NHS
South Yorkshire
Integrated Care Board

Non-Surgical Oncology Outpatient Transformation Programme / Service Change

JOINT HEALTH OVERSIGHT & SCRUITNY COMMITTEE

7th December 2023

1. Purpose of this Paper

The purpose of this paper is to provide an update on the progress of a review of non-surgical oncology (NSO) outpatient appointments. The paper sets out the engagement work we have undertaken to date, provides an update on the progress made on co-production of the future service model, and asks JHOSC to provide a steer on the next steps for this stabilisation phase of the programme.

2. Introduction

Work is underway to develop and agree a long-term sustainable model for the provision of non-surgical oncology (NSO) for patients in South Yorkshire and Bassetlaw and North Derbyshire. The work is being led by the South Yorkshire and Bassetlaw Cancer Alliance.

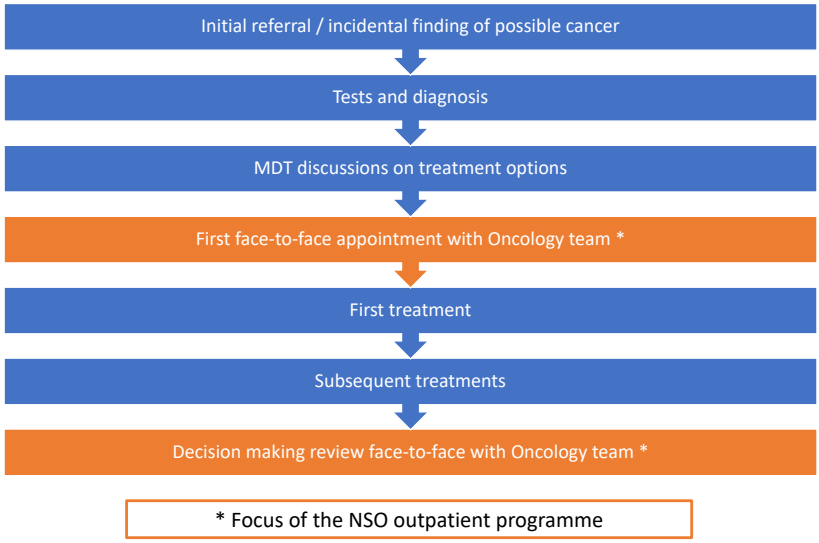
Non-surgical oncology is an umbrella term for treatments for cancer that are not surgically based including radiotherapy, chemotherapy and, increasingly, targeted therapies and immunotherapy.

These services are led by both clinical and medical oncologists and supported by a multi-disciplinary team consisting of healthcare professional groups including radiographers, nursing and pharmacy colleagues.

This programme of work is focussing on outpatient services only and excludes the delivery of radiotherapy treatments, albeit new patients referred into the NSO service who require radiotherapy, will be included for their outpatient consultation only.

Outpatient services form part of the overall pathway of care people may receive who have a cancer diagnosis. It is worth noting that nearly 40% of outpatient appointments are virtual, and 60% face to face, with some clinics operating with over 50% of appointments as non-face to face appointments.

Example patient pathway



Sheffield Teaching Hospitals NHS Foundation Trust is the lead provider for non-surgical oncology (NSO) services for South Yorkshire, Bassetlaw and the population of North Derbyshire.

All Oncologists are employed by Sheffield Teaching Hospitals and are based at Weston Park Cancer Centre (WPCC).

As the tertiary provider of specialist cancer services there are several services that can only be delivered at Weston Park Cancer Centre, including all inpatient services, radiotherapy and the more specialist chemotherapy regimens including concurrent chemoradiotherapy and trials. The cancer multi-disciplinary team will determine whether patients will benefit from non-surgical oncology opinions and treatments with the ultimate decision being taken with the patient following an outpatient consultation with the relevant Oncologist / Senior Decision Maker.

The commissioned out-patient model is based on an outreach service from WPCC with Oncologist presence at each of the five hospital sites (Barnsley Hospital NHS FT, Doncaster & Bassetlaw Hospital NHS FT, The Rotherham Hospitals NHS FT, Sheffield Teaching Hospitals NHS FT and Chesterfield NHS FT). Due to the reduced number of Oncologists and the complexity of Oncologist multi-tumour site specialism, there has not been consistency in terms of Oncologist presence across all the cancer tumour sites at all providers for some time.

