NHS Shropshire CCG
NHS Telford and Wrekin CCG

NHS Shropshire and NHS Telford & Wrekin CCGs
Joint Strategic Commissioning Committee Part 1 Public

to be held on Wednesday 17th March 2021
at 12.30pm via Teams

AGENDA

A=Approval R=Ratification S=Assurance D=Discussion I=Information

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
JSCC-21-03.075	Apologies	Ash Ahmed	I	Verbal	12.30
JSCC-21-03.076	Members' Declaration of Interests	All	I	Verbal	12.35
JSCC-21-03.077	Minutes and Action Tracker of Previous Meeting held on Wednesday 17th February 2021	Ash Ahmed	A	Enclosure 1A and 1B	12.40
JSCC-21-03.078	COVID Phase 3 Recovery	Julie Davies	I	Enclosure 2 to follow	12.45
JSCC-21-03.079	Breast Cancer Improvement Plan	Julie Davies	I	Enclosure 3	13.00
JSCC-21-03.080	Any Other Business	Ash Ahmed	I	Verbal	13.25
Date and Time of Next Meeting - Wednesday 21st April 2021 at 12:30pm					

Enclosure 1A

NHS
Shropshire
Clinical Commissioning Group

MINUTES OF THE JOINT STRATEGIC COMMISSIONING COMMITTEE HELD VIA MICROSOFT TEAMS ON WEDNESDAY 17TH FEBRUARY 2020 AT 12.30PM PART 1 PUBLIC SECTION

Present

Mr Ash Ahmed	Board Member/Chair
Dr John Pepper	GP/Primary Care Health Professional/Chair
Mrs Claire Skidmore	Executive Director of Finance
Mrs Fiona Smith	Primary Care Health Professional
Mrs Zena Young	Executive Director of Quality
Mrs Lisa Cliffe	Deputy Director of Transformation
Dr Julie Davies	Director of Performance
Mrs Sam Tilley	Director of Planning
Dr Julian Povey	STW CCG Chair
Mrs Claire Parker	Director of Partnerships
Dr Steve James	CCG Board Member
Cllr Andy Burford	Telford & Wrekin Council
Mrs Kay Holland	Deputy Director of Contracting
Mr Meredith Vivian	Lay Member Patient and Public Involvement
Mrs Laura Casey	Project Support (administrative support)

Apologies

Mr Dave Evans	Accountable Officer
Mr Jonathan Rowe	Executive Director of Adults Social Care and Health and Wellbeing, Telford & Wrekin Council
Mr Steve Trenchard	Interim Executive Director of Transformation
Mrs Donna Macarthur	Lay Member for Primary Care
Dr Deborah Shepherd	Medical Director

JSCC-21-02.058 - Apologies

Apologies were noted as above.

JSCC-21-02.059 - Members' Declaration of Interests

No Declarations of Interest were noted.

JSCC-21-02.060 – Minutes and Action Tracker of Previous Meeting – Wednesday 20th January

The minutes were agreed as an accurate record of the previous meeting.. In response to action JSCC-21-01.046 – COVID Update Dr Davies gave a verbal update on the clinical prioritisation process and the governance arrangements for this work on behalf of Dr Jane Povey; Dr Davies agreed to provide the slide for circulation to the committee. The committee agreed that a regular update on this work would be useful.

Action: Dr Davies to provide slide for circulation to the committee.

JSCC-21-02.061 – COVID Phase 3 Recovery

Dr Davies updated the committee on the position which has changed since the last meeting as the system responds to the second wave (referred to as third wave in Midlands). Highlights from the update are below:

