Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of NHS Lincolnshire Integrated Care Board

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 September 2023**
Subject:	**Cancer Care and Living with Cancer Programme**

Summary:

The Committee is invited to consider a report on Cancer Care for people in Lincolnshire, which was last considered by the Committee in July 2022. The report covers the impact of Covid-19 and recovery; performance, including a reduction in the number of national standards from nine to three; improvements; and the challenges and risks. There is also information on the Living with Care Programme.

Actions Requested:

The Committee is requested to consider and note the information presented in the report on Cancer Care and the living with Cancer Programme.

1. Background

The National Health Service (NHS) in England operates under the constitutional framework - the NHS Constitution. The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Cancer waiting times measure NHS performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures are used by us locally and nationally by NHS England and other organisations to monitor the timely delivery of cancer services to patients.

This NHS has made significant efforts to address cancer care and treatments through various initiatives and guidelines. The National Institute for Health and Care Excellence (NICE) develops guidelines and recommendations for referral, diagnosis, treatment, and management of various cancers. NICE guidelines are evidence-based and help inform but do not dictate clinical practice. They play a significant role in shaping the standards of care provided by the NHS.

At present we are measured against nine standards; however as of October 2023 these standards will be simplified and reduced to three standards. The most notable impact is the removal of the two-week wait standard, which set out a maximum timeframe of two weeks between the receipt of urgent referral for suspected cancer to first outpatient attendance.

The remaining three standards will be simplified and are as follows: -

- **28 Faster Diagnosis Standard (FDS)** - Maximum 28 days from receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer.

- **31 Day Standard** - Maximum one month (31 days) from Decision to Treat/Earliest Clinically Appropriate Date to Treatment of cancer.

- **62 Day Standard** - Maximum two months (62 days) from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer.

2. Covid-19 Impact

The Covid-19 pandemic has had a significant impact on cancer performance and treatment both locally and nationally, some areas have recovered quicker than others. We have some good news stories in Lincolnshire following Covid-19, our endoscopy unit was one of the quickest to recover in England and the recovery was utilised as a blueprint around the country, however other areas have not faired so well due to existing challenges. Lincolnshire is quite unique in its population demographics and its challenges; this has been recognised by the likes of Professor Sir Michael Richards during discussions around recovery.

In order to manage the strain on healthcare systems and reduce the risk of Covid-19 transmission, many cancer screening programs were temporarily suspended or scaled back. This has led to a decrease in the number of individuals being screened for various types of cancer, such as breast, cervical, and colorectal cancer. As a result, some cases that would have been detected through routine screening have been missed or diagnosed at a later stage.

The fear of contracting Covid-19 has deterred some individuals from seeking medical attention, including those experiencing cancer symptoms. Concerns about visiting hospitals and GP surgeries, where Covid-19 patients may be present, have led to delays in seeking diagnosis and treatment.

General practitioners (GPs) and primary care providers have faced significant challenges during the pandemic, such as increased workload, redeployment of staff, and the need to prioritise Covid-19 care.

Cancer treatments, such as surgeries, chemotherapy, and radiation therapy, have been affected by the pandemic. While efforts have been made to prioritise urgent and life-saving interventions, some patients have experienced treatment delays, modifications, or cancellations due to resource constraints, infection risks, or the need to shield.

The pandemic has had a significant psychological and emotional impact on cancer patients. Isolation, fear of infection, and reduced support systems have contributed to increased anxiety and stress levels among cancer patients and their families. This has led in some cases to patients who have become disengaged due to high levels of anxiety.

The long-term consequence of delayed cancer diagnoses and treatment during the height of the pandemic are still being assessed, and efforts are well underway to address the backlog of care and treatment and ensure the effective management of cancer services.

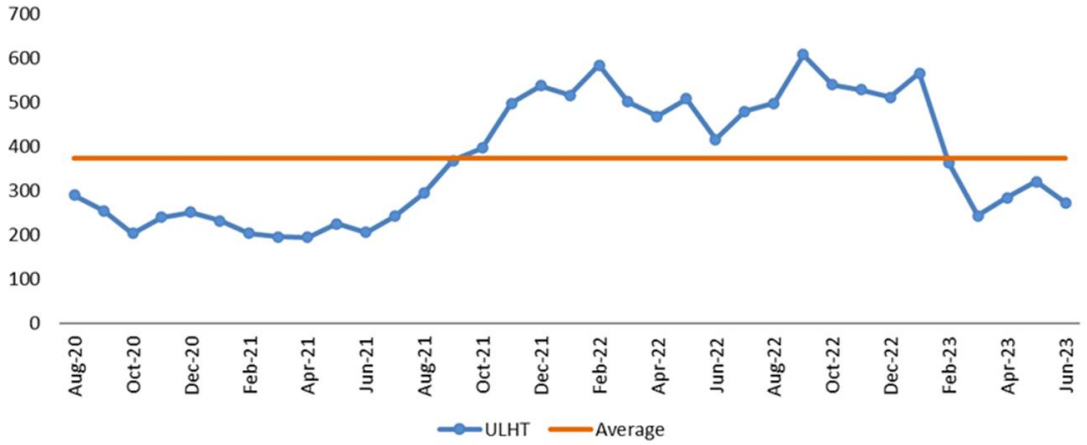
3. Recovery Focus

At the beginning of each financial year every Integrated Care System (ICS) is required to write and enact plans for the following year, see Appendix A. The Long-Term plan objectives remain unchanged for cancer in that by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis. This objective alongside achieving the new 28FDS target and reducing our 62-day backlog in Lincolnshire to 217 by March 2024 is the main area of focus.

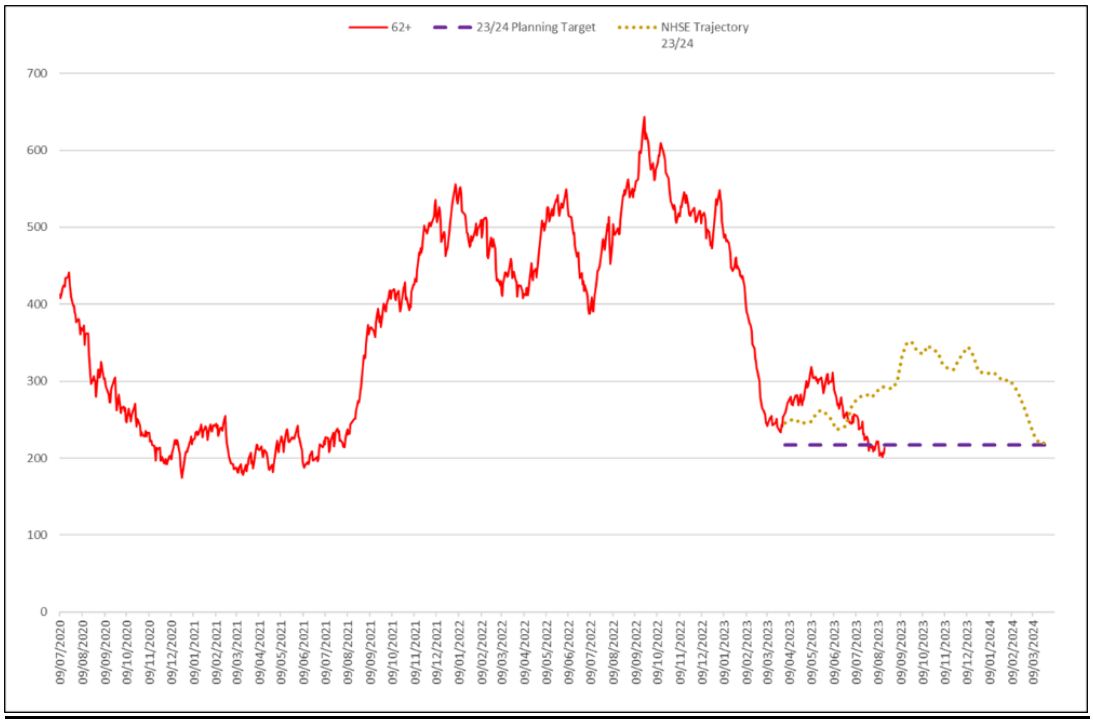
4. Performance

There have been significant strides made in reducing the cancer backlog as part of the NHS Recovery from Covid 19. Despite the challenges posed by the pandemic, our healthcare system has adapted and implemented innovative strategies to address the backlog of cancer cases. The pandemic prompted the development of virtual consultations, allowing healthcare professionals to continue providing essential care remotely where appropriate, ensuring that patients receive timely diagnosis and treatment. Additionally, the prioritisation of cancer services and the rescheduling of postponed procedures have contributed to a notable reduction in the backlog. The concerted efforts of the ICS have played a vital role in mitigating the impact of the pandemic on cancer care.