The commissioned NSO outpatient model became unviable for colorectal cancer in November 2021 resulting in the establishment of a temporary service model based on three-hubs (Sheffield, Chesterfield and Doncaster). In January 2022 the breast service became unviable leading to the establishment of a temporary two-hub model (Sheffield-Chesterfield patients attending WPCC and Doncaster-Rotherham-Barnsley patients being seen at the Breathing Space health centre in Rotherham). These changes were on the grounds of patient safety to manage the operational pressures due to the volume of existing and pending Consultant Oncologist vacancies. The Joint Committee of Clinical Commissioning Groups were informed of the requirement to establish a temporary service model for non-surgical oncology and the Joint Health Overview & Scrutiny Committee were briefed in November 2021, March 2022 and January, March and October 2023 by STHFT.

A case for change has been developed and a programme of patient , public and staff involvement is informing the development of longer-term sustainable models for NSO out-patient services.

3. The NSO Outpatient Temporary Model

The NSO outpatient oncology service delivery model has undergone some consolidation as a temporary service change to reduce the risk to key patient services. The table below outlines where on-site oncologists provide locality-based services and illustrates where there is variation of access for patients currently. Whilst breast services have been reduced to two on-site locations (WPCC and Breathing Space), LGI and urology tumour site teams are also under significant pressure, having already withdrawn on-site services from Barnsley and Rotherham.

Current NSO OP Delivery Model by Tumour Site and Location.

Tumour site	STH/WPCC *	Barnsley FT	CRH FT	DBTH	RFT	Breathing Space **
Breast	√	**	*	**	**	√
Head & Neck	√	*	√	*	*	
Lower Gastrointestinal	√	*	√	√	*	
Lung	√	√	√	√	√	
Urology	√	*	√	√	*	
Gynaecological	√	*	*	√	*	
Other	√					

The * denotes where patients are currently receiving services at Weston Park and ** at Breathing Space.

Ongoing workforce pressures across the NSO provider teams, requires constant review at operational level and to ensure that the risks associated with the delivery of each tumour site service, are minimised.

An opening equalities impact assessment (EQIA) undertaken in January 2023 informed our patient and public involvement planning and the development of proposals. As part of the involvement activity, we targeted and secured feedback from a number of communities identified as likely to be affected by the possible changes to non-surgical oncology outpatient appointments. The feedback we received is informing the mitigations taken as the NSO outpatient service delivery model is further developed.

3.1 Mitigations

There are several mitigations which are already being established to reduce any negative impact of any service change on patients throughout the entirety of their cancer journey as well as specifically in relation to the NSO outpatients. These include the following:

- Repatriation of chemotherapy treatments locally. This will ensure an equitable offer to all patients with regards to the chemotherapy that they are able to access at their local hospital
- Consultant led, team delivered approach facilitating local delivery of chemotherapy with or without the oncologist presence on site.
- Expansion of the charitable bus service from local hospitals to WPCC and temporary service sites
- Development of a breast supportive care model to ensure continuity of care.
- Reviewing Acute Oncology services to ensure sustainability within a new service model.
- Multidisciplinary team optimisation.

Whilst recruitment efforts continue, there has also been a focus on ensuring a multi-disciplinary team approach with everyone working to the top of their licence. This means ensuring that oncologists (or radiographers; pharmacists; advanced nurse practitioners) are only doing the activities that require their specialist expertise. Consultant radiographers, nurses and pharmacists form a crucial part of this extended NSO team, alongside developing roles for Advanced Clinical practitioners.

It should be noted that the repatriation transformation programme to ensure chemotherapy delivery closer to home has led to an increased level of chemotherapy treatment now being delivered locally to offset the requirement for patients to travel to Weston Park Cancer Centre (WPCC) for review.

4. System engagement in service model development

Key stakeholders, clinical and non-clinical staff, public and patients are involved and engaged in the service model development. Building on previous work, two key engagement events were held in June and September 2022 which resulted in co-production of three main options. This was supported by patients, staff including clinicians and voluntary sector colleagues from across the SYB and North Derbyshire Cancer Alliance footprint.

The options were agreed in outline only, acknowledging that the accompanying detail for each potential option would need to be determined. This approach was with a view that having outline options would provide some focus and a framework upon which to develop the assessment criteria. In turn this would support the development of the detail for each option ensuring public and patient involvement in the proposals.

The following three high level options were agreed:

1. Status quo. Acknowledging that this Option, and current model, is requiring temporary service model interventions due to the fragility of the Oncology staffing model.

2. Consolidation of all NSO outpatient services onto one site

3. A Hub and spoke model. The number of spokes to be determined by the proposed clinical models for the major tumour groups (Lung, Breast, Urology and Colorectal) through the options appraisal process to ensure delivery of safe clinical services, adherence to clinical guidelines and policies, and the availability of interdependent facilities.

