

## H2 Planning Cancer Overview – support for setting cancer trajectories

### 1. Background: 20/21 Cancer Planning Priorities

- Local systems, drawing on support from their Cancer Alliance, were asked to ensure that there is **sufficient diagnostic and treatment capacity** to meet the needs of cancer to:
  - return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on the national average) and
  - meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022 (*also referred to as the ‘treatment gap’*).

### 2. Progress Update

- Thanks to the hard work of staff, the number of patients seen following an urgent suspected cancer referral has been at record high numbers since March – a critical step in diagnosing and treating patients who did not present to services during the pandemic.
- However diagnostic and treatment volumes are not keeping up with this increased level of demand. There remains a significant gap in the numbers of patients who have not started treatment during the pandemic who we would have expected to. Treatment levels were only 100.2% of the number in July 2019 when adjusted for working days.
- The impact of this ongoing successful restoration of referrals and flat diagnostic and treatment capacity are:
  - The treatment gap has not significantly changed since March (sitting at 34,825 patients, but regularly fluctuating upwards and downwards dependent on working days per month and other incidental factors)
  - The >62 day waiting list has grown to over 23,000 patients in the past two months, with another 20,000 additional patients in the 34-62 day category.
- Our progress against the recovery aims falls significantly short of what systems forecast within the H1 Planning Guidance cancer trajectories:
  - Cumulatively, the plans anticipated that the required reduction in the 62+ day backlog would be achieved - yet the list has instead grown.
  - Similarly the plans forecast to reduce the 36,000 treatment gap by around 7,000 patients by September - yet there has been very little reduction overall.
- If activity remains at the current level, we will be unlikely to achieve the cancer recovery aims. We will have more patients waiting more than 62 days than we began 21/22 planning with and will still have a significant shortfall in first treatments (over 30,000).

### 3. H2 Cancer Planning Priorities

#### 3.1 Updated Guidance

- The cancer recovery requirements remain the same; the key focus for systems is to ensure there is **sufficient diagnostic and treatment capacity** to close the treatment gap whilst still seeing people to diagnose or rule out cancer as quickly as possible. Further focus has been added to reflect challenges since publication of initial guidance.
- With current capacity constraints, progress against these requirements will likely rely on use of IS (subject to capacity and capability); as well as targeted additional capacity

internally where this can be increased with minimal dependencies on wider elective resources such as theatres and inpatient beds (e.g. skin).

Aim	Specific deliverable	Metric	What are we expecting to see in ICS trajectories?	Additional Information
To continue to reduce the number of people waiting longer than they should for diagnostics and/or treatment	Return the number of people waiting for longer than 62 days to the level we saw in Feb 2020 (based on the overall national average) by March 2022	62d+ backlog (PTL)	Backlog returned to pre-pandemic level or lower.	<ul style="list-style-type: none"> <li>Some systems have seen rising backlogs in H1, making the ask for H2 more stretching.</li> <li>This has been updated from H1 to ensure systems who have performed well will not be penalised by any new ERF gateways linked to 62 day backlog.</li> </ul>
<p>To address the reduction in the number of people who have started treatment for cancer during the pandemic by:</p> <ul style="list-style-type: none"> <li>encouraging people with symptoms to come forward (and restoring the screening programmes)</li> <li>ensuring the capacity is in place to diagnose and treat the additional people</li> </ul>	<p>Address the shortfall in first treatments by:</p> <ol style="list-style-type: none"> <li>Increasing the number of people coming forward and appropriately being referred with suspected cancer (with a particular focus on groups under-represented among those who have come forward) to a level that will help address the shortfall in the number of first treatments by March 2022</li> <li>Ensuring there is sufficient diagnostic and treatment capacity in place to meet the increased level of referrals and treatment required to address the shortfall in the number of first treatments by March 2022</li> </ol>	No. urgent referrals (CWT)	<p>Shortfall in first treatments is recovered by March 2022.</p> <p>Analysis shows that we would need to see around <b>+20%</b> additional referrals and treatments as a minimum just to diagnose sufficient people to close the treatment gap (assuming no underlying growth and lower conversion rate during recovery). <i>This would be as high as +30% if historical annual growth levels are taken into account.</i></p>	<ul style="list-style-type: none"> <li>The referral and treatment metrics are <i>proxy measures</i> to support systems to plan for adequate diagnostic and treatment activity to meet the recovery aims.</li> <li>Whilst we recognise the feedback that patient presentation/routes to referral may change as a result of the pandemic, 2021/22 Q1 referral data supports the need to maintain increased capacity in urgent referral pathways. We know that recovering the screening services (particularly breast) is also crucial to achieving the cancer recovery aims.</li> <li>Similarly, whilst we have heard feedback that total treatments rather than first treatments might be more reflective of treatments post COVID, first treatments the national team felt to be a more accurate proxy measure for patients being diagnosed.</li> <li>The above reasons, coupled with feedback from Alliances that they valued consistent, standardised measures (rather than “shifting goalposts”), means the referral and treatment metrics remain the same as H1.</li> <li>The previously shared modelling tool gives an estimate of how the additional referrals and treatment might differ by geography and pathway. This will allow systems to breakdown the high level analysis of +20% of referrals and target their most challenged pathways.</li> <li>Whilst we concur with the feedback that FIT triage in primary care could lower referrals, the conversion rate and referral numbers so far have not justified an alteration to the model for H2 planning.</li> </ul>

