



Northern  
Cancer Alliance



North East and  
North Cumbria



England

# Non-Surgical Oncology Out-patient Transformation

## Joint ICT OSC Meeting

**25 September 2023**

Presented by:

**Angela Wood – Clinical Director Northern Cancer Alliance**

# Welcome and Introductions

Representative Officers:

Angela Wood – Clinical Director, Northern Cancer Alliance

Alison Featherstone – Managing Director, Northern Cancer Alliance

Julie Turner – Head of Specialised Commissioning, NHS England

Sheila Alexander – Programme Manager, Northern Cancer Alliance

# Background

# Timeline (previously shared with members January 2023)

Plan for 2023	Activity	Status
January	Update JHOSC on temporary changes	Complete
February	Finalise Strategic Option Planning	Complete
March	Continue Patient Engagement on strategic options	Continuous patient and public feedback in place
June	Clinical Check and Challenge Peer Review of model – South Yorkshire and North Yorkshire Cancer Alliance	Complete
August	Finalise plans	Complete Formal Governance now in place to make joint system decisions
September	Engage with JHOSC on Strategic Options Due diligence/governance	Slipped from July – JHOSC members to note preferred option and proposed way forward”
October	Commence Implementation	



# Why non-surgical services need to change

- Nationally recognised shortage in oncologist workforce – national predicted shortage of **28%** by 2025, regional prediction of **43%** reduction
- Regional variation in service provision and access
- New patient activity is up **9%**
- Demand for SACT (chemotherapy related services) is growing by **c10%**
- Additionally new NICE approved drugs are likely to become available within this pathway in the next 12 months
- The general increase in cancer incidences is circa **3%** to **5%** year on year
- All the above adds to extra demand and the pressure on services