To identify the essential criteria (hurdle criteria) for assessing the feasibility and merits of each potential option, staff involved in the NSO service, including commissioners, as well as the 5 hospital teams, were invited to provide feedback. They were asked to comment on what mattered to them for patients, for staff and in relation to estate and facilities. Rich and detailed responses, including those from the oncologists, were returned, which have provided the basis for determining the hurdle criteria. The hurdle criteria have been applied to the models, by the NSO Oversight Group, with support to continue to develop the hub and spoke model option.

We have recently carried out further stakeholder involvement to help define and clarify the minimum and maximum requirements for a hub and a spoke service and the clinical models for each of the major tumour sites (for the stabilisation phase of the programme)

4.1 Most recent public and patient involvement

Prior to the temporary service model an exercise was undertaken to establish patient insights to inform the development of the model. Key insights included the importance to patients and carers regarding:

- Continuity of care and access to support.
- Location. Services should be easily accessible via public transport.
- Sufficient car parking for those able to travel by car.

Further work was undertaken during the temporary service change to gain further insights into how changes had impacted on patients and what is important to them within their oncology services. This included surveys and semi-structured one to one interview. In addition to the points above the following were categorised as important to patients and carers

- Clear communication between appointments
- Time spent waiting for the appointment on the day. To ensure it is absolutely necessary or could it be provided differently, and the time be utilised more effectively.
- Time spent during the appointment.
- Welcoming environment, comfortable waiting areas and access to support.
- Facilities

An additional exercise was undertaken with regards to patient experience with virtual appointments. The positive elements identified were in relation to convenience, low cost and reduced risk of catching infection. Further improvements could be made in terms of ensuring compliance with scheduled time, broadening the scope and some patients were concerned that the lack of opportunity for a physical examination left them feeling vulnerable.

During March and April this year a further involvement exercise was carried out to understand patient and public views of their experience of non-surgical oncology outpatient appointments, and their views on what would make a good outpatient appointment.

The activity included:

- Patient Advisory Board session presentation 21 February
- Survey - online, door-to-door and by telephone 6 March - 13 April
- Public online discussion events on 20 and 24 March.
- 11 voluntary and community sector focus groups during March and April

954 people provided feedback in the listening exercise. They were from a wide geographical and demographic range. The survey was completed by 331 cancer services patients or carers and 510 local residents with no experience of cancer services or experience more than a year ago. Nine people took part in the public online

events. 104 people took part in the VCSO focus groups. The four local Healthwatch organisations also provided a joint written response.

The Cancer Alliance partners promoted activities through social media and patient and voluntary sector networks. A range of promotional and informative materials were produced including website content, a listening document and a podcast discussing the issue with senior clinicians and service leads. Postcards and posters inviting patients and carers to complete the survey were placed in the oncology non-surgical outpatient departments. In addition, paper copies of surveys were made widely available to reach all patient groups.

Following an Equalities Impact Assessment, groups were identified who were likely to be affected by the possible changes to non-surgical oncology outpatient appointments. Voluntary and Community Sector organisations representing these groups were approached to run focus groups and the survey was promoted in areas of health inequality.

Feedback across the responses emphasised the following factors as important for a good non-surgical oncology outpatient appointment:

- Seeing the same person at each appointment
- Short waiting times and updates about how long the waiting times are when at appointments.
- Good communication including communication about what will happen at appointments, any delays, information about support organisations, access to translators / interpreters, clear signposting to and inside the hospital / clinic.
- Privacy when relaying personal information and privacy / dedicated rooms for talking to nurses after consultations.
- In the waiting room, good wheelchair access and availability, refreshments, useful information about support
- Ensuring patients feel listened to, not rushed, and there is a relaxed atmosphere.

In relation to transport and access requirements, the following were raised:

- Parking difficulties, particularly at Weston Park, and the need for good parking availability and drop-off areas
- The location being accessible by good low-cost public transport
- Preference for the hospital / clinic to be close to home
- The time it takes to get to the appointment.

The focus groups who represented those identified by the equalities impact assessment mirrored in general the feedback from the survey and public events. Additional points and suggestions they made include:

- The importance of cultural awareness and access to qualified interpreters
- A preference for face-to-face consultations
- Mental wellbeing support following a diagnosis
- More information about shuttle services and patient transport
- A suggestion of financial help with travel costs

Findings from this report were presented to the South Yorkshire and Bassetlaw Cancer Alliance Board on 7 July 2023.

