

**Year End Report from the Humber Coast and Vale Cancer Alliance**

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| **Date** | 16 March 2018 |
| **Purpose** | Provide an update to CCG Governing Bodies and Trust Boards on the work undertaken in 2018/19 by HCV Cancer Alliance together with the risks to the programme for 2018/19 |
| **Key Considerations** | The report sets out the following information:   1. What we have achieved in 2018/19 2. Details of the Cancer Alliances commissioning intentions for 2018/19 and beyond 3. Details of the transformation programme we are undertaking through 2018/19- 2019/20 4. The risks around the transformation programmes due to under performance against the 62 day cancer target 5. Handling strategy to mitigate risks   NHSE Approach to the release of transformation funding throughout 2018/19 is as follows and dependent upon alliances meeting the 62 day cancer performance target:   * Decision to release funding to be based on actual cancer 62 day performance (average of last 3 months) – Q1 2018/19 would be based on October to December 2017 average performance * Proportion of transformation funding to be held back if performance is below 85% during the 3 months * Personalised 2018/19 implementation plans to be developed for each Alliance to include:   + Any required actions on 62 day performance   + Priority focus on 2018/19 planning guidance deliverables * Once an Alliance meets the standard, the proportion of funding that was previously held back will be released * Same principles to be applied to all Alliances * Funding will be allocated on a tiered approach; those achieving the 62 day standard will receive 100% allocation, those achieving 80-85% standard would get 75% and those achieving less than 80% would only get 50% of their transformation funding.   The Cancer alliance has undertaken a prioritisation exercise to ensure that funding is managed appropriately and a risk mitigation approach which is set out in the paper. Clearly the focus is to meet the 62 day performance target and receive funding as early as possible in 2018/19. |
| **Recommendations: The Governing Body/Trust Board is asked to:** | * Note work undertaken so far by the HCV Cancer Alliance * Note the challenges faced by the Cancer Alliance in delivering its work programme * Support the Cancer Alliance Commissioning Intentions for 2018/19 * Note the financial risk implications of not achieving the 62 day cancer target in May June and July 2018 and the mitigating actions being undertaken by the Alliance partners * Note that further updates will follow in due course |

**1.0 INTRODUCTION**

This report intends to provide an update to partner CCGs Governing Bodies and Trust Boards:

* What we have achieved in 2018/19
* Details of the Cancer Alliances commissioning intentions for 2018/19 and beyond
* Details of the transformation programme we are undertaking through 2018/19- 2019/20
* The risks around the transformation programmes due to under performance against the 62 day cancer target
* Handling strategy to mitigate risks

**2.0 WHAT HAVE WE ACHIEVED SO FAR?**

Since the HCV Cancer Alliance was formed early in 2017 we have achieved the following:

* Agreed its governance arrangements including:
  + The Cancer Alliance System Board
  + 4 programme areas – Early Awareness and Diagnosis, Living with and Beyond Cancer, Diagnostics, Pathways & Treatment.
  + Agreed capacity to support the 4 programme areas with a Senior Sponsor, GP lead, Secondary Care lead and programme manager for each programme.
  + Agreed Terms of Reference for a System Performance, Assurance and Monitoring (SPAM) Group to provide the Alliance Board with an assurance function as well as supporting the system’s performance against key performance and quality indicators. The group is fully operational and includes representatives from NHS Improvement and NHS England.
  + Agreed Terms of Reference for the Programme Executive Group which is fully operational and responsible for the daily management of the programme and making executive decisions within the delegated authority from the Programme Board as necessary.
  + Support to the 3 Locality Groups within the HCV footprint
* Agreed system transformation priorities and plans aligned to meeting the ‘asks’ of the national Cancer Taskforce report.
* Received funding approval from NHSE for system transformation priorities as follows:
  + Revenue funding approved is £0.9m in 2017/18
  + Revenue funding approved for 2018/19 of £3.5m and
  + Capital funding approved of £2m for 2018/19
* Signed agreements with Cancer Research UK and Macmillan for funding and commitment to:
  + strengthen the programme team with primary care clinical input,
  + improve stakeholder engagement and communications
  + increase programme capacity for the living with and beyond programme.
* Produced detailed programme plans for the Alliance main work streams:

1. Awareness & Early Diagnosis
2. Diagnostics Consolidation
3. Treatment & Pathways
4. Living with and Beyond Cancer

* Provided support to providers to deliver the 62 day standard target via special funding allocations
* Developed a detailed HCV Cancer Dashboard Report and Exception Report to support the system to deliver on waiting times performance
* Agreed with stakeholders the role of the HCV Cancer Alliance as a support for transformation of services at critical points pre-crisis and working to resolve system wide problems/blockages.
* With regard to transforming the lung cancer pathway and improving outcomes:
  + Organised the Improving Lung Cancer Stakeholder Event that took place on 1st December 2017 which involved patients, commissioners and clinicians as part of our Early Diagnosis work stream
  + Progressed the lung health check programme
  + Established the lung group with the view to roll out the optimal lung pathways and had discussions about setting it up as a Tumour Site Specific Group (TSSG)
  + Agreed to support the launch of a tobacco campaign in media in July 2018