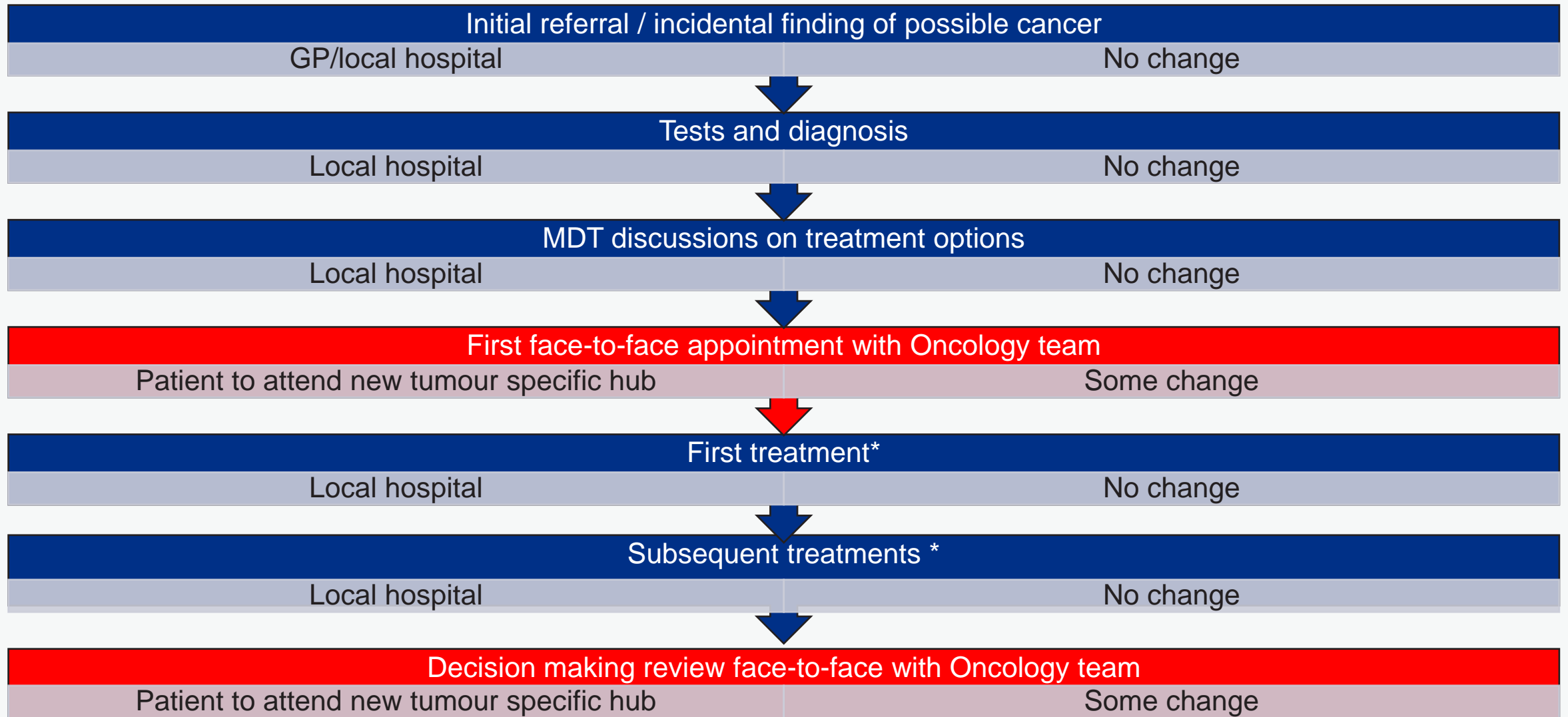
# Overview of oncology services

Oncology (cancer care)

**Non-surgical oncology:**  
Radiotherapy  
Systemic Anti Cancer  
Treatment (SACT)

**Surgical oncology:**  
uses surgery to treat  
cancer.

# Example patient pathway



\* NB Radiotherapy and surgical treatments will continue to take place at major cancer centres as they do now. Chemotherapy will continue to take place locally as it does now.

# Context

Within our North East and North Cumbria ICS we have:

- Two specialist cancer centres at Newcastle and South Tees which include Radiotherapy with some services also provided in North Cumbria by Newcastle.
- Chemotherapy delivery units at 19 sites
- This proposal does not change the sites for radiotherapy and chemotherapy services – they remain as close to home as possible
- Historical model of outpatient service delivery no longer fit for purpose:
  - Oncologists visiting multiple sites to deliver outpatient clinics around region. Inequity of access as model evolved over time with no strategic planning across whole region
- Capacity and Demand
  - Lack of resilience in workforce inability to recruit and retain enough staff
  - Increase in referrals and an increase in the complexity of treatment and the amount of treatment available
- Temporary measures
  - Newcastle implemented temporary measures from March 2022, and we have learned from them
- New service provision requires a new workforce model
  - Advanced Clinical Practitioners – 2 qualified, 11 in training – new curriculum developed
  - Role extension for several other posts Pharmacists , Nurses and Therapy Radiographers



# Previous outpatient appointment sites



Oncologist from	Trust	Site Local Authority Population 2018	Oncology Tumour Sites
Newcastle upon Tyne Hospitals NHS FT	Newcastle upon Tyne Hospitals NHS FT	Freeman Hospital Cancer Centre (300,196)	All tumour specific service provided
	North Cumbria Integrated Care	Cumberland Infirmary (324,000)	All tumour sites
	Northumbria Healthcare NHS FT	Wansbeck General Hospital (320, 274)	Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary
		North Tyneside General Hospital (205,985)	Lung, breast, colorectal, upper gastrointestinal
	Gateshead Health NHS FT	Queen Elizabeth Hospital (202,508)	Lung, breast, colorectal, cancer of unknown primary, gynaecological
	South Tyneside and Sunderland NHS FT	Sunderland Royal Hospital (277,417)	Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary, head & neck, urology
		South Tyneside District Hospital (150,265)	Lung, breast, colorectal
	South Tees Hospitals NHS FT	County Durham and Darlington NHS FT	Shotley Bridge Hospital
University Hospital North Durham (526,980)			Lung, breast, colorectal, upper gastrointestinal, hepato-pancreato-biliary (Palliative Pancreatic)
Bishop Auckland Hospital			Lung, breast, colorectal, urology
Darlington Memorial Hospital (106,695)			Lung, breast, colorectal, urology, upper gastrointestinal, head & neck, hepato-pancreato-biliary
North Tees and Hartlepool NHS FT		University Hospital Hartlepool (96,242)	Lung, breast, colorectal, urology, pancreas, hepato-pancreato-biliary
		University Hospital North Tees (197,213)	Lung, breast, colorectal
South Tees Hospitals NHS FT		Friarage Hospital (91,134)	Lung, breast, colorectal, urology
		James Cook Cancer Centre (277,263)	All tumour specific service provided