- The emergency activity trends show a reduction on previous winter activity in terms of both admissions and attendances;
- There has been a continual decline in A&E four hour performance but this has recovered over the last two weeks as Covid pressures reduce slightly;
- SaTH urgent referrals have recovered to previous levels but routine are still below previous levels;
- SaTH outpatient and elective activity reduced following decision to pause non-critical services in response to third wave and super surge requirements from region for critical care;
- Radiology diagnostics have remained well-maintained;
- RJAH have seen a reduction in outpatient activity and have paused elective work but continue to treat priority 2 and orthopaedic cancer patients on behalf of the system;
- RJAH diagnostics remain stable with signs of recovery in ultrasound;
- Cancer waiting times remain stable but increasing numbers are causing some concerns: some cancer going through Nuffield but complex cancer will be looked at by the clinical prioritisation group next week;
- Cancer two week waits have recovered to levels seen at the end of last year with some areas such as lung recovering to pre-Covid levels;
- Waiting list position remains a concern and will remain so due to the cessation of elective activity;
- As the system moves into de-escalation we must be mindful of workforce pressures but also balance the clinical risk associated with the backlog of patients

In response to queries from Dr Pepper, Dr Davies confirmed that the graph on slide 3 should read routine rather than urgent and that on slide 9 the decrease in referrals is attributable to the festive period. Dr Pepper asked whether the waits in the final slide in the green block were spread evenly over time or were coming close to 52 weeks; Dr Davies confirmed that the spread is not even and results from the pause in activity during the first wave. Work is underway to get clinical capacity to review and assess those patients not yet seen by a consultant as they do not form part of the clinical prioritisation work and this is a risk.

Dr Povey asked what steps are being taken to keep patients informed about their position on the waiting list and what to do if their condition deteriorates and whether this been agreed at a system level. Dr Davies confirmed that the system is close to getting this agreed and Dr Jane Povey has been supporting with this work. She explained that individual organisations have a responsibility to communicate with their patients who have already been seen and this is being managed through silver command. Those patients who have not yet been seen are not being communicated with yet; the CCG have offered call handling capacity via RAS and TRACS teams but there is a need for clinical capacity to make the engagement meaningful and options for this are being identified with an anticipated timeline for this to be in place likely to be agreed when the group meet on Tuesday.

Dr Povey asked how Primary Care colleagues are getting information about the waiting list positions for other services not included in this update such as community services, mental health services and physiotherapy services. Dr Davies agreed to pick up the position for community services through silver command and confirmed that she is reporting the overall community bed and services position to gold command however the ability to recover services is impacted by staff redeployment to the vaccine programme. Mrs Sam Tilley confirmed that this is discussed at silver command and that communication team colleagues are reporting that the status of services is being communicated to Primary Care colleagues

although the situation is fluid and the position can change. Feedback has been received that the information is not always getting through to the correct people and Mrs Tilley agreed to raise this issue again. Dr Povey raised concerns with diabetic services and community physiotherapy in particular and confirmed that nothing is coming to him as GP regarding the waiting lists in these services. Dr Davies agreed to get the position around these services at the community capacity and demand meeting and will circulate to colleagues.

Dr Pepper raised concerns around the numbers waiting for ophthalmology services and Dr Davies confirmed that there are clinicians in the specialty looking at the retinal clinic waits and those with sight-threatening issues are being prioritised as P2 patients and clinics are being maintained. The system is part of a regional elective recovery programme looking at prioritising high volume specialties including ENT, ophthalmology and orthopedics and a workshop is taking place to share best practice and look at ways to improve productivity. Long wait cataract cases are also being seen at Nuffield where possible.

Action: Mrs Tilley to raise the issue of communication around service status to Primary Care colleagues at silver command.
Action: Dr Davies to confirm the position around community services at the capacity and demand meeting and circulate.

JSCC-21-02.062 – Procurement Strategy

Mrs Kay Holland presented the paper and explained that the strategy has been developed as part of the move to a single strategic commissioning organisation and taking into account the legislation currently in place and will need to be reviewed as this legislation changes. Feedback from NHSEI and the CSU procurement team has been factored in to the document.