* With regard to improving early awareness and diagnosis:
  + Trained the first cohort of Cancer Champions
  + Produced the Business Case to roll out FIT within the HCV footprint
  + Agreed and signed an Memorandum of understanding (MOU) with York Hospitals for the materialisation of the FIT research included in the transformation bid
  + Agreed to support the launch of a tobacco campaign in media in July 2018

* With regard to improving diagnostic capacity:
  + Produced a diagnostics capacity and demand model for the HCV footprint
  + Progressed the procurement processes of kits to support the networked models of Pathology and Radiology
  + Recruited increased number of radiology staff
* With regard to improving treatment pathways:
  + TSSGs for Prostate, Colorectal and Vague Symptoms are also within the plans

**3.0 HCV CANCER ALLIANCE COMMISSIONING INTENTIONS**

We have engaged with commissioners, providers, STP representatives, NHSE and NHSI at our System Performance, Assurance and Monitoring Group. We have agreed the aims for the medium to longer term of the HCV Cancer Alliance as well as the specific Commissioning Intentions 2018/19, incorporating NHSE and NHSI Planning Guidance (Feb 2018) and providers aspirations.

**3.1 The HCV Cancer Alliance medium to long term aims agreed as follows:**

1. Delivering sustainably 85% performance on 62 day standard for the HCV Cancer Alliance footprint.
2. Improve awareness of cancer symptoms in the HCV population through the use of cancer champions and active case finding
3. Improve Diagnostics Capacity in the HCV Cancer Alliance footprint by investing in the services as well as being more efficient in the way we use resources through encouraging and facilitating the implementation of network models
4. Implement in the HCV cancer Alliance footprint the optimal lung pathways (complete pathway including primary care)
5. Implement in the system the prostate and colorectal high value care pathways (complete pathway including primary care)
6. Implement the Vague Symptoms Pathway (complete pathway including primary care)
7. Provide a consistent cancer recovery service for all patients across Humber, Coast and Vale through consistent risk stratification and a patient centred recovery package service offer which will improve patient experience. In first instance, to be applied to colorectal and breast cancer.
8. Explore the possibility of some hospital trusts becoming lead providers for some cancers.
9. Improve fragile services: ENT, Urology, Haemathology
10. Support the system to deliver the 85% performance target on 62 day standard
11. Reduce variation in referrals

**3.2 Commissioning Intentions 2018/19**

As a result of engaging with our stakeholders in the system, we have also agreed our absolute priorities for financial year 2018/9:

1. 62 Day Standard support
2. Transformational Projects:
   1. Networked Models of Pathology
   2. Networked Models of Radiology
   3. FIT Roll Out
   4. Lung Health Check Programme
   5. Cancer Champions Programme
3. Support fragile services and critical safety concerns/quality issues as requested
4. Set up Task and Finish groups for Cancer Site Specific Groups (SSG) for clinical high value pathways

**4.0 OUR TRANSFORMATIONAL PROGRAMMES**

The HCV Cancer Alliance is working towards system wide delivery of a number of transformational change initiatives that will support cancer services in the footprint to improve and meet performance standards included in the waiting times cancer dashboard and in particular, support the delivery in a sustainable manner 85% on the 62 day waiting standard. The transformational change initiatives are also designed to meet patient’s needs.

A detailed description of our proposed transformational change initiatives and outcomes expected from every single one of them can be found in Appendix A.

**6.0 RISKS**

There is an inherent risk in the proposed approach from NHSE to the release of cancer transformation funding in 2018/19.

The approach can be summarised as follows:

* The decision to release funding is to be based on actual cancer 62 day performance (average of last 3 months) – Q1 2018/19 would be based on October to December 2017 average performance
* A proportion of transformation funding is to be held back if performance is below 85% during the 3 months
* Personalised 2018/19 implementation plans to be developed for each Alliance to include:
  + Any required actions on 62 day performance
  + Priority focus on 2018/19 planning guidance deliverables
* Once an Alliance meets the standard, the proportion of funding that was previously held back will be released
* Same principles to be applied to all Alliances
* It is expected that funding would be allocated on a tiered approach;
  + those achieving the 62 day standard will receive 100% allocation,
  + those achieving 80-85% standard would get 75% and
  + those achieving less than 80% would only get 50% of their transformation funding.

This may have serious implications for delivery of transformation programmes within the original timescales, particularly for those Alliances who have already committed to funding transformation staff until March 2019 and have raised these risks, among others with the National team.