# Strategic Review



# Principles for strategic review

- Any future model is patient focused, clinically led delivers care as close to home as possible with a view to reducing inequality in current service provision across the region
- The view of patients or patient representatives are integral to proposed options
- Oncologist time is used to maximum efficiency recognising that the gap between supply and demand for the regional oncologist workforce is forecast to widen further in the next five years
- A broad range of alternate workforce options is considered along with role allocation, considering the 'at risk' groups, as well as training needs and skills required
- Oncology teams' working arrangements are designed in a way that ensures safe levels of specialised cover coupled with opportunities to enhance resilience through peer support and learning

*\*These principles have been adopted for future work too.*



# Strategic model development

- Whole day meeting with all stakeholders – providers, commissioners, public in 2019.
- Steering group of all key stakeholders
- Task and Finish groups with relevant expertise to assess and evaluate the potential options
- Public Engagement through whole process



# Options considered

## 1. Current model -No change

- Hub and spoke working for individual oncologists not wider system need - 16 geographical sites, specific tumour group offered at each site developed on an ad hoc basis.
- No system wide service and workforce planning
- Inequity of patient care and unsustainable due to increasing demand and complexity

## 2. Centralisation to the cancer centres with treatment as close to home as possible

- Not viable for patient travel and new estate required

## 3. A decentralised model

- Not viable due to potential lone working and inequity of service development - current model evolved from this

## 4. Clinical networks with tumour specific hubs and treatment as close to home as possible

- Developed in conjunction with the oncologists and met the core principles agreed at the onset of the NSO review process
- The main priorities were ensuring equity across the whole region in terms of service provision, the optimum use of the limited oncologist resource whilst most importantly guaranteeing that patients would continue to have their treatment and review as close to home as possible



# Decision making

The strategic options were taken through the relevant NENC Boards:

- Northern Cancer Alliance board
- Provider Collaborative
- Combined CCG forum (now ICB)
- Newly established NHS England and ICB Joint Committee

This allowed an opportunity to model, travel, health inequality impact and co-dependencies.

Current phase of the project to further engage on and develop the agreed model in detail prior to final sign off by March 24 will need to also go through all the respective boards/groups

# Preferred option (4)

## Clinical Networks of tumour specific hubs with treatment as close to home as possible

- Tumour specific teams (multidisciplinary) across NENC ICS for the major tumour groups (Breast, Lung, Colorectal, Urology). Every trust has at least one hub – therefore visiting oncologists.
- Centralisation of intermediate tumour groups to the 2 cancer centres and more collaborative working to build resilience in the services especially for the rarer tumour groups, supporting services and workforce
- Hub sites chosen to reduce patient travel impact as much as possible, no changes to co-dependencies such as the Multidisciplinary Teams (MDT), surgery, diagnostic services
- Ensure all chemotherapy can be delivered locally – increased services required at some sites thus reducing patient travel
- Supports new ways of working, digital solutions, new workforce models
- Reduce inequity – waiting times, clinical trials access, supporting services
- Improve patient safety and quality – communication, wrap around tumour specific model of care, Acute Oncology Services and out of hours access to advice, guidance and support (professionals and patients)

# Potential hub locations

Oncologist provision from Newcastle Hospitals		
Trust	Hospital site	Tumour speciality
Newcastle Hospitals NHS Foundation Trust (NuTH)	Freeman Hospital	All sites
	North Cumbria Integrated Healthcare NHS FT Cumberland Infirmary, Carlisle	Service provided by Newcastle and Carlisle Partnership
Northumbria Health Care NHS FT	Wansbeck General Hospital	Breast
	North Tyneside General Hospital	Lung, Colorectal
Gateshead NHS FT	Queen Elizabeth Hospital	Breast, gynaecology ( lung when workforce allows)
South Tyneside and Sunderland NHS FT	Sunderland Royal Hospital	Colorectal, Urology, Head & Neck
	South Tyneside District Hospital	Lung
County Durham and Darlington NHS FT	University Hospital of North Durham	Lung, Colorectal