Mr Meredith Vivian raised queries around sections 8.2 and 9.2 where there are references to Shropshire Care Closer to Home and asked that these be amended to reflect the move to Shropshire Integrated Place Partnership. He also referenced section 10 and asked that the document reflect the legislative requirements around public engagement in procurement. Mr Vivian also commented on references in the document to joint procurements and section 75 arrangements and asked whether colleagues at the local authority had been consulted on the document; Mrs Holland stated that she has not shared the document with the local authority and Mrs Skidmore explained that the document is an internal policy, she has no concerns with anything in it and it is a public document which can be viewed by local authority colleagues as necessary. Mrs Skidmore went on to confirm that the feedback from NHSEI on the document was very positive and complimented the work undertaken by Mrs Holland.

The committee approved and ratified the strategy subject to the amendments to sections 8.2, 9.2 and 10 proposed by Mr Vivian.

JSCC-21-02.063 - Any Other Business

Nothing raised.

Date and Time of Next Meeting

Wednesday 17th March 2021 – 12:30 – 13:30hrs via Microsoft Teams

Enclosure 1B

JSCC Part 1 (Public) Action Tracker – 17.02.2021

Action Reference	Action Required	Who	When	Comments
JSCC-21-02.060 – Minutes and Action Tracker of Previous Meeting	Dr Davies to provide update slide on clinical prioritisation for circulation to the committee.	Dr Davies	01/03/2021	Emailed for update 22/02/2021
JSCC-21-02.061 – COVID Phase 3 Recovery	Mrs Tilley to raise the issue of communication around service status to Primary Care colleagues at silver command.	Mrs Tilley	01/03/2021	Emailed for update 22/02/2021
JSCC-21-02.061 – COVID Phase 3 Recovery	Dr Davies to confirm the position around community services at the capacity and demand meeting and circulate.	Dr Davies	01/03/2021	Emailed for update 22/02/2021

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **NHS Shropshire, Telford and Wrekin CCGs**

Item Number:	Agenda Item:
JSCC-21-03.079	**Cancer performance joint action plan – recovery of performance for the 2 week wait Cancer Waiting Times (CWT) standard for suspected breast cancer**

Executive Lead (s):	Author(s):
Dr Julie Davies Director of Performance julie.davies47@nhs.net	David Whiting Performance and Assurance Manager david.whiting@nhs.net

Action Required (please select):									
A=Approval	A	R=Ratification		S=Assurance		D=Discussion	D	I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Main SaTH CQRM	23/02/2021	A,I
Quality & Performance Committee in Common	24/02/2021	S,I

Executive Summary (key points in the report):

- SaTH have kept the breast service open to patients for new referrals and treatment throughout COVID
- Since COVID began, the breast service was initially able to deal with the reduced demand but the first appointment time began to go above 14 days from August 2020 onwards
- The 62 day referral to treatment standard has also been failed since September 2020
- SaTH were initially only able to offer reduced numbers of slots per session due to COVID related Infection Prevention & Control (IPC) requirements in relation to radiology access, down from 125 to 75 per week, but this has now returned to full capacity due to completed estate works
- The suspected cancer and symptomatic referrals have different referral criteria but both have a target to be seen within 14 days
- The suspected breast cancer target is a right under the NHS Constitution but the symptomatic target is not, as it is not a referral for suspected cancer
- SaTH are currently failing both the suspected breast cancer standard and the symptomatic breast standard
- All referrals are seen in the order that they are received, regardless of which referral pathway is used
- Local SaTH data covering 2020 shows that suspected cancer referrals account for 96.2% (281 cases) compared to symptomatic 3.8% (11 cases) of all cancers found following a GP referral
- The currently waiting time for patients on either pathway for their first appointment is 21 days which has come down from a longest wait of 35 days in January 2021
- Numbers of breast referrals overall are now back to pre-COVID levels
- Nearly all patients are seen in a one-stop clinic which includes access to mammography and radiology
- Current demand is now slightly less than total capacity and SaTH are also looking to increase capacity wherever possible to see more people
- In January 2021 NHS England produced guidance to support cancer services during COVID with a number of actions that could be taken to support the breast referral pathway
- There have also been discussions with the breast team and the CCG exploring further ways that the current backlog could be addressed
- The trajectory for recovery shows that the backlog should be cleared by the end of June 2021 and performance on target from July 2021.
- There are a number of actions that would speed up the clearing of the backlog and help to maintain the ability to see all patients within the 14 day target
- There is further action that could also speed up the recovery which whilst high impact, would need agreement from commissioners, the breast service and SaTH management as it would be a change from the normal operation of the service
- There is evidence that other cancer services locally have taken steps to utilise limited capacity for