For HCV risks for each programme are summarised in Appendix 2

**7.0 FINANCIAL RISK MITIGATION - PRIORITISATON**

Because of the risk of delays to receipt or reduced funding the Cancer Alliances System Board has put in the following risk mitigation actions:

* Asked Provider Trusts whether any further support can be given by the Cancer Alliance which would dramatically enhance the likelihood of delivering 85% performance against the standard. No further action has been identified to date.
* Identification of funding that has already been pre-committed across all work streams e.g. people in posts.
* Completion of an exercise using weighted scoring criteria to understand Cancer Alliance System Board member views about which projects should be given the highest priority. The criteria and weightings were agreed at the Cancer Alliance Systems Board meeting on 12 March.
* An internal review of the forecast spend against each project with a view to reducing the scale, and consequently any uncommitted costs, of projects that were rated as lower priorities by stakeholders.
* A further review of each project to remove costs for items that are over and above the essential elements required for delivery of the agreed aims of the project.

The results of the prioritisation exercise are set out in Appendix 3.

This prioritisation will form the basis of the HCV Cancer Alliance Individual Funding Agreement with NHSE.

Clearly the main mitigation is to support our partners in being able to meet the 62 day target.

**8.0 CONCLUDING REMARKS**

Overall 2017/18 has been a year of significant progress and embedding for the Cancer Alliance thanks to all system partners efforts.

2018/19 will be a challenging year. We will continue to focus on improving patient experience, delivering value for money and ensuring excellent clinical outcomes and the delivery of transformational change to the HCV Cancer Alliance footprint. We will do so ensuring the Transformation Fund monies are wisely and effectively spent.

We will continue to ensure that the programme is clinically led. As HCV Cancer Alliance we will continue to work with our key stakeholders to develop and commission service improvements in cancer services that will support the system to meet the growing needs of our patients. We will continue to work with local commissioners, acute providers, primary care, the voluntary sector, local authorities, patients and the public to support the services to meet the dashboard waiting times targets and in particular the 62 day standard target.

As the HCV Cancer Alliance, we will continue to be a conduit for integration of services across the footprint. As such, we will support the clinical services review currently taking place within Humber Coast and Vale.

In order to achieve our ambitious commissioning intentions we will need to ask for continued support from our partner organisations.

We also want to thank the representatives of our partner organisations for their input and continued support so far.