Oncologist provision from James Cook University Hospital		
Trust	Hospital site	Tumour speciality
County Durham and Darlington NHS FT	Darlington Memorial Hospital	Head & Neck, Lung
	Bishop Auckland Hospital	Breast
North Tees and Hartlepool NHS FT	North Tees University Hospital	Breast, lung, colorectal, Urology
South Tees Hospital NHS Foundation Trust	James Cook University Hospital	All sites
	Friarage Hospital	Part of JCUH service





# Benefits of a tumour specific hub

## Workforce

- No single-handed clinicians - minimum of 3 Clinical and Medical Oncology Consultants
- Improved cross cover and resilience
- Multidisciplinary support - Prescribing Pharmacists, Clinical Nurse Specialists, Care Coordinators and admin are all essential
- New roles - Advanced Clinical Practitioners

## Standardisation of clinical ways of working

- More access to clinical trials
- Standardisation of clinical protocols and face to face appointments
- Agreed regional model for out of hours access to advice, guidance and support (professionals and patients)

# Peer Review

# Clinical model – Peer review Sept 2023



The purpose of the Peer Review was to:

- Provide a clinical peer review of the proposed model – to “check and challenge”
- Check we have considered safety, sustainability, co dependencies, quality standards, workforce, equity, and access
- Challenge any thinking to ensure all options have been considered and to ensure plans are in place to address any potential issues

The method:

- External peer review by two other systems, (South and North Yorkshire) with a senior external clinical chair to facilitate
- The panel members were peer experts in non-surgical oncology – including patient representatives
- Use of national criteria to evaluate service models



# Clinical model peer review outcome

- Support in principle for model, more robust, removal of single-handed practitioners
- Understanding that pooling teams reduces risks of cancellations and more flexibility
- Broader skill mix and increased team numbers to enhance clinical safety and patient experience
- Acknowledgement and support for navigator/co-ordinator roles
- Acknowledgement of consistency in user feedback to date
- Acknowledged proposed model still provides choices – hubs based on postcode, but patient can choose another hub
- Support for treatment as close to home as possible

On going work required to address and mitigate for changes:

- Concern over consultant workforce gap and reality of recruitment
- Acknowledged the need for robust out of hours provision and access to acute oncology
- Adoption of technology to enhance remote access to care
- Programme of involvement and engagement

Supported the suggested future work planning – task and finish groups in place to address all potential issues identified

# Engagement and Communications

# Engagement and communication

## 3 years of listening

### Engagement work

- ✓ Public engagement
- ✓ Clinical engagement
- ✓ Health impact assessment
- ✓ Travel assessment

### Temporary measures (for Newcastle)

- ✓ Patient feedback
- ✓ Staff feedback
- ✓ System feedback

### Continued public engagement

- ✓ Phased approach to listen to what matters to our patients
- ✓ Current questionnaires
- ✓ Planned focus groups



# Pre- engagement work -What mattered to our patients

All Engagement conducted in line with the Cancer Alliance co-produced public engagement strategy

Initial work adopted a three staged approach to understand what matters most to oncology patients, their families and their carers as well as potential future patients. So that Steering Group could:

- Understand the potential impact of change on patient experience
- Address aspects of health inequalities and work towards improving equity of access for those members of the community who experience the greatest levels of disadvantage and health inequalities
- Ensure transparency and an open dialogue with patient and the public at all stages of the review process
- Demonstrate how engagement activities have informed the oncology service review and new delivery model

**Stage one** involved developing a framework for speaking to people with lived experience, members of the public and representatives from community organisations who understand the impact of health inequalities on people living in some of our most vulnerable communities.

**Stage two** of the engagement process involved holding three focus groups to explore the key themes identified in the data analysis along with the risks and benefits of the current service model and the pros and cons of any potential service changes.

**Stage three** work had commenced, planning for future communication and engagement activities, being coordinated by a regional communications and engagement steering group. However, we then had to begin the temporary measures which offered further opportunity for engagement.