suspected cancer patients at the expense of symptomatic patients

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? There may be a need for further staffing resources in secondary care in order to meet the expected ongoing demand for breast services, as well as the backlog for breast screening – this is subject to a further piece of work which needs to be undertaken within SaTH	yes
3.	Is there a risk to financial and clinical sustainability? The demand for breast services compared to capacity risks the overall sustainability of the service, and additional actions to address this are brought in this paper for approval	yes
4.	Is there a legal impact to the organisation?	No
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement? These proposals have had input from the SaTH breast team. Further engagement will be required with SaTH and collaboration will also be needed from Primary Care in order to support the delivery of actions contained within this report if they are approved	yes
7.	Is there a patient and public engagement requirement? Once all actions are agreed and approved by JSCC in March then the CCG and SaTH will make a joint statement to the public, advising of ongoing delays and explaining what is being done to improve the situation, including expected timescales for reducing waiting times back to under 14 days	yes

Recommendations/Actions Required:

The Committee is recommended to;

- Support the following actions;
    - Primary care to use the advice and guidance service wherever appropriate
    - Primary care to indicate on referrals any relevant patient COVID information to help the breast service to plan bookings
    - Secondary care to stream all low risk patients (under 40s and men) in to non-Consultant led clinics wherever logistically possible
    - Secondary care to increase clinic capacity wherever possible
    - Primary & Secondary care to jointly and regularly audit referrals considered inappropriate by the breast team, to improve the quality of referrals
- Note the recovery trajectory produced by SaTH for delivery of the 14 day target from July 2021
- Consider whether priority should be given to patients referred on the suspected cancer pathway and support urgent discussions with the SaTH breast team if this action is agreed
- Note the recovery trajectory will be monitored via the fortnightly SaTH Cancer Performance & Assurance meeting of which the CCG is a member.

01 Introduction & Background

01.01 The NHS Handbook to NHS Constitution for England states that "(patients) have the right to be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected". The target for suspected cancer urgent referral from referral to first outpatient appointment (2 week wait) is 93% (see appendix 1 for a summary of all Cancer Waiting Times (CWT) standards).

01.02 There is an additional 2 week referral pathway for patients with breast concerns where cancer in not thought to be the cause by the referrer, known as the 'breast symptomatic' pathway, which also has a target of 93%. This in effect means that all patients with breast symptoms should be seen within two weeks, but only the referrals for suspected cancer are considered a constitutional right.

01.03 Throughout COVID, SaTH has continued to deliver the breast service to new referrals and current patients. The impact of COVID led to reduced numbers of referrals and reduced capacity in the service due to issues with staffing and reduced access to radiology due to the enhanced Infection, Prevention & Control (IPC) requirements, but referral numbers have now almost returned to normal. As a result of this combination of increased demand with reduced capacity the service has missed the target for seeing patients within 14 days of a referral since September and this has also impacted adversely on the 62 day referral to treatment standard.

01.04 NHS England has published updated guidance Urgent cancer diagnostic services during COVID-19 in January 2021 to support cancer services which has specific suggested actions for primary and secondary care for breast referrals.

