Lung - Faster Diagnosis	Spec Comm	PET scanning reports available within x [tbc] days of request	Tbc	

Topic	Lead	Action	Deadline	Connections to other Workstreams
Lung (referrals)	PCA	The Alliance to support the 20% of PCNs with most challenges for early diagnosis. This will include specific work to identify patients with lung cancer symptoms.	Dec 20	A&A CT & MRI
Lung (referrals)	Alliance	The Alliance will support wider engagement with the PCNs to enable them to address the cancer DES. Specific actions	Dec 20	
Lung (referrals)	Alliance	Alliance to explore expanding tool to include smoking rates by practice	Oct 20	
Lung (referrals)	Alliance	Communication (inc. webinars) to demonstrate the cluster of symptoms of lung cancer and distinguishing these from COVID-19, encourage x-rays	Oct 20	
Lung (referrals)	Alliance	Lung cancer case finding pilot – 40-80 yrs., current or ex-smokers, raised platelet count Proactively contacting and inviting for x-ray	Dec 20	
Lung (referrals)	PHE STP Public Health	Programme of communication to public on presenting to GP with symptoms and attending hospital if referred. To include existing engagement with community leaders through outreach teams (e.g. MMR vaccine)	tbc	
Lung (referrals)	STPs	Additional CT & MRI capacity esp. in Exeter Access, where additional scanner needed	Tbc	A&A CT & MRI
Non-site Specific Symptoms	Providers	Rapid Diagnosis Services starts for Non-Site-Specific Symptoms pathway by November 2020. This is particularly important to support GPs in managing patients with a negative FIT.	Nov 20	
Risk Stratified Pathways	Providers	Implementation of Risk Stratified Pathways that support a reduction in routine follow up. (This is the cancer version of *Patient Initiated Follow Up* in Phase 3 planning guidance)	Dec 20	
SACT	Spec Comm	Expand range of medicines that can be self-administered at home, including oral and sub-cutaneous medicines Have medicines delivered to home	tbc	
SACT	STPs	Ensure sufficient space to deliver timely SACT	Tbc	
SACT	STPs	Increase number of non-medical prescribers	Tbc	
SACT	STPs	Move non-SACT treatment out of SACT Units (e.g. infusions)	Tbc	
SACT	RCH	RCH to run webinar on local flow improvements	Oct 20	

Topic	Lead	Action	Deadline	Connections to other Workstreams
Skin	Alliance	All suspected cancer referrals (2ww for MM or SCC and routine for BCCs) to be accompanied by a digital dermatoscopes image. Images to be triaged with clinical referral by dermatology teams to correct clinic or discharged.	Mar 21	
Skin	Alliance	Agree workforce required for transition period to full teledermatology and routinely thereafter. Develop workforce for triage of digital images to be agreed and developed Maximise contribution of other clinicians e.g. nurses/therapists/technicians to release medical capacity	Dec 20	
Skin	Alliance	Deliver training for GPs in skin cancer diagnosis and use of dermatoscopes.	Dec 20	
Upper GI	Providers	Consultant triage of all request for OGD (referral and direct access) Job-planning required to support this	Sep 20	
Urology - Faster diagnosis	Providers	Virtual telephone triage systems introduced to allow appropriate men to receive an MRI without a face-to-face / OPA clinical appointment first. This should happen within 3 days of referral received	Dec 20	
Urology - Faster diagnosis	Providers	Multiparametric MRI should be performed before biopsy	July 20	
Urology - Faster diagnosis	Providers	mpMRI should be reported using the PIRADS or LIKERT score	July 20	
Urology - Faster diagnosis	Providers	Biopsies should not be carried out on men whose mpMRI score (PIRADS or LIKERT) is 1 or 2 where mpMRI NPV is over 76% Is 3 where mpMRI NPV is over 95% (tbc)	March 21	
Urology - Faster diagnosis	Providers	Local anaesthetic transperineal biopsies should replace all trans-rectal ultrasound guided biopsies	March 21	
Urology - Faster diagnosis	Providers	Transperineal Biopsies are carried out under local anaesthetic This means that general anaesthetic template biopsies should cease (unless contra-indicated)	March 21	
Urology - Faster diagnosis	Providers	Providers deliver a workforce plan to reduce the proportion of biopsies performed by consultant surgeons	Dec 20	
Urology - Faster diagnosis	Alliance	Prostatectomy should not be routinely offered for men whose Gleason Group 1. Any offers should only be made after a full MDT discussion.	Sep 20	

Topic	Lead	Action	Deadline	Connections to other Workstreams
Urology - Faster diagnosis)	STPs	Providers should explore the introduction of mpMRI & Biopsy in same day	Dec 20	A&A CT & MRI
Urology - Faster diagnosis)	STPs	Set up Urology Area Networks	Tbc	
Urology - Inter-provider transfers	Alliance	Standards of Care agreed for all tumours, to facilitate MDT Modernisation.	Dec 20	
Urology - Inter-provider transfers	Alliance	Urology Cancer Images/Histopathology only reported by sub-specialist radiologists/histopathologists Images reported by sub-specialist not re-reported	Dec 20	Image Sharing
Urology - Inter-provider transfers	Alliance	All images reported across Peninsula available to all MDTs	Tbc	Image Sharing
Urology - Inter-provider transfers	Alliance	Establish mpMRI reporting rota across Peninsula	Tbc	Image Sharing
Urology - Robotic surgery	Alliance	Map demand and capacity for robotically assisted laparoscopic prostatectomies (RALPs)	Oct 20	
Urology - Robotic surgery	UHP	UHP expand capacity for RALPs	Tbc	Capital for theatres space
Urology - Robotic surgery	Spec Comm	UHP commissioned for additional RALPs	Tbc	Capital for theatres space
Urology - Robotic surgery	UHP & RDE	UHP and RDE develop closer working arrangements for RALPS	Dec 20	
Workforce	STPs	Review skill mix to reduce non-specialist work being carried out by specialists (of all professions) Esp. endoscopists	Tbc	
Workforce	STPs	Increase number of nurse endoscopists	Tbc	
Workforce	Alliance	Develop competency based teams (e.g. Improving capacity and capability of non-registered workforce)	Tbc	
Workforce	HEE RT Network	Develop career pathways for radiotherapy physicists	Tbc	
Workforce	Alliance	Alliance will fund a workforce expert to support design of improved skill mix, inc. competency based roles for a variety of teams.	Dec 20	

Topic	Lead	Action	Deadline	Connections to other Workstreams
General	Alliance	Support development of one-stop clinics in all pathways. E.g. PMB Dermatology See & treat	tbc	A&A CT & MRI
IPC	STPs	Ensure sufficient • Testing for patients before diagnostics or treatment • PPE for staff	Oct 20	