# Temporary measures - engagement and feedback

## Patient experience

- Information leaflet produced to explain the changes
- Questionnaire sent to all patients
- Changes and adaptations of the service made based on feedback
- Questionnaire feedback informed next stage of the engagement work
- Importantly less patients moved than we had predicted

## Clinical and System feedback experience

- Positive feedback from clinicians regarding peer support in clinic.
- Ability to cross cover when a member of hub is on annual leave or unwell.
- Support in clinics from clinical pharmacists and consultant nurses.
- Improved opportunities for trainees as able to attend clinic supported even when their own supervisor is not present.
- Clinic co-ordinators have been valuable in ensuring all capacity is used by discussing with patients
- Using different I.T systems in different locations is challenging.





# Current and planned engagement for preferred model

**The aims of the engagement strategy are as follows:**

1. Continue to understand what matters most to oncology patients, their families, and their carers as well as potential patients in the future
2. Address health inequalities and ensure equity of access
3. Ensure transparency and an open dialogue with patients and the public at all stages of the review process
4. Demonstrate how engagement activities have informed the oncology service review and new delivery model

**This will be achieved through the following objectives:**

1. Engaging with people who have a lived experience of oncology services
2. Engaging with people who are more likely to experience the greatest level of health inequalities and inequity of access to health care services
3. Ensuring communication activities are accessible to the target audience
4. Development of appropriate feedback mechanisms to everyone involved in the engagement process