62+ Backlog Reduction at United Lincolnshire Hospitals NHS Trust (ULHT)

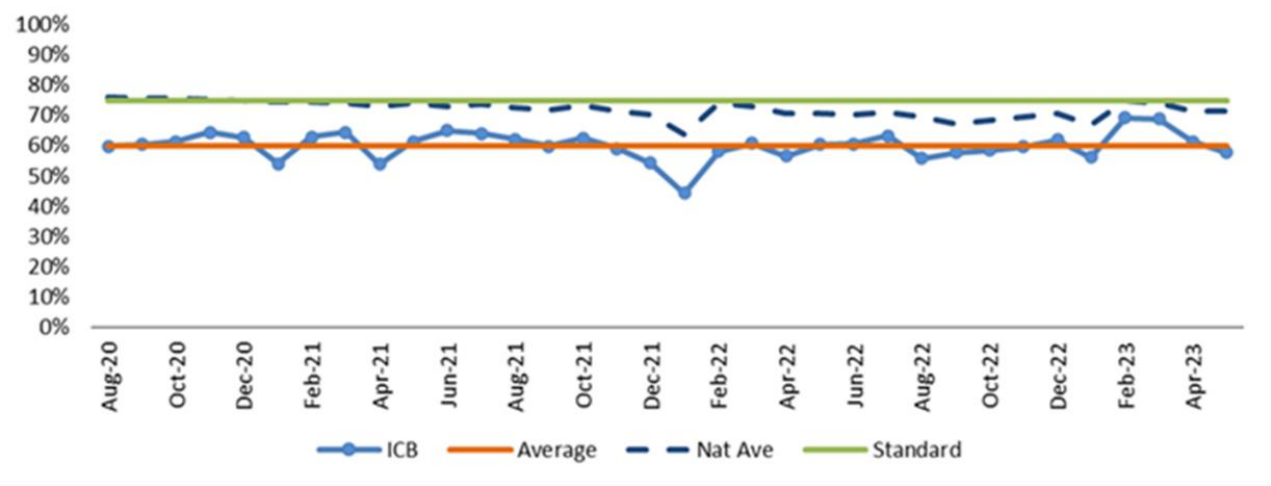


Current Backlog Position at ULHT

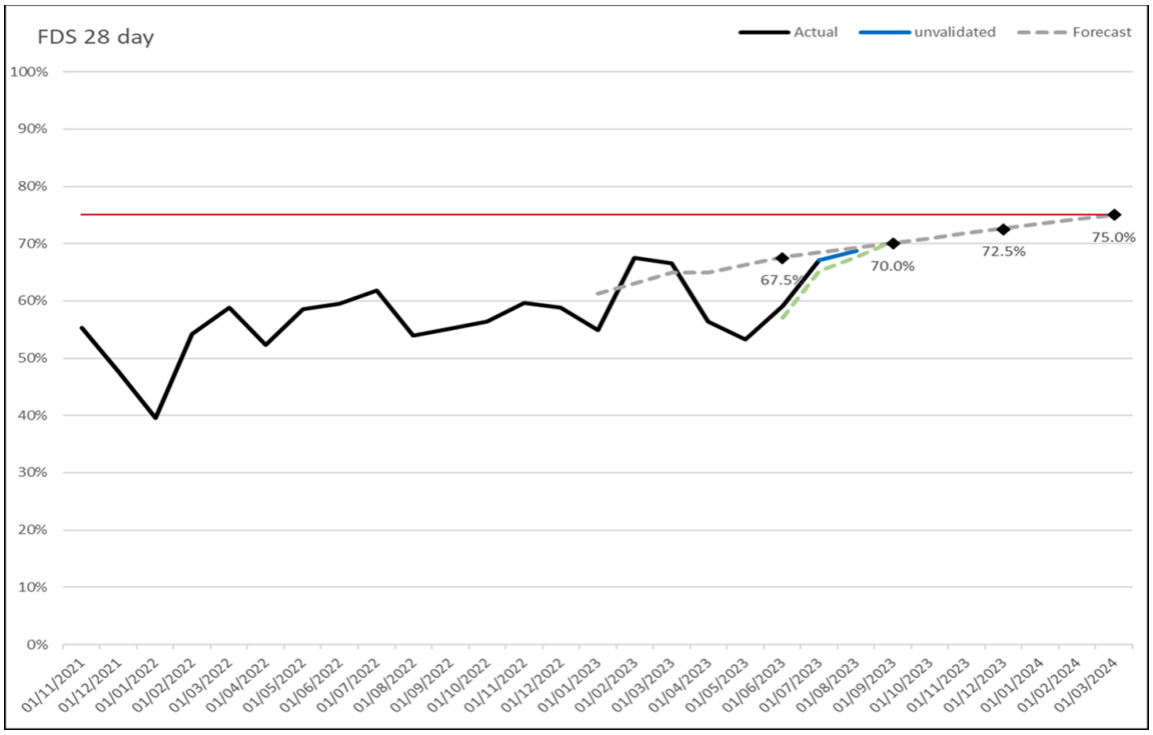


The new 28 Faster Diagnosis Standard (FDS) has been introduced to ensure patients who are referred for suspected cancer receive a timely diagnosis. The standard ensures patients will be diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. For patients who are diagnosed with cancer, it means their treatment can begin as soon as possible. For those who are not, they can have their minds put at rest more quickly. The target set by NHS England is to reach 75% on the 28FDS by March 2025. As you can see from the data provided this was proving challenging at the beginning of the year however August's performance is looking much improved.

28 Day Faster Diagnosis Standard
% of patients told Cancer Diagnosis Outcome within 28 days (Validated Position)



28 Day Faster Diagnosis Standard- August 2023
(Unvalidated position – ULHT only)



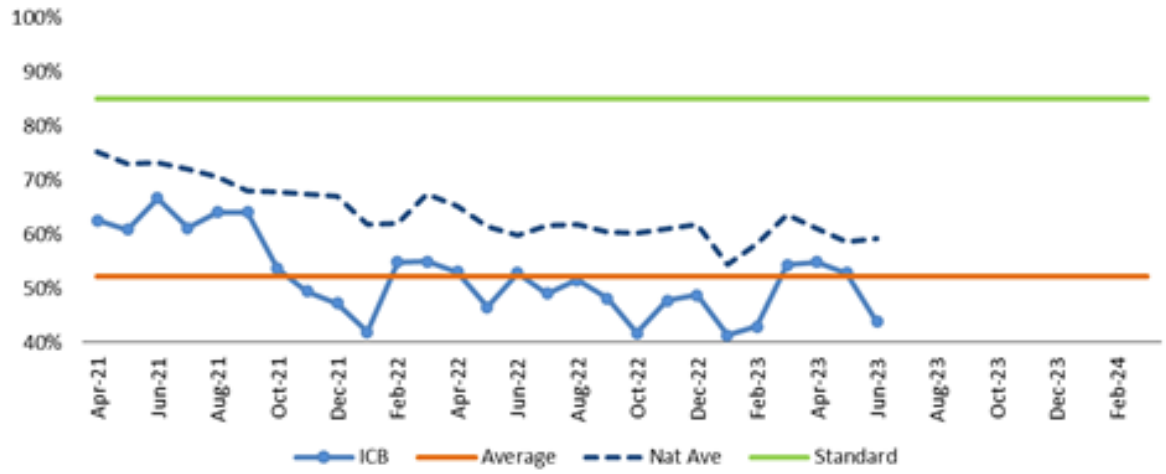
We also monitor patients waiting over 62 days and patients waiting over 104 days. Below you can see performance for all three trusts that contribute to the performance for Lincolnshire ICS.

62+ & 104+ Backlog – June 2023 **

	ULHT	NWAFT	NLAG
Patients waiting over 104 days	95	94	31
Patients waiting over 62 days	273	330	100

**June most recent validated (published performance data)
ULHT – United Lincolnshire Hospital Trust
NWAFT – Northwest Anglia Foundation Trust
NLAG – North Lincolnshire and Goole Foundation Trust

62-day Classic - Referral to Treatment Target



Alongside the objective to achieve the new 28FDS target and reducing our 62-day backlog in Lincolnshire to 217 by March 2024. NHS England have also set a new trajectory this August to achieve 70% of the 62-day classic target by March 2024, this target measures the time patients receive treatment for cancer within 62 days of an urgent GP referral. This target is usually set at 85% but has been reduced to 70% this year. The expectation is as the backlog reduces and the 28-day target is improving inevitably the 62-day performance target should improve.

5. Monitoring

NHS Lincolnshire Integrated Care (ICB) monitors the performance of all three trusts. The ICB review performance weekly through their ICB Executive meeting. A monthly performance update is presented to the ICB Service Delivery and Performance Committee where performance data is monitored monthly, a sub-committee of ICB Board, and the ICB System Quality and Patient Experience Committee where quality and experience issues would be identified, a sub-committee of ICB Board. The Cancer Board receives monthly performance reporting from ULHT and quarterly reporting from Northern Lincolnshire and Goole NHS Foundation Trust and North West Anglia NHS Foundation Trust.

6. Improvements

Against a challenging backdrop of emerging from a global pandemic, significant improvements have been made for the patients of Lincolnshire. The tireless dedication and resilience of healthcare workers, combined with strategic and operational planning, have paved the way for positive change. The crisis has highlighted the importance of collaboration and effective communication between healthcare providers to seek innovative solutions for the people of Lincolnshire.

All three providers that serve the patients of Lincolnshire have made positive improvements whilst also reducing their backlogs:

<u>North West Anglia NHS Foundation Trust</u>

- Implementation of new colorectal pathway
- Implementation of new breast pain clinic
- Staging CT same day following endoscopy
- Multi-parametric MRI commenced for prostate patients.
- Targeted Lung Health Checks commenced in a GP practice in Peterborough.
- Phase 2 of the Galleri Trial (new blood test to see if it can help the NHS to detect cancer early)
- Increase in capacity for one stop neck lump clinics.

<u>Northern Lincolnshire and Goole NHS Foundation Trust</u>

- Upper gastro-intestinal 2 week wait pathway moved to straight to test pathway – June 2023
- Protected slots for navigational bronchoscopy (lung) being worked on with Hull University Teaching Hospitals NHS Trust (HUTH) (should reduce the lung pathway by at least seven days). Plan to be in place from September 2023.
- Pathology – business case to bring biomarker testing in house. Joint working with NHS Lincolnshire ICB. Will have a positive impact on breast and lung pathways – reducing turnaround times from 19 days to 3-4 days, reducing the pathway by at least 14 days.
- Urology – two-stop clinic in place with protected multi-parametric MRI slots. Working on increasing capacity for biopsies – biopsy turnaround time.
- Best Practice Timed Pathways – implemented and monitored for all pathways.

- Joint transformation plan with HUTH for pathways that cross organisational boundaries (e.g., upper gastrointestinal, head and neck, gynaecology, urology)

United Lincolnshire Hospitals NHS Trust

- Implementation of the Rapid Access Colorectal Pathway November 2022
- Lung pathway redesigned to support Best Practice Timed Pathway, planned implementation September 2023
- Gynaecology post-menopausal bleed pathway implementation August 2023
- Galleri Trial Phase 2 – completed with a 92%
- Intensive support programme focussed on delivery of reducing backlog and Faster Diagnosis Standard.

7. Future Workplan

Our future work programme is very much in line with the NHS England guidance that is set out each year. We have specific ongoing pieces of work that the system is supporting ULHT in delivery and will impact in two ways either backlog reduction, and the FDS standard.