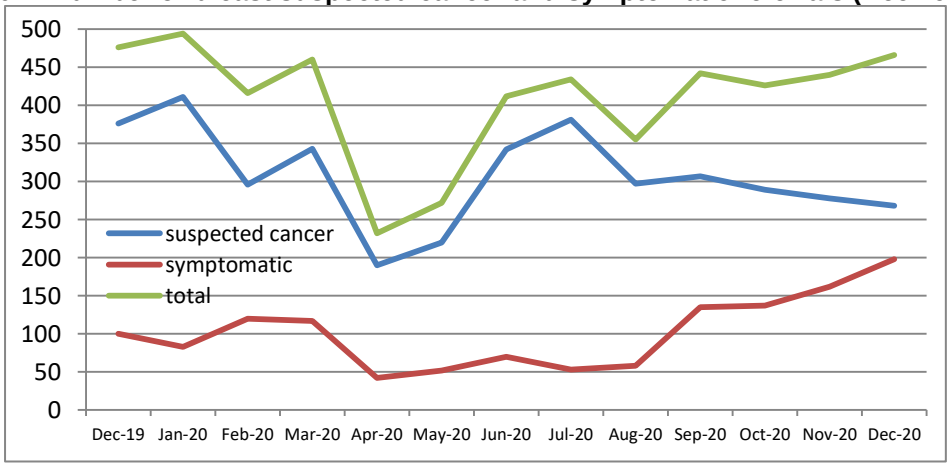
02 Current Situation

02.01 The number of people referred for a first outpatient appointment for either suspected breast cancer or breast symptoms dipped during the first quarter of 2020-21 (i.e. April-June 2020) but numbers recovered in the second quarter and returned almost to normal numbers in quarter 3. This was due to the reduction in referral demand during the first quarter of the year as a result of the pandemic.

02.02 Additionally, the breast screening service has a backlog to catch-up following a suspension of the service which means that the service needs access to its full mammography capacity. This backlog may also be contributing to extra 2 week wait (2ww) referrals being made as women have not been able to access screening.

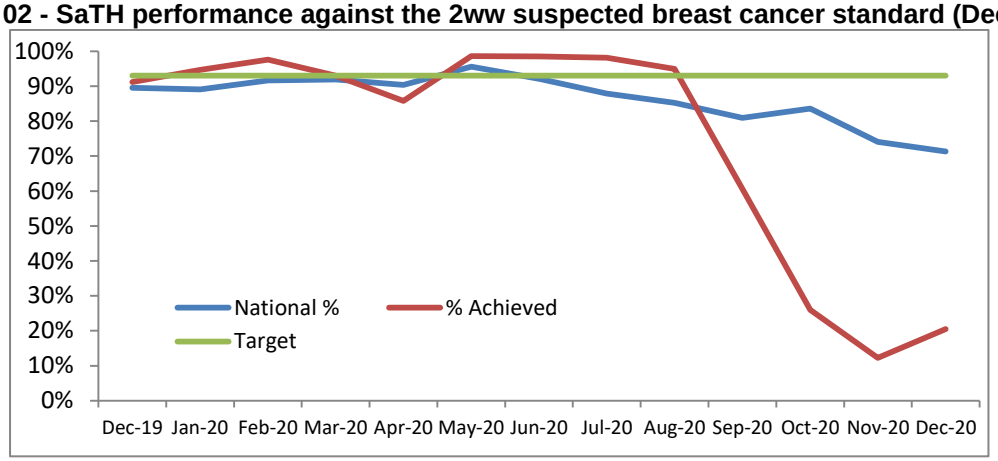
02.03 Note - the data for SaTH includes Powys patients which are 10% of total numbers seen. Almost all Shropshire and Telford and Wrekin patients are referred to SaTH, but there is no formal breakdown of these figures within CWT data.

Figure 01 - Number of breast suspected cancer and symptomatic referrals (Dec 19-Dec 20)