**APPENDIX A – HCV Cancer Alliance Proposed Commissioning Work and Outcomes expected**

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| **INITIATIVES** | **OUTCOMES** | **DESCRIPTION** |
|  | **1.0 Improving Awareness and Early Diagnosis (A&ED)** |  |
| **1.1 Cancer Champions** | * Increase public awareness of signs and symptoms of cancer * Increased awareness of risk factors for cancer and reduction in high risk behaviours and understand barriers to healthy lifestyles * Increase in the number of cancers diagnosed at an early stage * Reduction in proportion of cancers diagnosed via emergency presentation * Local volunteer education * Engagement of communities in the cancer agenda * Reduction in mortality under 75 | The Cancer Alliance aims to develop a model of Community Champions for Cancer across Humber, Coast and Vale. These champions are volunteers who receive training to enable them to educate and raise awareness of risk factors and signs of symptoms of cancer amongst their social circles through word of mouth and distribution of written information. The role will also include signposting to lifestyle intervention and support services. Whilst it is intended that the entire region will be covered by a network of community champions, the highest concentration of resources will be in those areas which have the highest risk populations, highest incidence of preventable cancers and highest rates of emergency or late stage presentations and vulnerable population groups. These target areas and populations will be identified using practice level data and through close working with colleagues in public health. This project builds upon the established programme in North East Lincolnshire which has achieved a 15% increase in the number of people who could identify signs and symptoms of cancer as well as an 11% increase in willingness to act on symptoms. The project will also learn from success elsewhere such as West London Tri borough and will have both Macmillan and CRUK partners as part of the project for continued shared learning and support |
| **1.2**  **Primary Care Education Workforce Training** | * Increased skills and confidence within primary care clinicians * Reduced variation in referral processes and access to early diagnosis * Improved patient experience * Increase in the proportion of cancers diagnosed at an early stage * Increase in survival at 1, 5 and 10 years * Improved management of COPD | We will ensure a continuous cycle of primary care education to reduce variation in practice and improving referral processes and safety netting, access to diagnostics and consequently earlier diagnosis and improved patient experience. The project will include the development of cancer champions across primary care. As part of this we will take a strategic approach to primary care leadership, developing a network of leaders across HCV who have clear mechanisms for providing: primary care input into each of the alliance projects, a link between primary and secondary care and a robust means of ensuring colleagues across primary care are engaged in the work plan and delivering on expectations. We will align policies relating to primary care prescribing such as for chemoprevention and ensure that primary care colleagues act on those agreements and we will support public health colleagues in raising awareness of developments within national screening programmes. General practice – GP leadership and peer to peer support is already in place. This encourages each practice to review their cancer data, carry out SEAs, use safety netting techniques and refer suspected cancers in line with NICE guidance. We intend to continue this cycle of support to further reduce variation in practice and to create opportunities to share the learning from audits. In addition, we are committed to working with academics and colleagues in cancer alliances across Y&H to develop a primary care quality standard. Metrics will be used to identify high performing practices who can share best practice and lower performing practices where targeted support (to either GPs or practice nurses ), may be required. Support will be based on learning from existing tools and practices (CRUK and Macmillan). Alongside this we will be working with pharmacists to increase their role in the recognition of early signs and symptoms of lung cancer and provision of advice and information to patients. Learning from the ACE pilots, we will explore the potential for pharmacists to refer patients for low dose CT scans. If successful, we will roll out this initiative to cover additional tumour sites. |
| **1.3**  **Active Case Finding** | * Improved patient experience * Increased uptake of national screening programmes * Reduction in variation in uptake across HCV * Improved accessibility of national screening programmes * Earlier detection of asymptomatic cancers * Reduction in late stage or emergency diagnosis of cancers * Improved outcomes and patient experience * More curative and less invasive treatments for lung cancer | There is variation in screening uptake across the HCV region with some areas performing above the England average and others underperforming. Screening uptake rates vary from 68-78% for breast screening, 56-64% for bowel screening. For cervical screening, uptake rates across HCV are higher than the national average but there are pockets of low uptake within areas of high deprivation. HCV also have significantly higher levels of lung cancer diagnosed via emergency presentation. If the staging profile for lung cancer in HCV matched the best In the country then an additional 104 patients would be alive after 1 year and an additional 48 after 5 years. This project aims to implement a multifaceted programme of initiatives to reduce variation in screening uptake and to encourage early identification of lung disease/cancer. This will be done through two routes: 1. Working with colleagues in the national screening programmes to : 1) target areas of low uptake within the three national cancer screening programmes, using evidence based approaches to increase rates. Initiatives will include but not be limited to; picking up patients who have DNA’d, staff education to increase opportunistic promotion of screening and employing GP endorsement of screening invites and removing barriers to access for vulnerable patients 2) monitor and support roll out of new initiative within screening programmes such as the roll out of FIT and HPV primary screening  2. Active case finding for early lung disease and easy access testing the use of a mobile CT scanner within the areas containing the high risk patients. Tested case finding tools will be adopted (Liverpool paper) and linked to the community champions’ work so demonstrating a suite of initiatives targeted at the high risk populations.  The project will also link into national campaigns and local public health initiatives to ensure consistency and avoid duplication. Both work streams will be piloted before full rollout across HCV. |
| **1.4**  **FIT Roll Out Symptomatic Patients** | * Faster diagnosis * Reduced capacity demand on colonoscopies * Improved patient experience * Reduction in A&E presentations * Increase in 1 year survival rate * A faster streamlined colorectal screening pathway | Colorectal cancer is the fourth most common cancer registered in England and a major cause of mortality and morbidity and uses a significant proportion of health service resources. It is the second biggest cancer killer but if diagnosed early enough there’s more than a 90% chance of successful treatment. Last year in the UK over 240,000 patients with lower abdominal symptoms were seen by a specialist following an urgent GP referral for suspected cancer. The majority of these will be referred for a colonoscopy however only about 4% of them will have cancer.  The quantitative Faecal Immunochemical Test (FIT) is a new cost efficient, take home test that has potential use in acting as a “rule-out” test for significant bowel disease for symptomatic patients. The test is currently being piloted in multiple areas across the UK e.g. Lanarkshire, Tayside, Dundee and London and has been shown to accurately predict which patients are at highest risk of a serious condition. Results have suggested that through designing a FIT pathway in general practice, colonoscopy demand could be reduced significantly by approximately 40% in this group of patients. This has the potential to free up significant endoscopy capacity for high risk patients. This project aims to work with the other cancer alliance across Y&H to design a FIT pathway, which can be applied across the HCV sub region. The rollout will be phased, piloting the pathway first in areas of that have the greatest need, followed by mobilisation across HCV. |