The future work plan sets out specific projects that ULHT is delivering to support all three standards.

- Right sizing of colorectal services at ULHT
- Reconfiguration of gynaecology services to ensure future sustainability through nurse led clinics at ULHT.
- Implementation of Best Practice Timed Pathways across all tumour sites.
- Supporting GPs with education on cancer signs and symptoms
- Working locally and regionally to roll out initiatives to support early diagnosis to improve survival rates.
- Galleri Trial Phase 3.
- Rolling out targeted lung health checks trial.
- Multi-disciplinary team Rose projects to reduce variation, and increase efficiency and quality.
- Bowel screening health inequalities project focusing on the Core20+5 [*an approach to reducing health inequalities for children and young people]* using co-production and community development approaches.

8. Challenges and Risks

Cancer Services in Lincolnshire and nationally are not without challenge. Lincolnshire suffers from a number of the key challenges however some are worsened by our geography and a wider collaborative approach across the system is needed to ensure Lincolnshire is recognised as a positive place to live and work to in, workforce shortages are not unique to Lincolnshire however we do have a greater struggle to recruit from outside Lincolnshire than many other areas of England and the UK. Staff shortages, including doctors, nurses, and other healthcare professionals, have been a persistent challenge for the NHS. Recruitment and retention are

difficult due to factors such as heavy workloads, burnout, and the impact of Brexit, which has affected the availability of overseas healthcare workers.

We are experiencing a growing demand for services due to factors such as an aging population, the prevalence of chronic diseases, and advances in medical technology. This places strain on resources, leading to longer waiting times and increased pressure on healthcare professionals.

While technology offers great potential for improving healthcare delivery, integrating, and upgrading systems across the NHS has been a complex task. The implementation of electronic health records and other digital initiatives has faced challenges.

There are significant health inequalities across Lincolnshire compared to our neighbouring counties and populations in the UK. Socioeconomic factors, lifestyle choices, and access to healthcare services can contribute to disparities in health outcomes. Addressing these inequalities is a complex and multifaceted challenge.

Lincolnshire and the UK's demographic profile is changing, with an aging population and increasing multiculturalism. The NHS must adapt to provide culturally sensitive care and meet the specific needs of different population groups, including those with language barriers or specific health conditions.

The NHS and social care systems are interconnected, and the lack of integration can lead to inefficiencies and gaps in care. Co-ordinating long-term care and improving the transition between healthcare settings is essential for patient well-being. The ICS considers the need to continually address the populations Health Inequalities within the cancer programme. The Programme will continue to work with the system to address the inequalities, understand the specific inequalities and work with the populations to mitigate and improve the inequalities.

9. Conclusion

In conclusion, the state of cancer care in Lincolnshire is showing sustained signs of improvement. However, there is acknowledgment that there is still work to be done in order to meet the desired standards of care for cancer patients in the county. The healthcare professionals and organisations involved in cancer care for the patients of Lincolnshire are passionate about their work and are dedicated to making further improvements.

There is a recognition that gaps exist in the current cancer care system, and efforts are being made to address them. The aim is to provide more integrated and comprehensive care to cancer patients in Lincolnshire. Collaboration and integration with the wider healthcare system are seen as essential to bridge these gaps and enhance the quality of care provided.
By working together and striving for continued improvement, the goal is to ensure that cancer patients in Lincolnshire receive the best possible care and support throughout their journey. The commitment to ongoing progress and the dedication of the passionate teams involved in cancer care in the county are key factors in driving these improvements.

10. Lincolnshire Living with Cancer Programme

The Living with Cancer (LWC) programme aim is to develop person-centred local support for people living with cancer, their carers and significant others in Lincolnshire. We are implementing personalised follow up pathways and personalised care across acute services and in communities for people on all cancer pathways and geographical areas in Lincolnshire.

Our approach is ***'we are creating a better and sustainable future for supporting people LWC, involving and integrating all relevant parts of the health and social care system, using the assets we already have, supporting people in the place they would like and in the way they would like, and placing people at the centre of everything we do.'***

The programme is delivered via sub programmes and enabler workstreams:

- Acute Programme
- Personalisation Programme
- Community Development Programme
- Workforce Development Programme
- Digital Programme.

In October 2022 we secured recurrent funding for the programme which was originally funded by MacMillan, and this has secured to continuation of the programme.

Achievements Since September 2022

Whole Programme:

- Our three LWC Strategies 2023 – 2025 are currently proceeding through governance and will be adopted in October. These are: the Lincolnshire LWC Strategy; the Integrated Cancer Workforce Development Strategy; and the Cancer Digital Strategy 2023 – 2025. These are informed by strategic alignment with national, regional and local strategies and policy (including 'Better Lives Lincolnshire' and NHS Lincolnshire Five Year Forward View), data and patient experience.
- The 2022 National Cancer Experience Survey showed an increase in overall patient satisfaction score from 8.6/10 to 8.8/10. We have developed an integrated action plan to address individual question scores which are less than the national average or have shown no improvement.
- We have developed a LWC dashboard to enable us to demonstrate impact using quantitative and qualitative data. This has been very well received regionally and we have recently demonstrated it to other trusts in the region and further afield.
- The LWC team awarded a national Macmillan Excellence Award in the Integration category at the Macmillan Professionals Conference in November 2022. The programme was commended for its ambition, commitment to patient and public involvement, its achievements and taking a whole system approach to improve the quality of life for all people living with cancer in the county.

- We are sharing our work and approach nationally via Macmillan Webinars and three workshops and two posters at the forthcoming Macmillan Professionals Conference in Glasgow in November 2023. The programme has also been recognised internationally via a presentation at the International Psycho Oncology Symposium World Congress in Milan in September.

Patient Engagement

- Our 2 Cancer Co-Production groups continue, with a plan in place to continue after funding finishes next year, and we also have a Cancer Expert Reference Group who meet every 3 months.

Acute Programme

- Increasing number of people are having their needs identified and Care and Support plans set both soon after diagnosis and at end of treatment. There is evidence that a supportive conversation and identification of peoples' holistic needs and referral to other services, both in the hospital and closer to home, can improve peoples' outcomes and patient experience. Data from holistic needs assessments influences service development and delivery to better meet the needs of communities.
- Working with clinicians in ULHT to bring about consistent end of treatment summaries to be sent to GPs and patients.

Personalisation Programme

- Working with breast prostate colorectal and endometrial pathways to embed personalised follow up pathways and for stratification of patients onto clinically suitable follow up pathways to become business as usual.
- Operationalising remote monitoring module to ensure that those patients who are on a self-management pathway are supported and monitored appropriately. The impact of this may be that outpatient appointments are saved because patients are not having to come into hospital needlessly and outpatient appointments can be reused to reduce waiting times.

Community Development Programme

- The community development programme has generated a lot of interest regionally and nationally.
- The team focus on the quality improvement of Cancer Care Reviews, integration with primary care, and locality teams, supporting teams with complex cases (of which there are an increasing number) and health and wellbeing interventions.
- 1400+ community assets mapped and shared with Connect to Support.
- 5 'Fighting Fit' sessions taking place around the county. Lincoln (one day time and one evening), Mablethorpe, Gainsborough, Grantham and Boston. New sessions will start in Bourne at the end of September, and we are hoping to start sessions in Market Rasen later in the autumn. Fighting Fit is a collaboration with the Lincoln City Foundation and leisure providers across the county.

- We're also working with the National Trust looking at fitness sessions for people living with cancer at Belton House and potentially other National Trust sites around the county.
- Psychological and emotional support are one of the most frequently cited things that people would like to have following a cancer diagnosis. There is now support at all different levels of distress across the county. We now have 3.2 WTE Clinical Psychologists and a Video Therapy service for people experiencing the most profound distress. This is due to a joint funding bid with Lincolnshire Partnership Foundation Trust to Macmillan and East Midlands Cancer Alliance.
- We have secured funding for 2 years from Macmillan to recruit a project manager to scope a model to ensure people can get their needs identified in the community, as at the currently this can only be done in the hospital.

Future Work

- We have identified the most common co-morbidities (mental health, MSK, Diabetes, cardio-vascular disease) and we will be starting work on how more complex patients with co and multi morbidities can best be supported.
- Collaboration with Primary Care Transformation and Long-Term Condition Programmes to identify which parts of the programme can be used to support people to live well with other long-term conditions.
- Support in Workplaces and Pharmacies.
- Volunteer, Peer Support, and community champions.
- Out of county – we are actively engaging with other trusts (eg NWAFT, NLAG) to ensure that patients treated in other Trusts have access to community and voluntary services in their home communities.
- Our next Health and Wellbeing focus will be on fatigue and pain.
- We know that the consequences of treatment have a profound impact on many people living with cancer and we're supporting the late effects and consequences of treatment clinics in ULHT to secure recurrent funding.

11. Appendices

These are listed below and attached at the back of the report	
Appendix A	2023-24 Priorities and Operational Planning Recovery Plan Narrative Submission - Cancer

12. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Louise Jeanes, Cancer Programme Director, NHS Lincolnshire Integrated Care Board.

2023-24 priorities and operational planning

Recovery Plan Narrative Submission

Version Number	Date	Details of change
V1.0	26 Jan 2023	Initial version

Introduction

1. Overview

This template focuses on the immediate priority set out in the 2023/24 priorities and operational planning guidance: **to recover our core services and productivity**. ICBs are asked to submit a system narrative plan for the recovery of performance for the 2023/24 financial year, setting out:

- the overall system approach to recovery planning for their system
- key actions system partners will take to recover their core services and productivity
- key assumptions that underpin their numerical plan returns.

Narrative submissions will be reviewed by national and regional colleagues as part of plan assurance and to identify cross-cutting themes and issues.

2. Interactions with other templates and guidance

This submission focuses on the overall approach to recovery of core services and productivity as well as specific plans for elective, cancer, and diagnostics services.

A separate template with a focus on UEC recovery, bed capacity and system flow will be released alongside publication of the national UEC Recovery Plan (expected at the end of January). An additional return on ambulance demand and capacity will be sought from ambulance providers and lead commissioners. These returns will inform the process for the allocation of additional capacity funding above that already included within issued allocations.