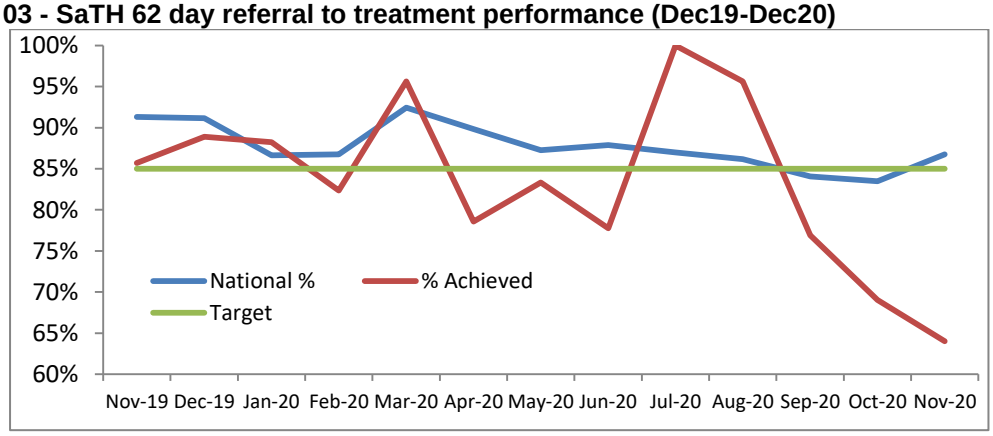
02.04 Performance against the 2ww standard for suspected breast cancer referrals for SaTH shows that there has been a marked fall off since September 2020. In the latest data for month 9 in 2020/21 (December 2020) this equated to 213 people referred for suspected breast cancer not being seen within 2 weeks with a further 179 on the symptomatic pathway and a maximum waiting time of 35 days for a first appointment.

Figure 02 - SaTH performance against the 2ww suspected breast cancer standard (Dec 19-Dec 20)



02.05 The 2ww performance has also impacted on performance against the 62 day standard. These pathways are linked because only patients originally referred for suspected cancer get included in the 62 day standard performance.

Figure 03 - SaTH 62 day referral to treatment performance (Dec19-Dec20)

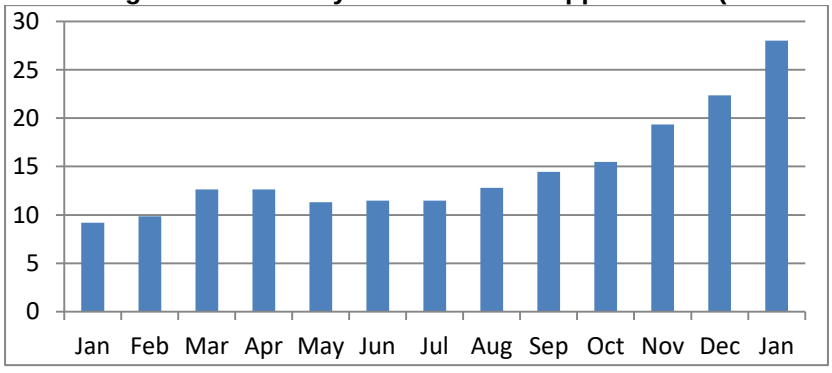


02.06 Following the recent issuing of a revised 2ww referral form, there is a significant shift to using the symptomatic pathway showing in the latest data – in the latest 3 months this has increased to over 1/3 of all referrals from an earlier average of under 20%.

02.07 The average day that all breast patients (both pathways combined) are booking at the end of January 2021 is 28 days. During January 2021 the wait reached a maximum of 35 days. This has now reduced to 21 days as at the beginning of March 2021.

02.08 A number of other local large cancer services have currently suspended their pathway for referring breast symptomatic patients. This means that they have given priority to suspected cancer referrals over those where cancer is not suspected by the referring GP. The information about whether the GP suspects cancer or not is indicated on the referral form used by primary care.

Figure 04 - Average number of days wait until first appointment (all breast referrals) (Jan 20-Jan21)



02.09 For the period January-December 2020, local data shows that of the 292 cancers found following any GP referral across Shropshire, Telford and Wrekin and Powys referring in to SaTH, only 11 (<4%) came from symptomatic referrals.