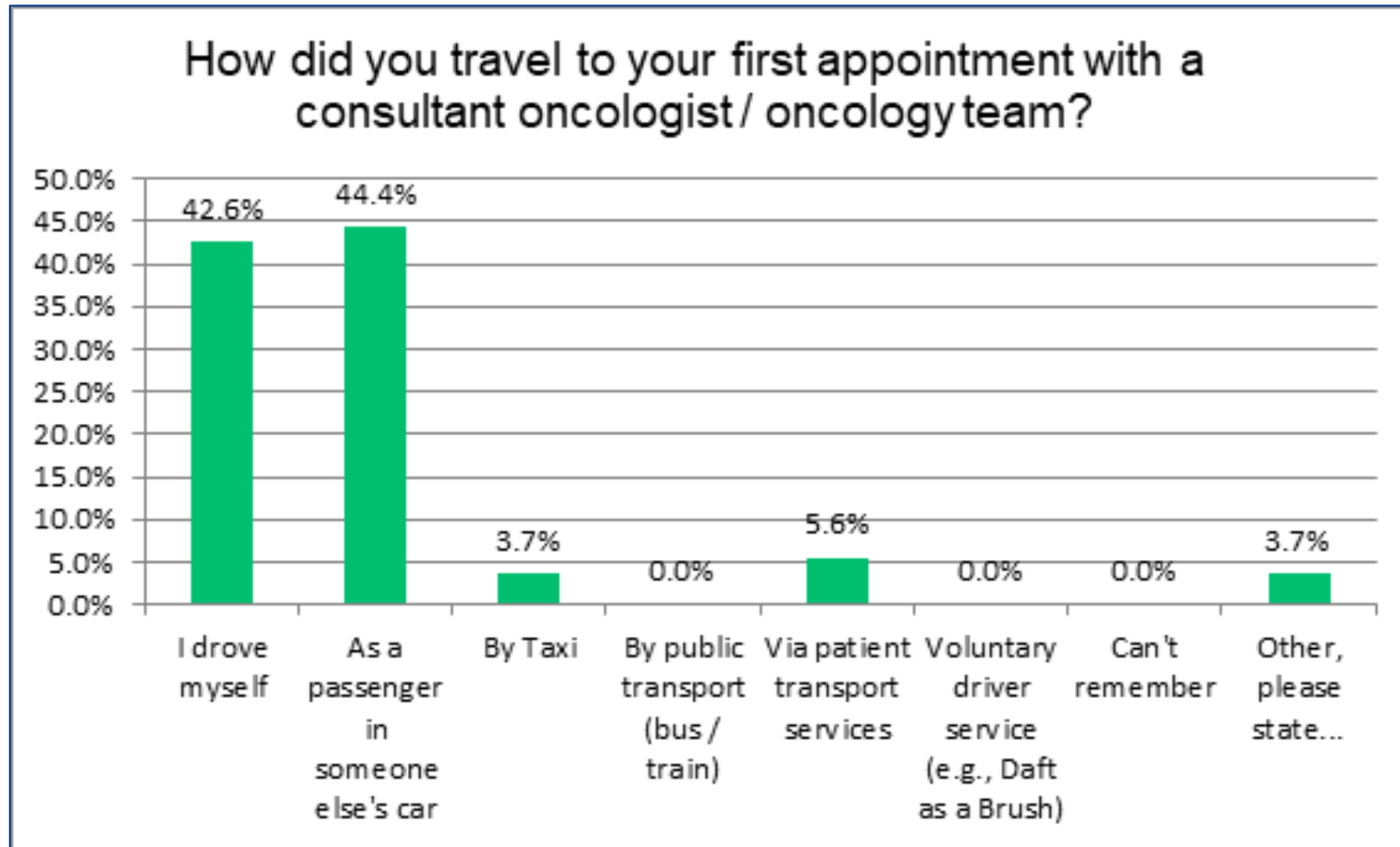
# Current and planned engagement

## Ongoing work:

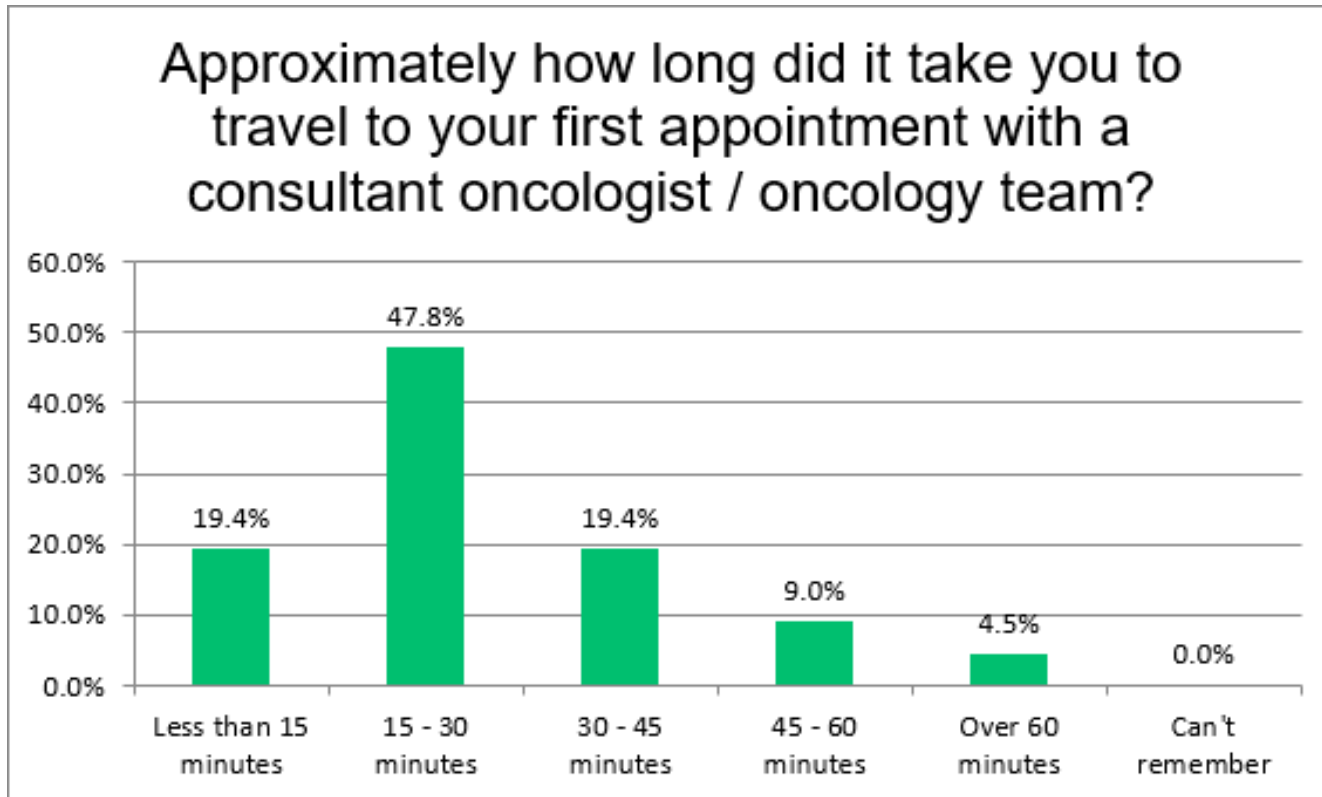
- All Engagement continues to be conducted in line with the Alliance co-produced public engagement strategy [The NCA Framework for Public Involvement - Northern Cancer Alliance Northern Cancer Alliance](#)
- Lay representative on all strategy groups and the Alliance Involvement Forum participation continues
- Task and finish group established – to consider the proposed model
- Current questionnaires and planned focus groups (based on learning from the questionnaires)