The General Practice Access Recovery Plan is expected to be published at the end of February and there will be a linked system recovery plan submission requirement. We are therefore not asking for a narrative submission covering primary care as part of the 23 February draft plan submission.

3. Submission process and contacts

Narrative plans should be submitted at ICB level, using this template, to the appropriate regional planning mailbox (see table below) for **draft submission by 12noon Thursday 23 February 2023** and for **final submission by 12noon Thursday 30 March 2023.**

Further information including a list of all activity and performance metrics can be found within the submission guidance and supporting documents available on the NHS Planning FutureNHS collaboration platform.

Any queries relating to this submission should be directed to regional planning leads:

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net

East of England	england.eoe-planning@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

4. Guidance on completing the narrative submission

Responses should succinctly and clearly:

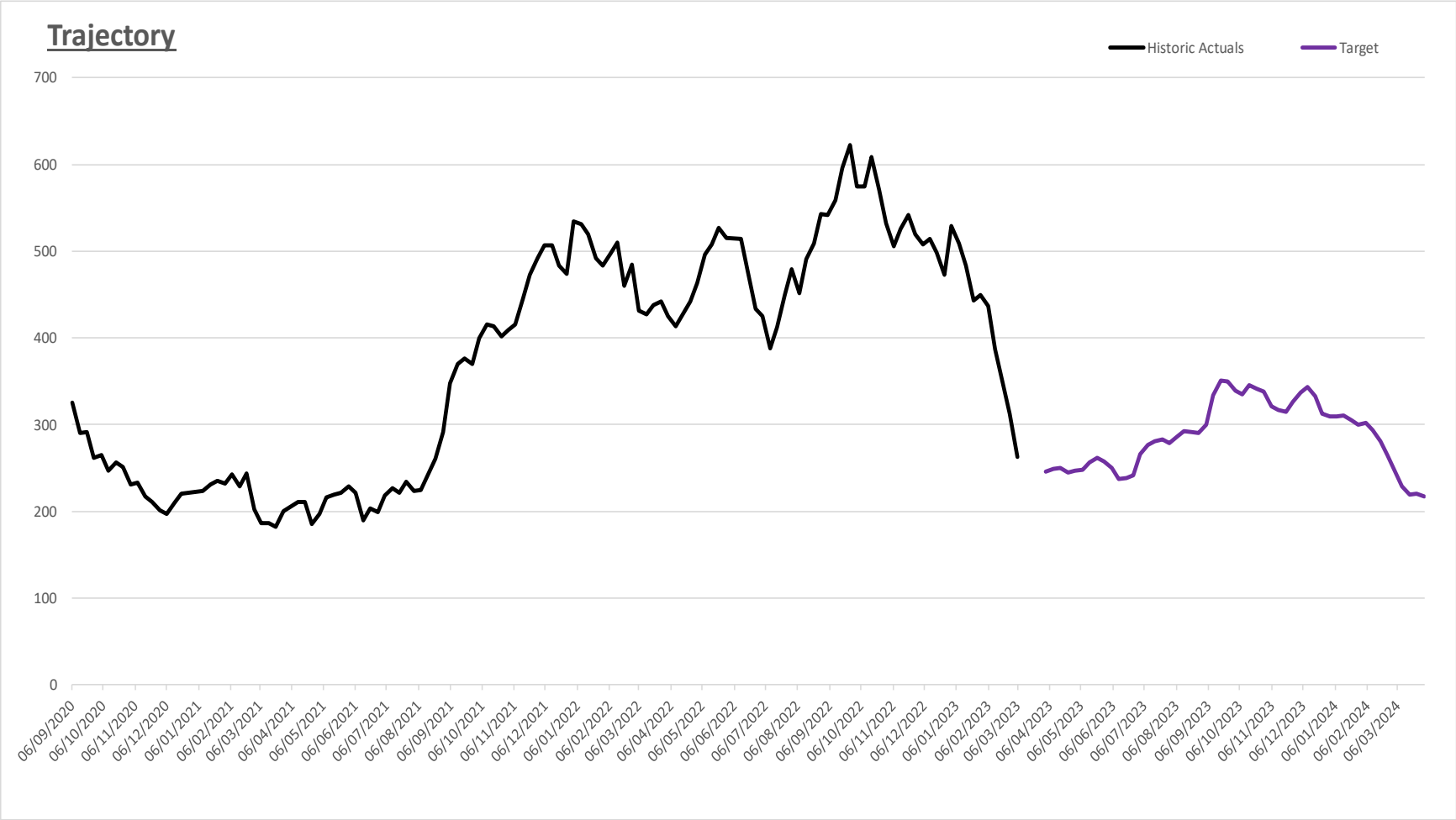
- summarise the current and planned position / performance
- articulate the actions and assumptions that underpin the numerical submission, including:
    - plans to deliver the key evidence-based actions set out in the annex of 2023/24 priorities and operational planning guidance
    - key demand and capacity assumptions
    - activity, workforce, and financial plans and transformation goals that will support delivery of the objective
- set out key delivery risks and/or dependencies on other elements of the system recovery plan
- make links where relevant to other ICB partner plans (e.g. Cancer Alliances).

Please complete all sections. Further instructions to support completion are set out below and within each section of the template.

Cancer

How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements set out here?

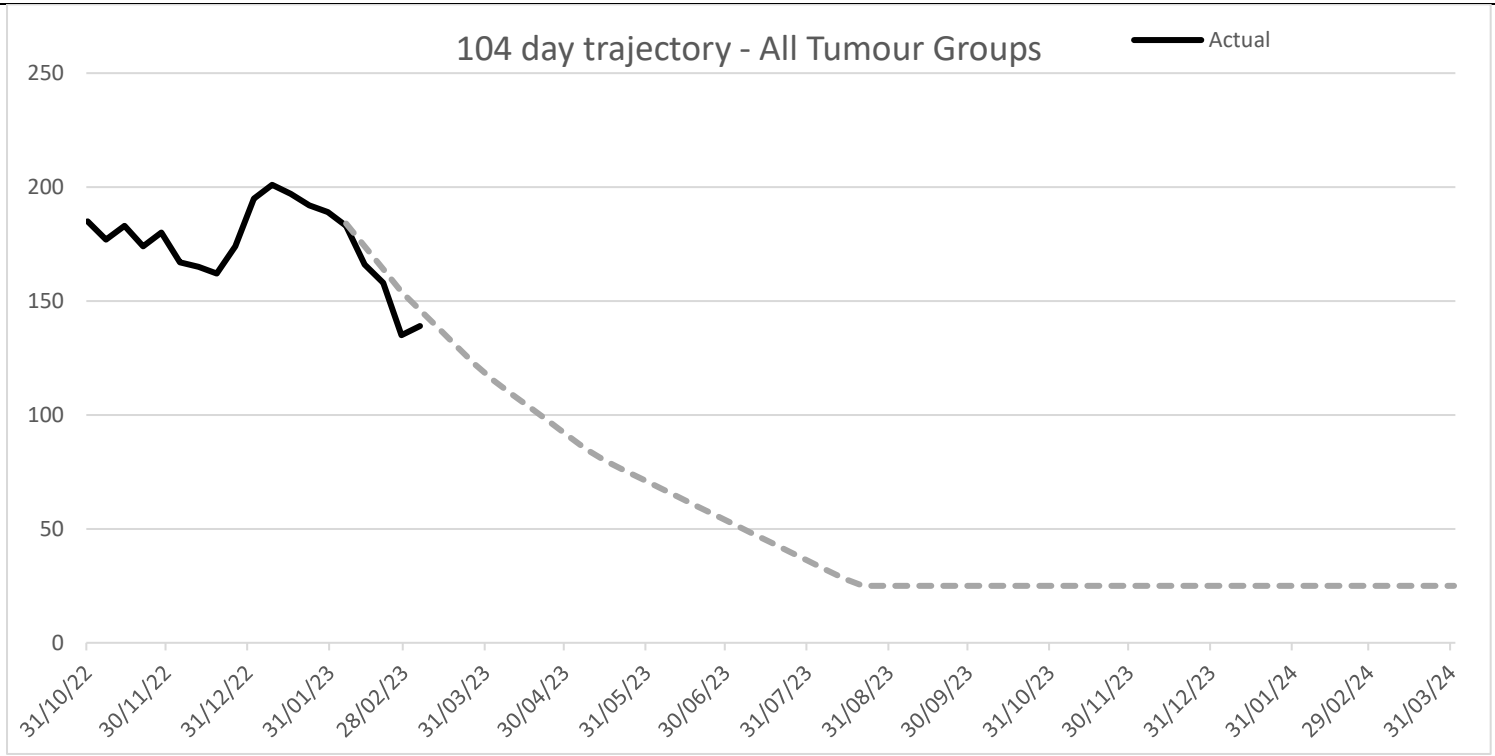
Trajectory 2023/ 2024



	Summarise the current and planned position / performance • Lincolnshire have been in Tier 2 since July 2022 and have focussed efforts on reducing the overall 62-day backlog performance, the original trajectory was to get to 151 by March 2023, this has been very difficult to achieve due to several risks and issues across the system see risks above. • The focus over the past 6 months has been on the colorectal pathway this pathway made up approx. 60 % of the overall >62-day backlog, as of February it is now approx. 45% of the overall backlog • The expectation now for Lincolnshire is to achieve 217 patients waiting over 62 days by March 2024 • The following will detail out the actions and assumptions that underpin the numerical submission • EMCA Service Development funding SDF (Placed Based Funding) will support and deliver the priorities set out in the operation planning guidance and local initiatives that will clearly link to recovery and planning • The SDF funds support medium-term planning and strategic investment. SDF is non-recurrent, and can only be used for revenue expenditure, not for capital purchases. • Risk for the system due to the ICB 30% running costs cuts and recruitment freeze, awaiting direction to understand regards externally funded posts. **Assumptions and actions, key demand, and capacity assumptions** • Address clinical risk on P2 cancer patients. This is consistent with the cancer improvement plans to reduce backlogs and overdue P2 patients. • C2AI continues to be in place and effective to prioritise patients requiring surgery • Attraction and retention of core clinical, managerial, and administrative workforce including business unit workforce. • Appropriate pre-assessment, theatre capacity and post-operative beds are available for patients requiring surgical treatment. • Capacity and demand will remain stable. • Emergency care pathways will not impact the delivery of cancer pathways.