|  | **2.0 Diagnostics Consolidation (DC)** |  |
| **2.1**  **Diagnostics Capacity and Demand Model Development and Analysis** | * Increased earlier stage diagnosis/reduced A&E presentation * Increased patient survival rate * Improved patient experience and outcomes * Improved local access to diagnostic services * Streamlined, standardised and evidence based pathway * Increased process efficiencies & effective use of diagnostic capacity (equipment and workforce) * Reduced unit cost of diagnosis | National cancer data indicates that the Humber, Coast and Vale struggle to maintain compliance with cancer waiting times on a consistent basis for all cancers. Reviews of patient level data across HCV show that delayed access to diagnostics is a common reason for breaches on 31 and 62 day pathways and will be a key factor in the future ability to meet the 28 day ambition.  Whilst each provider has undertaken work on demand and capacity modelling and monitors this on an almost continual basis, this data, and consequently the actions required have not been modelled through on a regional basis.  This project aims to develop a detailed understanding of the as-is service capacity, demand, performance and financial flows associated with diagnostics across the whole of HCV and how this will be impacted by future demand projections (drawing on the UCLH model). This work will support the treatment and pathways work for the priority tumour sites as well as the development of vague symptom pathways and the networked model for radiology and pathology. The work will need to take account of non-cancer as well as cancer diagnostics. This information will support the development of a single service specification and the implementation of new operating models and changes to pathways which may be required |
| **2.2 Networked Models of Pathology** | * Better staff retention and more efficient use of workforce * Faster turnaround times and earlier diagnosis * Ability to meet 28, 31 and 62 day standards * Capacity for MDT pathway for diagnosing vague symptoms * Strengthen professional leadership * Support the case for networked approach to service delivery * Better able to meet patients individual needs and improved patient experience | Pathology play a critical role in the diagnosis, prognosis and monitoring of cancer and the number of patients being referred to pathology services is increasing. Multiple Carter reviews have endorsed networked pathology services that are set up with consolidated specialist services in a core site with satellite laboratories feeding in.  The shortage of Consultant Histopathologists is a key risk to the sustainability of cancer diagnostic services both regionally and nationally. This is likely to remain at least into the medium term (5 to 10 years) regardless of any recruitment and training initiatives. It is widely recognised that more could be made of the opportunity for improved skill mix by better utilisation of advanced practitioners and laboratory technicians. Early discussions suggest that there is an opportunity to grow the workforce (2 additional advanced practitioner roles per provider) to help create capacity to service the ever increasing demand for diagnostics. This project therefore aims to further develop the advanced practitioner and technician workforce in pathology and ensure consistency in their use across HCV. We propose to protect the sustainability of our pathology services in two ways. Firstly, we will develop a Digital Slide Scanning Service so diagnostic material can be shared remotely between sites. This will allow workload to be shared more efficiently between available histopathologists both locally and elsewhere, and faster referral to tertiary experts for opinion and MDT review. Secondly, we will enhance the regional Biomedical Scientist workforce by increasing advanced practitioner roles in specimen dissection and biopsy reporting, initiatives that have already been implemented and have borne advantages in Hull and elsewhere in the UK and Europe |
| **2.3**  **Networked Models of Radiology** | **2.3.1 Quality**     * Meet tumour site timed pathway aspiration * Improved patient experience as an outcome of rapid diagnosis and efficient pathway delivery * Whole pathway performance improvement (28, 31, and 62 day) and timely MDT review * Increased capacity to meet increasing demand through both demographic changes and increased awareness   **2.3.2 Efficiency**     * Increase reporting capacity * 6000 plain film per month * 12000 complex radiographs per annum (from released consultant capacity) * Support IPT policy and patient handovers between sites * Facilitate timely MDT review * Rapid access to specialist opinion * Manage peaks and troughs in demand across HCV   **2.3.3 Value**   * Reduced outsourcing costs * Improved workforce recruitment and retention   **2.3.4 Equality**   * Sustainability of 28, 31 and 62 days across whole HCV footprint * HCV system adherence to agreed turnaround times standard across HCV * Common standards and expectations in place across HCV * Equitable access to specialist opinion | This project aims to procure a system that will act as task administrator enabling network working for radiology reporting |
|  | **3.0 Treatment and Pathways (T&P)** |  |
| **3.1**  **Optimal Lung Pathway** | * Reduce variation in care * Achievement of 28, 31 and 62 day standards * Earlier diagnosis and increase no. of people with who have better performance status & eligibility for treatment * Improved patient experience (rapid pathway) and outcomes e.g. improve overall and 1-year survival * Fewer hospital out patients attendance (CT Fast Track) * Proof of concept for STP wide shared commissioner and provider arrangements * Avoidance of A&E admissions and decreased emergency route diagnoses | In HCV, lung cancer is the third most common cancer in terms of actual patient numbers and was responsible for 855 out of the 3,847 cancer deaths in HCV in 2013.  It is reported that up to 89% of lung cancers are preventable, with the incidence of lung cancer across HCV predicted to increase by 1.8 % annually. This suggests an opportunity to reduce future incidence of lung cancer over time. At present only 21% of lung cancers in HCV are diagnosed at stage 1 and 2 and if the staging profile for lung cancer matched the best in England then an additional 104 people would be alive after 1 year and an additional 42 after 5 years.  This project sits alongside the ambitions of the early diagnosis, diagnostics and LWB projects to create a new end to end pathway for lung cancer. This strand of the work aims to implement (and place in contracts with all acute providers), as a minimum, the national standard pathway for lung, with a stretch ambition of implementing the optimal pathway, developed by the Clinical Expert Group (NHSE) for lung cancer. The latter has been designed to meet waiting time targets set out in the Independent Cancer Taskforce report, reduce delays within primary care relating to chest x-ray reporting and referral times (shorten time to diagnosis by 2-4 months) and to improve outcomes by ensuring that the majority of patients are diagnosed within 14 days and treated within 28 days. Establishment of this pathway may create the need: to transform the way lung cancer services are delivered across HCV, and to develop joined commissioning and contracting and provider arrangements, learning from the move towards accountable care organisations in West Yorkshire and other vanguard sites. |