<p>To continue to improve performance against the Cancer Waiting Times Standards in order to reduce the time between referral and diagnosis of cancer.</p>	<p>Meet the Faster Diagnosis Standard from October ensuring that 75% or more of patients receiving a communication of diagnosis of cancer (or a decision to treat if made before a communication of diagnosis within 28 days) from Q3. <i>Where lower GI is a barrier to achieving the FDS, there is an expectation that sites will be fully implementing FIT and, where applicable, CCE, to reduce colonoscopy demand and therefore shorten the pathway for those patients who definitely require one.</i></p>	<p>Faster Diagnosis Standard (CWT)</p>	<p>No planning trajectory is required but expectation that plans are in place to support achievement (e.g. data validation, review of pathways most challenged).</p>	<ul style="list-style-type: none"> <li>• The key benefits of introducing this standard are to: <ul style="list-style-type: none"> <li>○ speed up time between referral and diagnosis of cancer, particularly where faster diagnosis is proven to improve clinical outcomes</li> <li>○ reduce anxiety for the cohort of patients who will receive a diagnosis or an ‘all clear’ but do not currently receive this message in a timely manner.</li> </ul> </li> <li>• The initial performance threshold for achievement of the FDS will be set at 75%. The threshold has been chosen to consolidate what is currently a broad spread of performance and provide some stretch to providers.</li> <li>• Working with regional/ICS diagnostic programmes will be crucial to accelerating delivery of FDS.</li> </ul>
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**Existing cancer data reports can be accessed here:** [Recovery Reports - Cancer Alliances Workspace - FutureNHS Collaboration Platform](#)

- The following actions set out in the Planning Guidance and CA planning pack remain relevant and will continue to support local recovery:
  - extend the centralised clinical prioritisation and hub model established during the pandemic for cancer surgery to patients on cancer diagnostic pathways (starting with endoscopy where appropriate), ensuring a joint approach across cancer screening and symptomatic pathways. It is clear that in many geographies it will not be possible to provide sufficient diagnostic and treatment capacity within existing services, and so all systems are strongly encouraged to utilise Independent Sector capacity where this is available for diagnostic procedures and lower-complexity cancer treatments.
  - accelerate the development of Rapid Diagnostic Centre pathways for those cancer pathways which have been most challenged during the pandemic. As outlined in the 2021-22 Cancer Alliance Planning Pack, Cancer Alliances should accelerate current RDC implementation to achieve 50% population coverage for non-site specific RDCs by March 2022 and work with colleagues to ensure the plans for Community Diagnostic Hubs support and meet the needs of the RDC programme and patients with suspected cancer.

### 3.1 H2 planning support

- Updated data packs (with ICS level breakdowns)

These include 2 sections:

- a) Feedback on H1 planning (forecasts using H1 data to assess achievement of planned trajectories and recovery aims)
- b) Data to support H2 planning (our assessment of the level of activity required to meet the recovery aims)

- Data surgeries

Recognising the complexity of the data, and the varying analytical capacity within local systems, CADEAS have scheduled a number of individual surgeries for local systems to discuss the trajectories and support the planning process. There will also be sessions towards the end of the H2 planning period to support assurance of the plans.

Book into the surgeries via this link: [CADEAS H2 planning surgeries](#)

- System first/hub models for cancer

A number of Alliances outlined innovative approaches to embedding system first/hub models in their H1 plans. We have collated these to support shared learning and dissemination of good practice.

Link to summary: [Hub model and approaches summary](#)

- £20m Elective Recovery Fund activity

All Alliances have received funding to enable management of high volumes of referrals and streamline the front end of the pathway. These cover five models:

- Rapid triage for prostate cancer.
- Lumps and bumps clinics.
- Rapid access skin clinics including teledermatology.
- Triage and referral management for most challenged pathways.
- Cancer symptom hotline.

We have developed an [ERF page](#) on the Workspace to help Alliances share best practice.