	• The increase in GP opening hours will not result in an increase in 2ww referrals.
	• Ensure that GP teams can directly refer to chest, abdomen and pelvis CT scans, brain MRI and abdomen and pelvis ultrasound
	• Pathology, Endoscopy, Radiology and Oncology provision is stable with capacity available.
	• Job Planning Review will not have an adverse impact on cancer recovery
	• Align cancer recovery with the high-volume low complexity programme
	• Review of Peripheral Clinics and Clinic Utilisation Reviews will have a direct and indirect positive impact on cancer recovery.
	• Implementation of the Outpatient Improvement Group workstreams including:
	  ○ Increasing Non F2F
	  ○ Increasing PIFU
	  ○ DNA reduction
	62 backlog number trajectories
	• The overall achievement of the 62-day backlog will reach 217 by March
	• Continue to work with the divisions to support the reduction in backlog for Colorectal, UGI, Prostate and Lung and Gynae, the 28-day actions (see below) will support the 62 day backlog reductions
	• These five specialities have the highest numbers in the backlog and have scope for greatest improvements in backlog reduction, however we will work with all specialities to ensure pathways are optimised and administrative flows are supported
	• Deep dive into speciality areas with the divisions to understand the reasons for delays in the specialties, set out improvement plans that will support backlog reduction and 28-day performance
	• Continue to manage the tip overs 62 and 104 days
	• Work with Primary care to understand potential changes in referral management that will support improvement to pathways but consider impact on PC

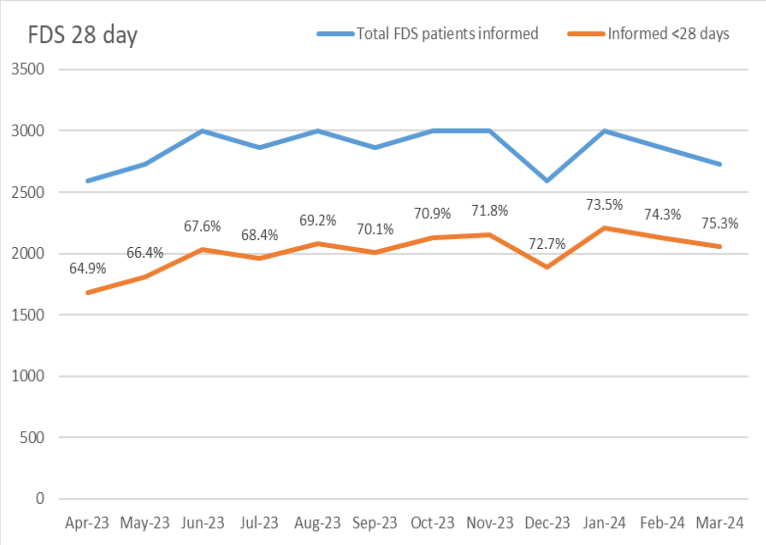
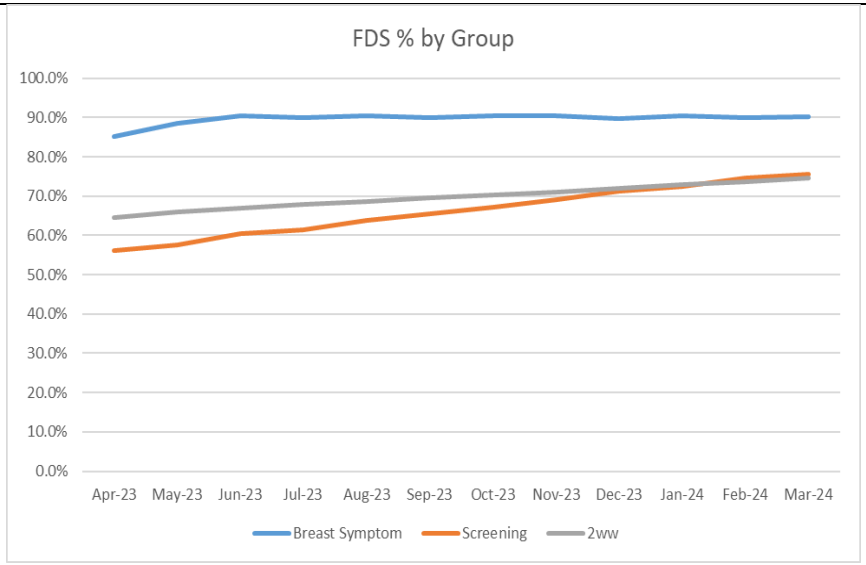
	• The IST model pathway analyser will be performed on Prostate and Gynae to truly understand where the constraints on the pathways are. • Working with key specialities/ divisions to understand the key constraints outlined from the results of the analysis • Work on the cohort of patients that do not have a Decision to treat DTT, 86.5% of the total backlog do not have a DTT • Maximising 62-day backlog reduction work continues to reduce both –ve FIT and NO FIT from the PTL • Identify quick wins in administrative flows, identify workforce constraints that will support faster turnarounds and removal of patients from the pathways • Increased cancer trackers in the Cancer team are supporting twice weekly tracking to support vulnerable pathways e.g., Colorectal and Urology **104-day trajectory** • Patients waiting over 104 days makes up 40% of our backlog >62 days • Implement and follow SOP for Golden patient programme across all specialities • Deep dive into the disengaged patients to understand true delays and work with the divisions to understand what is required for each patient to move forward on the pathway or move off • SDF have funded a 104 Navigator to co-ordinate and navigate complex patients off the pathway • For the long waiting patients with significant complexities, design process to execute “Patient best interests” – aim to reduce backlog where primary care agreement is needed • Identify patient cohort who are disengaged in the pathway process and determine action and next steps to engage



Risks for 62-day backlog

- System financial position: the latest financial plan reflects delivery of the 104% of 19/20 elective activity target, however under achievement of the activity restoration could result in reduced ERF which is a risk for the financial position. The current forecast for 22/23 outturn has also meant that some potential elective recovery solutions are being delayed from their implementation due to the ‘double lock’ financial process in ULHT. All ISPs are overperforming against the budgets due to the volume of patients being transferred away from the NHS acute sites.

	• Non-elective pressures/capacity: continued occurrence of critical and major incidents that impact on availability of workforce; Access to theatre capacity is reduced due to competing Emergency and Elective pressures; Insufficient provision of post op beds; Requires system support for discharging patients who are medically fit. • COVID: while prevalence has decreased compared to last year there is still adverse impact on elective delivery i.e. pressures on staff sickness and isolation as well as patients cancelling appointments and surgery at short notice. Infection, prevention and control procedures and social distancing guidelines are in line with national guidance. • Workforce: Significant workforce issues - sickness & absence; reduction in workforce with existing staff moving into specialist roles/inability to recruit to more junior roles; reluctance to undertake additional sessions due to exhaustion; heavy reliance on locums; transformation planning requires the same clinical and operational staff as business as usual. • Patient complexity: Disease progression of those patients waiting is resulting in longer operating time requirements and longer recovery time. This also includes the capacity to treat cancer patients as well as long waiting routine patients that require all day theatre lists. • Additional diagnostic demand is expected when starting to clear the outpatient waiting lists. Any focus on recovering the cancer position also adversely impacts on diagnostics and elective activity. • Pre-operative assessment: Relatively fragile pre-operative assessment service, including physical capacity for the service. • ULHT Non substantive funding posts needs thorough evaluation by April, independent EMCA review by May and Investment Panel sign off by June to approve the longer-term affordability. **NWAFT** • Continue to build upon the existing strong relationship, attending weekly PTL update meetings & Cancer Board, working collaboratively with Cambridgeshire & Peterborough ICB to ensure we address issues and concerns. Oversee performance, share, and learn from good practice. **NLAG**

	• Work towards a more open and meaningful relationship with our colleagues at NLAG. Visibility is not as good as we need it to be, nor is communication. Need to get to a point where we are receiving more regular updates with better dialogue around what the issues and delays are as they also impact on patients coming into ULHT.
How will your system meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days?	  **Faster Diagnosis – Best Practise Timed Pathways (BPTP)** Delivery of the FDS is critical to operational performance improvement, and the ICS is advanced in working with partners in toward compliance with multiple tumour site BPTPs. The elective recovery strategy published in February 2022 commits the NHS to delivering the 75% Faster Diagnosis Standard (FDS) target, by March 2024.