Figure 5 - Cancer outcomes of all breast referrals received by SaTH Jan-Dec 2020

CCG / health board	total referrals	total cancers	% of all cancers found	conversion rate
Shropshire total	2691	175		6.50%
suspected breast cancer	1988	169	96.57%	8.50%
symptomatic	703	6	3.43%	0.85%
Telford and Wrekin total	1646	81		4.92%
suspected breast cancer	1147	76	93.83%	6.63%
symptomatic	499	5	6.17%	1.00%
Powys total	482	36		7.47%
suspected breast cancer	459	36	100%	7.84%
symptomatic	23	0	0%	0.00%
Total - all providers	4819	292		6.06%
suspected breast cancer	3594	281	96.23%	7.82%
symptomatic	1225	11	3.77%	0.90%

02.10 In the financial year 2019-20, the proportion of under 40's referred for suspected cancer was 36% of all patients, and for those referred on the symptomatic pathway this was 28%, the overall proportion being 30%.

Figure 6 - Number and proportion of referrals for under 40s

year 2019/20	under 40s	total referrals	% under 40s
Suspected breast cancer	536	5140	36.0%
symptomatic	1453	1489	28.3%
Total	**1989**	**6629**	**30.0%**

03 Current service provision

03.01 The SaTH team now offering five 'one-stop shop' clinics a week with each having 25 patient slots. These are offered to a mixture of suspected cancer 2ww and symptomatic patients, in the order that referrals are received. Occasional extra clinics are being offered whenever there is staffing available to deliver them. 5 of the slots in each clinic that are used for patients under 40 – these are lower risk patients and do not require Consultant input.

03.02 The 'one stop shop' means that there is access to radiology and mammography for all patients as part of the outpatient appointment, if needed. The staff who are needed for these clinics are as follows; 1 breast Consultant, 1 middle grade staff, 1 nurse practitioner, 2 Consultant radiographer/radiologists, access to mammography, 2 admin staff.

03.03 Due to COVID, there was an initial reduction in clinic capacity to 15 slots because of staff redeployment, staff self-isolating and reduced access to radiology due to needing dedicated COVID safe access. Initially, radiology required a separate entrance for COVID patients that reduced capacity, but following recent building estates work to increase access there are now protocols and systems in place to allow clinics to operate back to the full pre-COVID capacity of 25 slots.

03.04 SaTH are reviewing all cases where patients have deferred appointments and contacting patients to encourage them to attend in a timely manner. In some cases such patients are being given virtual appointments to aid assessment and give reassurance to patients.

04 Recovery of the 2ww suspected cancer target

04.01 SaTH have prepared the following recovery trajectory, based on current demand for both breast referral pathways and expected capacity. Current demand has now returned to pre-COVID levels so is not expected to go any higher.

Figure 08 – 2ww and breast symptomatic joint improvement trajectory

Cancer Waiting Times - 2 Week Wait (TARGET 93%)														
Cancer		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total Year End**
	2ww - Patients Referred	341	371	353	377	318	364	412	385	376	411	296	343	**4347**
	2ww - Patients Breached	116	77	32	20	20	20	20	20	20	20	20	20	**405**
Breast	% Compliance	66.0%	79.2%	90.9%	94.7%	93.7%	94.5%	95.1%	94.8%	94.7%	95.1%	93.2%	94.2%	**90.7%**

04.02 This shows that breast services would be booking for referrals on referral both pathways within 14 days by the beginning of July 2021. This does factor in the impact of Easter

04.03 There are a number of actions that could be considered have come from the NHSE publication Urgent cancer diagnostic services during COVID-19 in January 2021, with further possible ideas from joint commissioner and service provider discussions.