| **3.2**  **High Value Care Pathways (Prostate and Colorectal)** | * Consistent approach * Improved patient experience * Improve clinical outcomes/survival rates * Reduced variation in access to services * Streamlined approach – faster and more effective approach to care * Addresses local variation | Improving cancer outcomes through streamlined and efficient end to end patient pathways remains an important vision for commissioning cancer services. The Yorkshire and Humber Clinical Network has been working with local commissioners, providers and public to develop high value care pathways for prostate and colorectal cancer. The product was: an analysis of findings and recommendation of the model, defined, standardised and timed pathways and High Value Commissioning Pathway Guidance. The high value care pathways are based upon recent clinical evidence and up to date patient insight and are informed by recommendations from the ‘Achieving World Class Cancer Outcomes, A Strategy for England 2014-2020’.  This project aims to apply the principles and recommendations from this work to HCV in order to ensure consistent and systematic approach which is equitable across the Alliance. This approach will also include National Cancer Taskforce recommendations regarding MDT audit of deaths within 30 days of active treatment, pathways for metastatic cancer and effective MDT working. |
| **3.3 Chemotherapy Services Review** | * Improvement in patient experience and outcomes * Provision of chemotherapy in community settings * Appropriate treatment * An understanding behind the increased cost of chemotherapy to HCV * Cost saving opportunities | We will link with the service review that has been developed to provide NHS England Specialised Commissioning with an in-depth understanding of chemotherapy funding and contracting in the region, which in turn will support wider projects and reviews in chemotherapy and cancer services. There are two work streams:  1. To engage with providers and other stakeholders across the region to produce a commissioning strategy for the funding of chemotherapy preparation across Yorkshire and Humber.  2. To engage with providers and stakeholders to develop a detailed understanding of current finance and contracting models, including any sub-contracting models. |
| **3.4**  **Vague Symptoms** | * Reduced appointments and need for patients to travel * Reduced time referral to diagnosis and earlier diagnosis * Increase proportion of Cancers diagnosed at S1/2 * Reduced Emergency presentations * Improved patient experience (reduction in CCG variation) * Reduced pressure on diagnostic services * Improved patient experience | It is widely recognised that the presentation of patients with ‘vague symptoms’ can make diagnosing cancer in primary care difficult. A GP with a 2,000 patient list will see approximately 6-8 new cancer diagnoses a year but will see many patients with symptoms/signs that could represent cancer (Rubin et al, 2015). Humber, Coast & Vale are therefore planning to design and implement a new vague symptoms pathway using learning from ACE projects and best practice models. This links with the development of GP Champions, pathways for cancers of unknown primary and smarter use of diagnostic capacity. As part of this work, we will also be exploring the use of technology to reduce the amount of appointments that patients need to attend and increase their ability to understand and manage their cancer.  The development of a pathway that acknowledges the need for separate diagnostic routes for alarm symptoms, non-specific symptoms and vague symptoms has already shown success in Denmark with around 16.2% of patients placed on the vague symptom pathway being diagnosed with cancer (Ingeman et al 2015). In the UK, McMillan and CRUK have been assisting a number of CCGs across the UK, as a part of the ACE programme, to develop a variety of different pathways. After analysing potential options HCV plan to rollout of the selected or newly designed pathway in a two phased approach, focusing in phase one on those areas of greatest need before mobilisation on a larger scale. |
|  | **4.0 Living with and Beyond Cancer (LWAB)** |  |
| **4.1**  **Risk Stratified Follow-Up** | * Releases capacity of outpatients * Reducing patient outcome variation * Improving patient experience * Developing a system wide infrastructure to support LWBC * Increased capacity for primary care * Remote monitoring capabilities for better patient care | In order to improve quality of care and support those living with and beyond cancer The Cancer Survivorship initiative (NCSI) alongside NHS improvement have been leading the development of a new stratified model of care and support that addresses the holistic needs of patients. The stratified model has been implemented successfully across Northern Ireland (with support from MacMillan) and London with findings leading to both an increased capacity for clinical follow ups and increased patient experience. There is currently an inconsistent approach to the application of Risk Stratified Follow up pathways across the Humber, Coast and Vale sub-region. This project aims to ensure that follow up pathways (including self-management, remote monitoring, rehabilitation and equitable access to AHP resources) are implemented on an equitable basis across the region. This will be achieved through; staff training, the development of Care Coordinator/Navigator roles and the development of supporting IT infrastructure to support remote monitoring. Rollout will be phased - Breast, Prostate, Colorectal (18/19). |
| **4.2**  **Recovery Package** | * Consistent approach across providers * Improved patient experience * Improved survival rates with reduced variation across areas * Faster streamlined analysis of patient needs * Remote access of eHNA (ease of access) * Paper-free eHNA (lower cost, environmentally friendly) * Addressing the holistic needs of the patient * Improved access to lifestyle advice | There are now almost 1.8 million people living in England who have had a diagnosis of cancer. In terms of cancer prevalence, there are currently an estimated to be 53,000 people living in the HCV living with and beyond a diagnosis of cancer. We expect this to rise to circa 82,000 people by 2030. A Recovery Package (RP) has been developed and tested by the National Cancer Survivorship Initiative (NCSI) to assist people living with a diagnosis of cancer to prepare for the future, identify their individual needs and support rehabilitation to enable people e to return to work and normal lifestyle as possible. The RP is a combination of different interventions, which when delivered together, have been shown to improve the outcomes and coordination of care (Macmillan 2015)). The package consists of four elements: holistic needs assessment (HNA), treatment summary, cancer care review and a patient education and support event. Within HCV a recent baseline highlighted that there is currently no consistent model being used across the locality and where a model is being used, it is not consistently adopted. This project aims to embed consistent RP across HCV enabling every person appropriate, equitable and timely access to all elements of the RP by 2020. Included in the scope is the creation of an e-HNA which should improve efficiency and ease of access to outputs. The project will have a phased roll out Year 1 – Colorectal and Breast and Year 2- Lung and Prostate. There will be learning to be shared from the work which is being carried out by the Brain and CNS team which will be incorporated into our approach. Design and development of RP will also be co-produced and meet the needs of patients who are hard to reach, vulnerable and who may find it difficult for whatever reason to engage in these processes |