	The Faster Diagnosis and Operational Performance programmes account for the largest portion of the increase in place-based allocations for 2023/24, with improvement being an increasingly high priority overall. Six pathways remain priority across EMCA for delivery of FDS, including prostate, lower GI, upper GI, skin, gynae, and breast which account for up to 80% of all FDS breaches. In 2023/24 the ICS will continue to mobilise tumour site specific plans to sustainably achieve the FDS minimum standard, and work between secondary care and primary care to identify/resolve constraints and mitigate identified risks across clinical, operational and administrative levels. This will include ensuring dedicated project management and clinical leadership to support change and education, undertaking a baseline audit of diagnostic turnaround times (TATs), identification of opportunities where funding can be used to expand diagnosis and treatment capacity to meet increasing levels of demand, as well as continuing to establish the technical ability to routinely capture data across the BPTPs in order to enable targeted resource and effort to simplify processes for earlier and faster diagnosis. **28-day FDS Assumptions and Actions** • Lincolnshire are expected by March 2024 to reach in all specialities FDS trajectory of 75% • Lincolnshire will meet the milestone trajectories set for June 67.5%, Sept 70%, Dec 72.5% and March 75%. • For every suspected cancer referral simultaneous 28- & 62-day pathways are commenced, for the majority of these patients (circa 90%) both pathways end at the point of the non-cancer diagnosis. • Therefore, achieving the 28-day standard will remove the bulk of the patients from the PTL allowing better visibility of the remaining patients to ensure they are treated within the 62-day standard. • Where best time practice pathway are available the assumption is these will be implemented, the required best time practice timed pathways will ensure the trust is compliant with the 28-day standard the focus requested by NHSE is to

	focus on Prostate and Colorectal, locally we will expand our improvements to work with Gynae, Lung and Upper GI, Haematology. • Rapid diagnostic pathways will improve the 28-day FDS Standard- RACCP, FRED, UGI, GYNAE • There will be sufficient diagnostic capacity to support these pathways. • Use of CDCs and GP direct access to support diagnostic capacity and will support FDS standard • Maximise use of wider local independent sector diagnostic and treatment capacity • There will be sufficient workforce to support the delivery of these pathways. • Primary care will support appropriate referrals therefore reducing and preventing delays in the patient pathway. • The implementation of the best-timed practice pathways will reduce waiting times for critical investigations and decision making. • The implementation of best-timed practice pathways will implement rapid triaging so patients can access the right tests, first time, through use of appropriately staffed one stop clinics. • The pathways will be integrated with timely reporting of the diagnostic investigations. • These pathways will reduce anxiety and uncertainty of a possible cancer diagnosis with less time between referral and receiving the outcome of diagnosis. • Improved patient experience from fewer visits to the hospital and avoiding emergency admission. • Patients will be engaged in the 28-day pathway to minimise patient choice delays. • Clinicians will understand and engage with the changes being proposed. • There will be sufficient funding to support set up of the pathways. • System support for promoting the importance of Co-Production and patient voice. • Continued funding to establish and embed Co-Production groups. **Colorectal Assumptions and Actions**

	• New Rapid Access Colorectal Cancer Pathway RACCP will continue to be embedded within Primary care • Continued implementation of the admin triage will ensure large reduction in wasted clinical slots at Nurtel and first OPA. • Referral rates will remain approx. 110 p/w • Demand on the refreshed A&G service will steadily increase, additional resource planned • Reduction in colorectal demand has significantly reduced demand on endoscopy - Colonoscopy capacity evaluation required to understand shift in capacity to support planned care pathways • Monitor rejection and re-referral rates to ensure compliance with new pathway • Continue safety netting process for FIT +ve patients referred-back to primary care • Continue robust communication plan to ensure primary care are aware of increased patient experience, increasing conversion rates, improved mortality rates • Focus will continue on improving 31day and 62-day pathways to ensure improvement in 62 day performance • Following an evaluation of the RACCP a workforce analysis will be required to right size the service • Continuation of posts for 3 Band 6 CNS and 4 Band 4 CNS and one Colorectal Consultant to be funded by SDF for 23/24 • SDF funding for 23/24 have funded Colorectal and Urology navigators to Band 4 x3 to support both pathways improvements **FIT Assumptions and Actions** Comprehensive use of FIT as a patient risk stratification tool in NG12 patients is critical for making the best use of our available colonoscopy capacity, ensuring patients on the lower GI pathway can be diagnosed promptly and improving bowel cancer diagnosis and survival in England in the long term. FIT remains an expectation for 2ww referrals to the LGI/Colorectal pathway (subject to exclusion criteria), and we will continue to implement guidance whereby at least 80% of all referrals are accompanied by a FIT.

	We will work with EMCA and clinicians across secondary and primary care to enable compliance with the BSG/ACPGBI guidance to improve existing pathways and target a reduction in the number of colonoscopies performed on patients with FIT<10ug. • FIT pathway in place • Lincolnshire have adopted the BSG/ ACPGBI guidance to ensure FIT tests are available in Primary care • All GP practices have the ability to order, and request FIT as appropriate • GP Practises will continue to use FIT as a triaging tool in primary care, with positive results being used in RACCP referrals • 80% of all RACCP referral will be accompanied by a positive FIT • ICB will ensure funding to provide and process all FIT requests will continue • Pathlincs will continue to provide a 48-hour results service, despite increased demand • GPs will continue to advise on optimum way for patient completion to avoid spoiled results • FIT is also being applied retrospectively to the cohort, where clinically appropriate, so those patients with a FIT negative result and no ongoing clinical concerns indicating colorectal cancer, can be stepped down onto alternative pathways or discharged in line with British Society of Gastroenterology & Association of Coloproctology of Great Britain & Ireland guidance, and colonoscopy capacity can be prioritised for higher risk patients. • Continue engaging with primary care, to ensure awareness of completion importance • Continue to monitor results via monthly audit from a health inequalities lens to drive potential further support geographically. • Monitor the reduction in Colonoscopies undertaken on FIT negative patients • Further embed refreshed A&G service and NSS pathway to ensure FIT negative patients with ongoing clinical concerns can be referred and actioned within 48hrs • FIT negative with no ongoing clincal concerns will be referred back for PC to manage • Continue excellent communications with service provider to ensure all pathways are being accessed and utilised appropriately as a cohesive ICS

Skin Assumptions and Actions

- Teledermatology in place across Lincs ICB Demand on pathway does not outstrip capacity.
- GPs continue to utilise Dermatascope's, Advice & Guidance and SPOT clinics to streamline patients into the most appropriate pathway.
- Performance remains stable and continues to achieve 28 FDS.
- Work with clinical and management teams within ULHT to scope a 2ww Teledermatology pathway.
- Closely monitor performance to ensure skin continues to meet performance targets.
- Ensure Primary Care clinicians are encouraged to use Dermatascope's to enable secondary care clinicians to have access to high quality dermoscopic images.
- Work with Primary Care to resolve issues with regards to the use of devices that work in conjunction with the Dermatascope's.

Prostate Assumptions and Actions

- ACPs now all trained and training to continue for any new starters for development
- Maintain ringfenced beds for patients after robotic surgery, as avoids cancellations
- Robotic surgeons to remain in workforce and support staff keep with ongoing training
- SDF funded stable PSA CNS to support Remote monitoring of prostate patients and reduce demand on OPA capacity
- One stop clinic's available, action required to ensure availability of capacity
- New Grantham theatre, look to scope increasing surgery
- Increase TPLA lists from Pilgrim & Lincoln to also have lists at Grantham & Louth

	• Work with TACC to Increase Anaesthetic assessment capacity • Virtual clinic, after MRI, is being added to pathway, to avoid patients having to come for a F2F OPA and give specialist overview to avoid patients going for biopsies unnecessarily and improve FDS • Using the virtual clinic, hopefully reduce the number of patients unnecessarily going for biopsy, which will then help with pathology delays. Currently waiting on average 12.5 days for reports, but if we can reduce the demand, we can reduce the impact on the lab and reduce the waits. • Look to reduce MRI reporting times, 85% of reports take 4 days – working with radiology and ensure Urologists highlight the 2ww patients appropriately to help with reporting prioritisation • Mp-MRI in place. LATP is already supported by ACP team. 3 Middle grades complete a list, for their own development and training purposes. • Working with C&A to improve booking times of the clinical triage. Currently booked within 3 days for most patients but trying to reduce this further by looking at demand and capacity and booking process. • SDF funded stable PSA CNS to support PFUP and remote follow up **Lung Assumptions and Actions** • Continue to deliver the elements of the BPTP for the Lung pathway • The pathway will achieve 54.5% 28-day FDS by March 2024 • The Lung pathway will aim reduce the referral demand, which will allow the 28-day FDS to become achievable- this piece of work is ongoing and a system deep dive plans to identify the problem and put future strategies in place to support secondary care • Demand on the routine and urgent pathways will increase • Implementing a triage CNS will minimise inappropriate patients going for an unnecessary CT and will reduce the demand through the pathway

	• There will be increased clinical workforce on the Lung pathway, currently down by 5 full time consultants • Recruit a triage CNS to risk stratify patients using the q-cancer score • Agree and sign off roles and responsibilities for the triage CNS • Create a robust communication plan to ensure up current comms is sent out to primary care regularly to allow primary care clinicians to be up to date with the current routes in for respiratory patients • Engage with primary care colleagues around BPTP and the guidance/referral criteria to ensure we are receiving appropriate referrals • Set up a clinical reference group to run the pathway changes through • Continuation of SDF funding of Locum Lung Physician for 1 year to support recovery **Upper GI Assumptions and Actions** • The BPTP will be in place by March 2024 • The pathway will achieve 60.1% 28-day FDS by March 2024 • The referrals received will be complete and appropriate to prevent delays further in the pathway • By implementing the clinical triage this will improve the pathway performance for both 28 day and 62 day • The triage CNS will be recruited to in a by April 2023 • Recruit a triage CNS to sit at the front end of the pathway, in line with the Best practice time pathway • Agree roles and responsibilities – to include: • Receive referrals and complete initial triage to OGD, CT or OPA. • Telephone patients who require STT to optimise direct access to diagnostics and reduce DNA's – could attend OGD with the patient. • Work closely with the Cancer Navigator team to oversee tracking of patient on a Cancer pathway and ensure it is progressing.