Location	Suggested change	Expected outcome
Primary care	Use of new advice & guidance service to support primary care and offer advice as to whether patient needs onward referral	Increase care in primary care and reduce unnecessary referrals to secondary care
	Indicate COVID-19 symptoms/shielding status (as per NHSE guidance)	Secondary care to plan appointments offered to patients taking into account patient COVID status
	Indicate whether patients are suitable for virtual clinical triage or need a face-to-face assessment in secondary care (as per NHSE guidance)	Secondary care to stream patients in to virtual clinics – for symptoms such as breast pain only, gynaecomastia, bilateral nipple discharge
	Cancer clinical lead for the CCGs to regularly audit referrals with secondary care to improve quality of referrals	Increase the quality of referrals using evidence provided
Secondary Care	Virtual clinical triage to be used to determine suitability for appropriate breast assessment (as per NHSE guidance)	Currently being done for small number of patients, but experience of these shows most patients still need to be seen in clinic
	Stream more of appropriate patients (such as under-40s and men) into non-Consultant led clinics	Free up one stop clinics for suspected cancer referrals
	Increase clinic capacity so that the backlog is caught up quicker	Ad-hoc clinics are already used whenever possible
	If it is felt that a patient requires imaging, but that cancer is unlikely, they can go straight for imaging without having to attend a one stop clinic	Release capacity in one stop clinics for query cancer patients
	Stream patients so that suspected cancer referrals are given priority over symptomatic patients	Free up one stop clinics for suspected cancer referrals to take priority over symptomatic referrals

05 Summary and Conclusion

05.01 SaTH have provided a recovery trajectory based on expected demand and activity, that should recover both the suspected breast cancer and symptomatic 2ww referral pathways to within 14 days by the beginning of July 2021.

05.02 There are a number of actions that can be carried out that should further improve the time that people are seen on these pathways, namely;

- Primary care to use the advice and guidance service wherever appropriate
- Primary care to indicate on referrals any relevant patient COVID information to help the breast service to plan bookings

- Secondary care to stream all low risk patients (under 40s and men) in to non-Consultant led clinics wherever logistically possible
- Secondary care to increase clinic capacity wherever possible
- Primary & Secondary care to jointly and regularly audit referrals considered inappropriate by the breast team, to improve the quality of referrals

05.03 There is a further action that would impact on reducing the backlog more quickly, by prioritising suspected cancer patients. This could be considered for the short-term whilst the referral time is recovered, and considered in the future if the service came under similar pressure again.

- The breast team to prioritise patients referred on the suspected cancer pathway into one stop clinics in the short term. This would not increase the overall recovery time of both pathways but would mean that suspected cancer patients are seen first. Any such change in prioritisation would impact unfavourably on the breast symptomatic pathway and the target would continue to be failed until the beginning of June and it must be remembered that a small number of cancer cases are found via this route

05.04 Due to the tight timescales for this paper, these actions have not been fully agreed with SaTH, so the recommendations are for the CCG to consider and approve them and then for the CCGs Performance and Assurance manager to work with SaTH colleagues to gain their support for implementation.

Recommendations/Actions Required:

The Committee is recommended to;

- Approve the following actions;
    - Primary care to use the advice and guidance service wherever appropriate
    - Primary care to indicate on referrals any relevant patient COVID information to help the breast service to plan bookings
    - Secondary care to stream all low risk patients (under 40s and men) in to non-Consultant led clinics wherever logistically possible
    - Secondary care to increase clinic capacity wherever possible
    - Primary & Secondary care to jointly and regularly audit referrals considered inappropriate by the breast team, to improve the quality of referrals
- Note the recovery trajectory produced by SaTH for delivery of the 14 day target by the beginning of July 2021
- Consider whether priority should be given to patients referred on the suspected cancer pathway and support urgent discussions with the SaTH breast team if this action is supported
- Note the recovery trajectory will be monitored via the fortnightly SaTH Cancer Performance & Assurance meeting of which the CCG is a member

Appendix 1

Cancer Waiting Times Operational Standards

The current measures and the operational standards are:

- Two weeks from urgent GP referral for suspected cancer to first outpatient attendance (93%)
- Two weeks from referral with breast symptoms (where cancer is not suspected) to first hospital assessment (93%)
- 28 days from urgent GP referral for suspected cancer, urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) or referral with breast symptoms (where cancer is not suspected) to the date the patient is informed of a diagnosis or ruling out of cancer (operational standard to be confirmed)
- 62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia) (85%)
- 62 days from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment (90%)
- 62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set)
- 31 days from diagnosis (decision to treat) to first treatment for all cancers (96%)
- 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery or radiotherapy) (94%)
- 31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti cancer drug therapy, e.g. chemotherapy) (98%)