**APPENDIX 2**

For HCV risks associated with delayed funding for each programme are summarised as follows:-

**Early Diagnosis:**

The first part of the programme spend for Early Diagnosis hinged on getting staff in place to move the programmes forward and do some of the back ground work.  For example, B7 project support\Volunteer co-ordinators\setting up the Cancer champion programme and agreeing the contract with NE Lincs Care Plus Group as well as getting Clinical leads in place, social marketing for the lung programme and some analytical and evaluation support.  Most of these roles are on fixed term contracts.   If the funding going forward is held back due to 62 day performance the biggest risks to the work stream are:

* Funding for the staff already appointed to March 2019
* Ability to establish and run the Lung Health Check programme.  Any uncertainty and delays in preparing the tender and subsequent procurement of the van will significantly impact on the ability to deliver this programme before March 2019.  Timescales for this are already extremely tight.   Linked to this is the recent agreement by the HCV lung teams to look at the RAPID diagnostic work that Manchester have shared with a view to replicating this across HCV.  This will support achievement of the 62 days standard and is the start of implementation of the optimal lung pathway.   We do not want to lose the engagement and enthusiasm of the clinical teams which could happen if there is no support for this.
* The outline business case for the roll out of FIT has just been done and people are being trained on the modelling.  It will be difficult and take longer to role this out across HCV if we do not have the funds allocated from the transformation fund to do this across the whole HCV area (Hull already have funding to extend the pilot).    From our discussions at the Early Diagnosis Delivery Board this has the potential to make a huge difference to patients\save money by reducing the number of people requiring colonoscopy/CT, etc. and speed up the pathway again to support delivery of the 62 day standard.
* If we go ahead and appoint the 3 Volunteer Co-ordinators then the programme will continue but potentially not at the pace and scale as originally planned.

**Diagnostics Consolidation:**

* The procurement of an imaging system to support a networked model of pathology will be stopped (the procurement process can only take place if we have all the funding, partial funding will halt the programme altogether)
* The procurement of a work administrator system to support a networked model of radiology will be stopped (the procurement process can only take place if we have all the funding, partial funding will halt the programme altogether)
* These programmes support delivery of 62 day standard by enhancing diagnostics capacity.

**Treatments and Pathways:**

* The clinical engagement process for tumour sites groups for Lung, prostate and colorectal has already started. The most advanced one is the lung group which has been now operating for some time (this process also support delivery of 62 day target).
* There is a risk here that the work will be significantly reduced/progress delayed as the trust need resources to back fill consultant time.
* Again this supports delivery of the 62 day standard within the HCV footprint

**Living With and Beyond**

* Delays to the programme and in particular risk stratification and care planning.

**Host Risks**

There are also risks for ERY CCG as it is hosting the HCV Cancer Alliance.