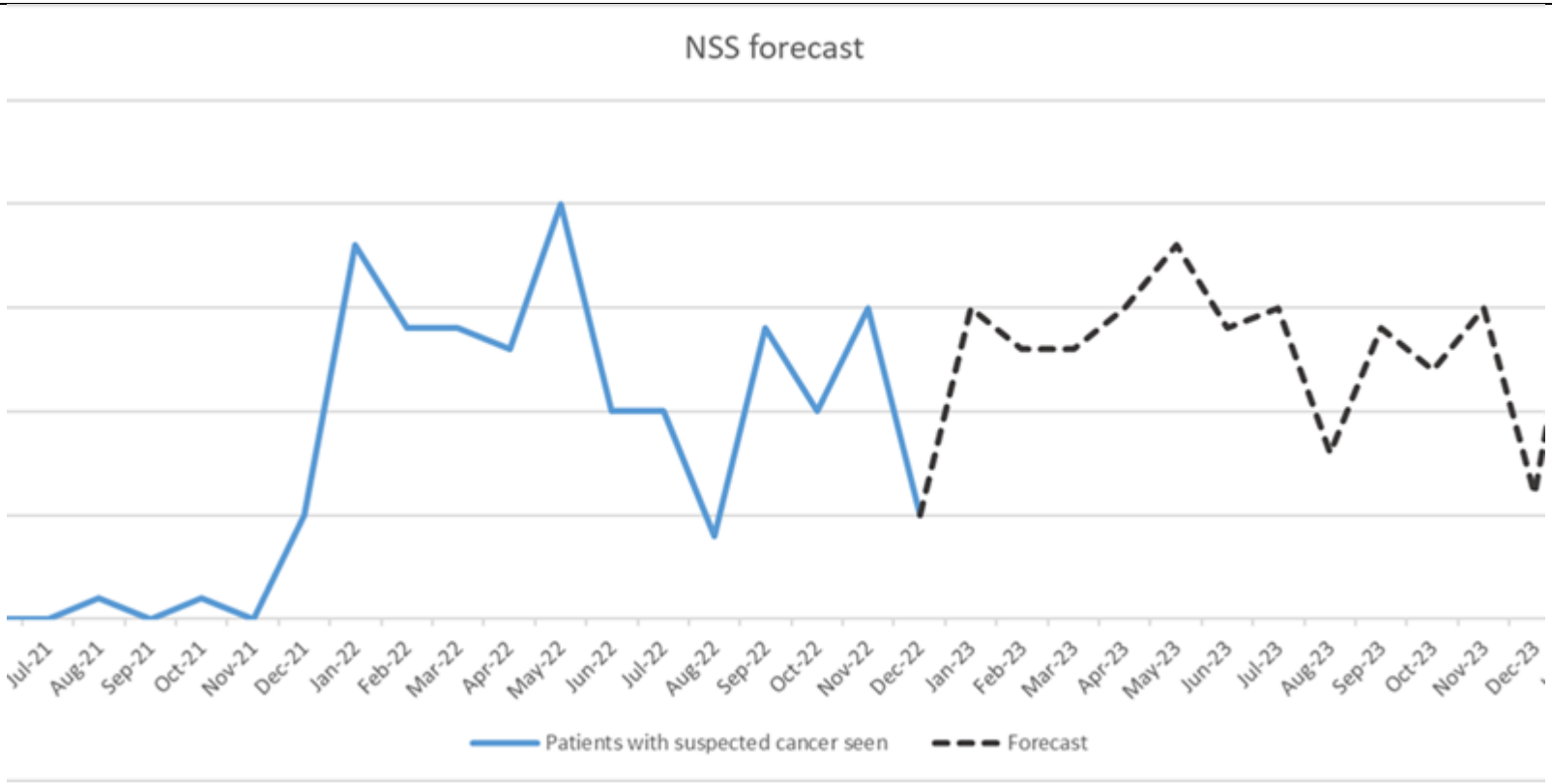
	• Work towards the possibility of taking on UGI triage post-investigations which would include responsibility for stepping patients down from cancer pathways and discharging them back to the care of their GP. • Map out the new administrative process for the pathway which includes the CNS triage at the beginning • Monitor the progress of performance when the pathway goes live on a weekly basis • Adapt the referral form to ensure all elements are included that will be needed for the clinical triage • Meet with endoscopy and radiology to inform them of the new proposed pathway • SDF funding 23/24 has funded a HPB CNS for 2 years to support the tertiary pathway for patients with HPB cancers **Gynae Assumptions and Actions** • New urgent pathway and PMB pathway will improve performance by June 2023 • Nurse triage/referral grading will remain in place following pilot. • Improve referral form to ensure patients are streamlined into the correct service e.g., cervical • Continue work with gynaecology strategy to review the service needs. • Implement 90-minute standard for Gynae to remove patients from the pathway sooner. • Implement new urgent gynaecology pathway to provide an alternative for GPs. • Implement PMB clinic for new HRT patients as these patients are low risk of having a cancer. • Review workforce needs against demand • Review PMB clinic capacity to ensure capacity is on the correct site to meet demand. • Ensure both main hospital sites are following same pathway and not creating inequalities. 62 days • Ensure greater oversight of patients listed for surgery to ensure patient mix meets bed availability to avoid cancellations. • GPs will request Ultrasound at the time of referral which aligns to the BPTP

	• PMB pathway will only be effective with appropriate capacity – requires diagnostic support. • Investment in non-consultant workforce required to bring in new roles to provide sustainability • Ultrasound capacity a key enabler for Gynae recovery. • Needs to be an appreciation of the time requirement to train new staff – dual funding/running during training – the training ask/timescale needs to be reflected in the trajectories. **Risks and Mitigations** **Colorectal** • There is a risk that primary care colleagues will continue to bemoan the additional tasks required of them as part of triage process prior to referral • Backlog remains a high proportion of total PTL and requires maintained focus • +104s are a large proportion of backlog, complex cases requiring more clinical interventions **FIT** • Primary care are stretched at present and pushing back with additional tasks required pre-referral • Health inequalities issues in the East of our county, may prevent timely completion and returning of FIT tests **Skin** • GPs do not utilise A&G, Dermatascope's and SPOT clinics leading to the 2ww pathway becoming overwhelmed by demand. • Due to good performance motivation may not be present to implement a 2ww Teledermatology pathway. • Not all GP practices have a Dermatascope, and some are not utilising them due to issues with additional kit i.e. mobile phones.

	Prostate • Pathology delays impacted by increased number of biopsies / high referral numbers. • Challenges in booking of appointments and early escalations due to staffing issues with Choice and Access • ACP job plans being changed, due to ACP Lincolnshire framework, meaning 20% of their hours to be training and supervision, impact on to core work in diagnostic clinics? • Second cancer navigator funded until July 23 **Lung** • There is a risk that the demand on the lung pathway will continue on an upward trajectory, but this should be mitigated by the triage CNS and the new proposed pathway utilising q-cancer scores • There is a challenge filling new vacancies withing the medical division, there is a risk that these roles will go unfilled **Upper GI** • There is a risk the CNS position may not be filled in a timely manor • There is a risk that the business case for substantive fundings after 12 months will not be agreed which is a risk to the pathway, to mitigate this the business case will be put in in a timely manner to allow time to amend with any suggestions • Referrals with little or lack of information will delay the patient's pathway – a robust delivery plan will support primary care being fully aware of changes made. **Gynae** • GPs continue to utilise 2ww pathway despite alternative more appropriate pathways being in place. • Access to beds post-surgery may continue to be an issue if emergency demand continues to create pressure. • Workforce remains fragile in areas including colposcopy.

How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?	• There are several programmes that will all impact the increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. • This includes Non-Specific Symptom pathway • Screening Programmes including Bowel Breast and Cervical • Lynch Syndrome • Health Inequalities and timely presentation • The Primary Care DES and primary care pathways • Targeted Lung Health Checks • Use of FIT in Primary care • Liver Surveillance • Grail. • Some of these programmes are in their infancy and we are being guided by the EMCA to implement and therefore we are not yet seeing the impact- but they are included in the Lincolnshire plan for 2023/24. **Non-Specific Symptom Pathway** **Rapid Diagnostic Service for Non-Specific/Vague Symptoms (NSS)**

	The ICS has an established NSS across the geographical footprint with Trust/s and will continue to enable and will implement further awareness campaigns through primary care networks. In 2023/24 we will enable sustainable delivery of 100% population coverage NSS pathways through increased engagement of primary care and building further capacity with commissioning arrangements for NSS pathways. The ICS will agree a trajectory to demonstrate increasing referrals throughout the year. • System wide NSS pathway in place across Lincs, NWAFT and NLAG also offer NSS pathways • Deliver 100% population coverage for NSS • Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25



Assumptions and actions

- Every GP practice will have submitted at least 1 NSS referral
- Every GP practice will have at least 1 appropriate patient who fits the correct criteria for this pathway
- 100% of GP practice have access to the NSS pathway
- The NSS pathway will continue to achieve 28-day FDS
- The NSS pathway clinical staff will be funding by ulht to enable the sustainability of the pathway

	• The NSS pathway patient navigator will be funding by ulht to enable the sustainability of the pathway • The clinical staff will be job planned appropriately to allow for two triage meetings a week • Demand on the NSS pathway will increase on an upward – manageable trajectory • Continue engaging with primary care, spot targeting practiced that haven't referred into the pathway, this will include supportive information and monthly comms. • Audit the pathway on a monthly basis to monitor referral numbers from primary care • Meet with radiology lead to ensure that the interventional radiologist have the time job planned into their job plans to allow the NSS to become BAU • Meet with CSS divisional lead to ensure that the geriatrician consultants have the time job planned into their job plans to allow the NSS to become BAU • Support the pre diagnosis CNS team in seeking substantive funding through a bid to CRIG to enable the pathway to become BAU • Support the patient navigator in seeking substantive funding through a bid to CRIG to enable the pathway to become BAU • Lincolnshire have calculated a lower demand based on own modelling and experience of demand coming through for over 2 years, 100% population coverage has been achieved since go live July 2021, so all practices have access to the pathway, however some practices may not have referred due to suitability. **Risks and mitigations** • There is a risk that the pre diagnosis team and the patient navigator will not be approved for substantive funding due to a large bid going to CRIG, to mitigate this this has will be a priority for SDF/Accelerator funding • Subject to patient appropriateness the target may not be achieved i.e. some practices may not have a patient that fits the NSS criteria therefore will not need to refer in which will result in the goal of 75% coverage not being achieved. **Lynch Assumptions and Actions**