# Feedback to date

# Work in progress feedback based on existing journeys



# Work in progress feedback based on existing journeys



For over half of respondents, their journey for their first appointment took on average about 15 to 30 mins.

Over 85% of respondents the journey took less than 45 minutes.



# Virtual Appointments

47% of patients had a virtual appointment (by telephone or video call) with the oncology team

Of those who had virtual appointment:

- ✓ 83% were very satisfied/satisfied with their experience
- ✓ Dissatisfaction/concerns related to:
  - ✓ Not receiving the call on time
  - ✓ Confusion about what would happen (in advance of appointment)
  - ✓ Age of patient; computer literacy and hearing difficulties
  - ✓ Communication difficulties (perceived as more of a 'listening experience')
- ✓ 10% received support from a family member / friend to access this

Of those who did not have a virtual appointment 15% would consider having a telephone appointment and 23% a video consultation

# Impact assessments to date

## Health Inequalities

- Potential impact – positive and negative
- Multiple evidence sources
- Results inform process
- Results support improving access and outcomes
- No evidence it improves (or worsens) discrimination

## Travel

- Potential impact – positive and negative. Used adding an extra 15mins as a baseline.
- Evidence sources (real time data)
- Car and public transport
- Hub positions informed by the travel assessments

**Continuous review and monitor**



# Health impact assessment for preferred option

**Completed to assess likely impacts of the proposed service change and provide further insight to reduce potential barriers/discrimination**

The impact assessment outlines:

- What impact (or potential impact) service review outcomes will have on those within protected characteristics groups
- The main potential positive or adverse impact for people who experience health inequalities
- What engagement and consultation has taken place
- The key sources of evidence that have informed the impact assessment
- An understanding that this will need to be

**updated throughout the course of development and continuously updated as the piece of work progresses**

**monitored regularly to ensure the intended outcomes are achieved**





# Health impact assessment findings

- ✓ Will support compliance with the Public Sector Equality Duty in
  - advancing equality of opportunity and
  - fostering good relations
- ✓ Unsure it will address
  - tackling discrimination
- ✓ Proposal will support reducing health inequalities faced by patients in
  - Reducing inequalities in access to health care
  - Reducing inequalities in health outcomes



# Travel impact assessment

- Pre – engagement work “what matters to me” considered travel issues – distance and parking which informed the travel analysis
- The working group agreed that travel and parking became more of an issue when the other points were not delivered (Communication and information, the importance of coordinated, efficient and timely care, knowing who to contact, seamless transfers between hospitals/departments, feeling involved and listened to at all stages of care)
- Considered reducing number of journeys by using video consultations to reduce unnecessary travel if suitable for the individual and their clinical situation
- Have also considered mitigations particularly increasing the use of "daft as a brush"



# Travel impact assessment for preferred model

Considered travel by car and by public transport

- Please note - most people travel by car for cancer treatment

The average travel time for patients is for the average amount of time it took patients to get to the site that they originally attended.

- For example, the average travel time for patients to get to the Friarage by car was 28 minutes and the average by public transport was 62 minutes
- Travel to attend oncology out-patient appointments was not uncommon in the original service model

The percentage of the cohort of patients who can travel to a specified hospital within no more than an extra 15 minutes

Decisions for hub locations considered travel as well as other factors such as services already at that site, estate and other service co-dependencies

# Next steps – high level

Plan for 2023/24	Activity
September	JHOSC are asked to note the preferred option and the next stages of work
October	NHS England to undertake the 5 key test regional assurance process
November	Take through system governance i.e., joint commissioning committee and provider collaborative
December	Formalise the changes; contractual commissioning
March	Implementation of the new out-patient clinical model

# Thank You and Questions