**Appendix 3: Output of HCV Cancer Alliance prioritisation exercise and associated impact**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Project** | **Rank** | **Initial amount of funding** | **25% reduction** | **Revised spend** | **Impact** |
| Networked model of pathology | 1 | 947,000 | 710,250 | 822,500 | Two band 7 posts have been removed from the pathology project funding. This is not expected to impact on project delivery during 2018-19 but there will need to be future discussion about the need for these posts after 2019, once the digital equipment is in place. There is no change to the budget for the digital equipment procurement and this will progress as planned. The monies for the 6 additional band 7 posts across HCV have already been committed and will be honoured. |
| Networked model of radiology | 2 | 2,035,000 | 1,526, 250 | 1,792,500 | The costs of maintenance, systems integration and data storage costs have been removed from the project costs. The procurement is due to be completed at the end of 2018-19 and these costs would likely be realised in 2019-20 rather than 2018-19. Risks will be mitigated through a strong procurement and contracting process to include warranty and initial set up and transfer costs. Further discussion will be required with providers to ensure the risks can be managed, before further progress is made. A band 7 project post across radiology and pathology has also been removed from the costs. This will not impact on the progress of the panel due to additional support from existing alliance resources. The overall budget for the procurement is unaffected but will require permission from the Cancer Taskforce to convert some revenue to capital. The money for the 6 additional band 7 posts across HCV has already been committed and will be honoured. |
| Optimal pathways for lung | 3 | 0 | 0 | 100,000 | The delivery of optimal and high value pathways has scored highly with stakeholders and a budget of £100,000 has been created to support the development of clinical task and finish groups to drive this work forwards. This money has been created from within the monies allocated to the treatment and pathways work stream. This budget will not meet all the funding requirements to implement the pathways and the cost of this is yet to be understood. This will be flagged as a future funding gap in the submission to the national team so that we can be considered for any further monies that are made available to support delivery of the NHS Planning Guidance priorities. |
| High value care pathways | 4 | 0 | 0 | Budget shared with optimal lung pathways | As above. |
| Roll out of FIT  (including costs to support improvements in bowel cancer screening access) | 5 | 421,000 (285,000 FIT and 136,000 bowel screening uptake) | 315,750 (213,750 FIT and 102,,000 bowel screening) | 242,000  (222,000 FIT and 20,000 bowel screening) | The budget has been reduced due to emerging evidence regarding the costs of implementation as set out in the draft YH outline business case and the Hull and ERY pilot work. It is not expected that the planned roll out will be impacted by this reduction. The cost of a band 7 bowel screening data analyst has been removed and this piece of work will be absorbed into the demand and capacity modelling work, which is already in progress. The band 7 bowel screening project post will support the rollout of FIT. Clinical leadership to support increased uptake of bowel screening is unaffected. |
| Risk stratified pathways | 6 | 845,000 | 634,000 | 465,000 | The funding for band 7 and 8a project management and leadership posts has been secured via another route. There has been a reduction in the number of band 7 posts to support project delivery across the region, from 6.5 posts to 3 (one for each locality). The full complement of band 4 posts has been maintained (four for each locality)and there has been a slight reduction in funding for clinical leadership to support risk stratification. The trajectory for delivery of risk stratification and elements of the recovery package will be revised to show a reduced speed of implementation due to decreased resources. |
| Recovery package | 7 | Shared budget with risk stratified pathways |  |  | As above. There is an interdependence between the implementation of risk stratified pathways and roll out of the Recovery Package and the budgets have not been separated. |
| Lung health checks | 8 | 424,000 | 318,000 | 418,000 | There has been a minor reduction in funding to reflect the part time nature of an admin post that will support delivery. This does not impact on the ambitions or ability to deliver the project. |
| Primary care workforce education | 9 | No specific budget aligned to this | n/a | n/a | There has been no specific budget aligned to this. The delivery of primary care workforce education will be through existing lead GP posts, CRUK facilitators, protected learning time events and the roll out of FIT for symptomatic patients which will require support from primary care. There is no reduction in the planned level of education. |
| Vague symptoms pathway | 10 | 641,000 | 481,000 | 150,000 | A significantly reduced budget means there will be reduced opportunity to build on the existing Hull pathway and to develop a pathway in York/Scarborough, meaning fewer patients will benefit overall. There is no change to the position with regards to Northern Lincolnshire where there was no commitment to pathway roll out during 2018-19. |
| Cancer champions | 11 | 267,000 | 200.250 | 200,000 | The majority of this funding has already been committed prior to the prioritisation exercise. Savings have been made through a reduction in admin support. There should be no impact on the planned outputs of the project. Costs of project evaluation have been removed and a cost neutral means of achieving this will need to be found. |
| **TOTALS** |  | **£5,580,000** | **£4,185,000** | **£4, 189,000** |  |