	Genomics is a rapidly developing field for early detection of cancer, with leadership from both the Genomic Medicine Service Alliance (GMSA) East and EMCA. During 2022/23 clinical champions were identified for both colorectal and endometrial cancers for Lynch syndrome, with investment into both pathology, nursing and education. In 23/24 alongside S7A commissioning of Lynch syndrome where 100% of patients attending bowel screening will be tested, Lynch testing will be fully rolled out (>90% completion of initial tumour testing for both colorectal and endometrial cancer in audit samples) across colorectal and endometrial tumour sites to enable equity of reduced risk of health inequalities, with further targeted funding invested to support early diagnosis. Additional targeted funding will be provided. • Lynch Champions now in place • Improve early diagnosis as part of the NHS long term plan • Every patient with a new diagnosis of colorectal and endometrial cancer will have the first available tumour sample tested for MMR • All appropriate patients are sent for germline testing • All patients will have appropriate referrals to genomics team, for counselling and roll out of family testing • Do audit in Q1 of 30 patients to ensure at least 90% of patients are being IHC/MSI tested • MSI testing test to be introduced in March/April for Lynch testing at ULHT (currently going to Birmingham for IHC testing) • Generic pathways have been shared, specific ULHT pathways to be completed and agreed with all clinical and pathology teams. • Pathology reporting training being offered to colorectal teams, for MSI and germline report reading. • Admin supported for CNS' colorectal team being scoped, but to high numbers they may be expected to support with. • Monitoring and audit of Lynch screening patients, to ensure reports read in timely manner and referrals actioned correctly. • Primary care comms to educate and inform

	• Map out administrative support process • Work with cancer Somerset team, to look at how we can record these patients to track pathways and data collecting. • Genomics team supporting with difficult patient conversations • Referral proforma being created for endometrial and colorectal to the genomics teams **Risks** • Added workloads to a fragile service in colorectal • Impact on CNS teams, workloads, burn out. • Pathology reporting timeframes not certain yet **Screening Assumptions and Actions** • Screening teams will continue to attend the systems Early Diagnosis & Screening Board. • Recovery of the breast screening service will remain on trajectory. • We are unable to influence time to first appointment within bowel screening, national target is to see patient for 1st OPA within 14 day, with an internal target of 10 days for colonoscopy which may then need pathology making the 28FDS difficult to achieve. • The trajectory for lowering bowel screening age will remain on target. • That those in the lower age groups for bowel screening will continue to be less likely to engage with the service • Work with screening service to identify reasons why patients with a positive bowel screening result are not coming forward within 14 days for their 1st OPA, consider health inequalities as part of this work. • Engage with patients who have only recently become eligible for bowel screening due to lowering of age limit for screening.

	• Continue to work with GP practices to improve access to cervical screening and address health inequalities across the system including but not limited to the cervical text messaging project. • Ensure secondary care oversee screening FDS separately from standard 2ww FDS to enable clear sight of the issues preventing ULHT meeting the 28FDS for screening. **Risks, Issues & mitigations** • Patients who are now becoming eligible for bowel screening due to the age reduction are of working age and may be less likely to engage with the pathway due to work commitments and also perception that they are less at risk due to their age. • GPs do not have capacity to engage with patients who do not come forward for cervical screening due to current demand. • May be unable to influence national standards for 1st OPA in bowel screening programme making 28 FDS unattainable. **DES** • Those practices already meeting the DES requirements will continue to do so. • Maintain and grow the existing support pack to encourage greater engagement with the cancer team to ensure standardised approach to the DES • Continue to increase participation in videotext for cervical screening uptake to support screening element of DES. This is to include video texts in Eastern European languages to try to bring this group of patients forward. • PCN DES to support utilisation of FIT on RACCP. • Promote utilisation of Cancer website and Clarity Team-Net to ensure primary care education and diagnostic support tools are easily accessible • Increase usage of Ardens across General Practice to support safety-netting. • Utilise PCN Peer Review meetings and review of diagnoses to support education of appropriate pathways and educational opportunities. • Continue to visit and engage GPs face to face to maintain visibility and keep channels of communication open.

Health Inequalities Assumptions and Actions

- Performance reporting development for health inequalities within cancer in 23/24 will focus on 62 day wait and 28 day Faster Diagnosis Standard (FDS) for colorectal (Q1/Q2) and lung (Q3/Q4) - dashboards for these areas will split data by ethnicity and deprivation
- In 23/24 the health inequalities programme will lead a piece of work that focusses on Colorectal screening improvements the aim is to.
    - Reduce the staging form III/ IV down to I/ II
    - Improve Screening update
    - Reduce Emergency Presentations of colorectal cancer
- This programme of work will focus only on the bowel screening pathway and target the 20 % most deprived areas, the programme will deep dive and analyse the data.
- Work with targeted populations using the co-production approach to set interventions with local populations who have previously disengaged with bowel screening.
- The development of the East Coast CDC in Skegness will support the highest areas of deprivation, with a high prevalence of cancer, and will support patients with accessing diagnostics locally to ensure early identification of cancers.
- Using population health management to support the programme
- EMCA is building a community of practice for cancer inequalities through collaboration with our systems and wider partners and including development workshops focusing on data/evidence/best practice/sharing and learning.

Risks

- Analyst capcity to deep dive the data
- Disengaged populations to work up interventions

Targeted Lung Health Check (TLHC) Programme

- Lung cancer is a less survivable cancer and the UK National Screening Committee recommended in September 2022 the introduction of a national targeted lung cancer screening programme using the Targeted Lung Health Check programme as the basis for national roll out in England.
- Lung cancer is responsible for 23% of cancer mortality in the East Midlands, and as a result, early diagnosis of this tumour type is critical to improving outcomes and increasing survivorship; TLHCs have a significant positive impact on health inequalities and population health and in the East Midlands alone diagnosed over 100 cancers early through initial projects.
- TLHC is a multi-year initiative with additional, targeted funding allocation. The project will require multi-disciplinary team (MDT) and clinical leadership across the ICS in primary and secondary care, and as a national priority for mainstreaming as commissioned service over the next 2-3 years we will collaborate with appropriate stakeholders internal and external to the ICS in working with EMCA to initiate planning and mobilisation toward go live/expansion in 23/24 and early 24/25.
- The project requires up to 9 months of preparation prior to go live with investment in a team including dedicated clinical and project management support, and investment in CT scanner capacity (fixed or mobile).
- We will enable delivery through appropriate investment of targeted funding, align investment with priorities and developing community diagnostic centres (CDCs) toward meeting an ambition of 50% population coverage by April 2025 and 80% by April 2026, prioritise places with the highest lung cancer mortality, and ensure accurate and timely collection and reporting of management information for all local projects.

GRAIL/NHS Galleri

- The East Midlands was an early adopter for the GRAIL trial, and in 2023/24 the ICS will continue to support retention & onward referral of patients in the NHS-Galleri Clinical trial.
- With EMCA we will enable evaluation of the trial and further opportunities to reduce health inequalities to access in conjunction with multiple genomic deliverables led by the GMSA East and EMCA.

Early Diagnosis for Liver Cancers

- Liver cancer is a less survivable cancer and rates have more than doubled over the past decade and are continuing to rise. NICE Guidance recommends 6-monthly ultrasound surveillance for those with cirrhosis, but current delivery of this recommendation is extremely mixed.
- Working with EMCA as part of a less survivable cancer strategy we will build on work during 22/23 to identify more people at high risk of liver cancer to diagnose more liver cancers at an early stage.
- This will include at provider level the establishment of systems and processes to invite those eligible for liver surveillance where these do not exist, ensure sufficient ultrasound capacity is commissioned to provide 6-monthly liver surveillance to people with cirrhosis/advanced fibrosis, and where identified invest in pathway navigation to improve attendance at 6-monthly ultrasound surveillance for patients with cirrhosis/advanced fibrosis.
- In addition, we will work with both EMCA and established Hep C operational delivery network (ODN) to confirm sustainable commissioning arrangements and facilitate discussion between secondary and primary care to establish data collection system.

Innovation – MDT ROSE

- The EMCA MDT-ROSE programme continues to develop, encourage, support and embed improvements in Multi-disciplinary Team (MDT) working across the East Midlands to reduce unwanted variation in clinical practice/outcomes and improve the care and experience for both staff and patients.

	• The ICS will continue to work with EMCA Expert Clinical Advisory Group leads to enable the rapid and precise diagnosis of cancer and orchestrating of the best practice personalised treatments for each person to achieve the best possible clinical outcomes, quality of life and experience of care through targeted improvement initiatives. • This includes specific projects and sharing of good practice, and the ICS will continue to support approach to EMCA wide agreement and implementation of Standards of Care to reduce unwanted variation to inform local improvement initiatives that target inefficient/ineffective MDT practices/processes.

Diagnostics	
How will your system increase the percentage of patients that receive a diagnostic test within six weeks (in line with the March 2025 ambition of 95%)?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to: the expansion of diagnostic capacity including through the CDCs programme, as well as the work to improve diagnostic productivity through digital investments in pathology and imaging networks and through diagnostic services reaching optimal utilisation rates [1]]* *[1] CT: 3-4 scans per hour, MRI: 2-3 scans per hour [2], NOUS: 3 scans per hour, Echo: 1 scan per 45 mins, including reporting, and Endoscopy: 95 % of planned endoscopy lists taking place. For acute sites with a proven higher than average case mix complexity, the optimal range for MRI is 1-3 scans per hour.*
How will your system deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to: improving pathology and imaging networks productivity, including through digital diagnostic investments and optimal rates for test throughput, and the expansion of diagnostic capacity including through the CDCs programme]*
How will your system increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template', and should refer to draft guidance on direct access which is available on the NHS Futures Collaboration Platform]*

Productivity and efficiency	
Describe the systematic approach you have taken to understand where productivity has been lost across the system due to the pandemic. What are the key areas that have been identified as reducing productivity?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to:* • *confirmation of whether the system had undertaken a review of productivity as part of recovery planning. If a productivity review has not been completed, please confirm that this has been scheduled.* • *quantification (where possible) of the key areas that have been identified as reducing productivity in your system.]*
What actions will you take to restore underlying productivity?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to:* • *how the system will support a productive workforce including taking advantage of opportunities to deploy staff more flexibly.* • *how you have assured yourself that expected productivity increases are in line with planned workforce growth.* • *any support required to deliver planned productivity improvements.]*
What key changes will you make to improve operational efficiency within your system?	*[Responses should address the areas set out in Section 4 'Guidance on completing the narrative submission template' and include specific reference to the efficiency measures within section 1H of the 2023/24 priorities and operational planning guidance as well as other key opportunities across your system.]*
What mechanism has your system put in place to ensure your planned efficiency can be delivered recurrently in full in 2023/24?	*[Please reference the HFMA's self-assessment materials on putting core elements in place to support board assurance over financial sustainability]*

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