4.2 Impact of the Engagement and Feedback

The feedback from the engagement activity has been incorporated into the design and development of the criteria, options, and models for the stabilisation phase. This feedback is based on people who have experience of using the services, and local residents with no current experience of cancer.

Area of Development	Feedback	Impact
Travel	85% of people using services told us that they travel to appointments by car and 98% of local residents told us that if diagnosed with cancer that they would expect to travel by car. 33% of people told us that they were willing to travel up to 45 mins to an	We carried out a travel assessment to understand what the impact of moving clinics would be on travel times. We developed a new criterion to ensure that all options were assessed against a travel time of no longer than 45 minutes. All options must meet these criteria to be viable. We are continuing to expand the charitable bus service bus at Weston Park and also carrying out further

	outpatient appointment, 18% would travel up to 60 mins	travel analysis with public transport as part of the stabilisation phase.
Continuity of Care	55% of people told us that seeing the same clinician at each visit was important.	Continuity of care has been incorporated into the assessment criteria we have used for the viability of the models. The proposals for the stabilisation phase develop further the team model with clarity on the number of teams, role development and will provide greater continuity of the team for each location
Waiting Times	Around a third (36%) of current cancer patients and carers told us short waiting times were important to them. That rose to half (53%) among local residents with no experience of cancer services in the last 12 months. 41% of current cancer patients told us they would likely choose another hospital if it meant a shorter waiting time.	The proposals for the stabilisation phase clinical models support the offer of choice of location and the enhanced team working across areas supports effective waiting list management. The proposed models provide greater resilience and cross cover to manage the waiting lists.
Location	Two thirds (66%) of current cancer patients shared that the hospital or clinic where the appointment is held is important. One third (32%) of people who don't have experience of using cancer services in the last 12	We have taken this into account in developing the proposals for the stabilisation phase and looked where we can offer safe and resilient service with the workforce available. We plan to extend the trial of virtual clinics during the stabilisation phase to further support access to services.

	months chose this as an important factor.	

5. Approach to Change

The overall vision for the NSO Outpatient service is to support the equality of access, provide a more resilient service which can offer more personalised care.

This work is also within the context of an overall change process for NSO Outpatient services. The first phase is to ensure stabilisation of services moving through to transformation over the next 5-10 years.

The drivers for change for the SYB NSO Outpatient Programme are:

- Improved patient experience
- Workforce pressures
- New and developing treatments.

The service has been operating with temporary changes to some parts of the service since late 2021 which has meant that service planning and making workforce decisions for some services has been very difficult.

For this next phase of programme development, to move towards the vision, it is important that we **stabilise** the services to provide workforce resilience, organisational development time for the teams and adjustment of the SLAs.

For the stabilisation phase of the NSO OP model development the focus is on the major tumor groups

- Urology
- Breast
- Lung
- Colorectal

To stabilise these services for patients and staff in the short to medium term, we plan to ask commissioners to adjust the contracts for these services to reflect the reduction in number of locations in-person outpatient appointments are provided from to ensure clinical safety and staff resilience.

This phase is also required as we need to ensure that future sites can meet the hub and spoke requirements, as no site currently meets all the requirements. In particular, there are further discussions regarding digital solutions, team working and estate that need to take place. This phase always us to build the capability in support of a longer-term model.

This will give us a proper foundation from which to focus on addressing the long-term challenges facing these services and to develop a more ambitious future model that factors in future estate requirements.

This means also that there will be a phasing of any changes and an assurance of the readiness for change as part of any implementation process.

6. The Stabilisation Phase Proposed Models

Proposed Option: Hub and Spoke (generic) model

As a result of the assessment of the options, applying the hurdle criteria, the hub and spoke model has been supported for the stabilisation phase of the programme.

This means that:

- Patient safety and patient outcomes can be supported by the clinical teams
- The hub will offer services to all cancer groups: specialist and all major tumour groups.
- A reduced number of spokes will support the major/ common tumour groups and work in collaboration with the hub.
- The models support improved patient safety and quality and continuity of care for patients and staff which has been identified through our engagement process as one of the key requirements.
- Single handed consultant practices are reduced and removed; team working to wrap around tumour specific models of care is facilitated and better training opportunities for the development of the future workforce are enabled.
- Acute Oncology Services and Out Of Hours access are protected.
- Travel times across the SYBND should not be significantly impacted and patients will be offered choice of locations.
- All chemotherapy/Systemic Anti Cancer Treatments can continue to be delivered locally with increased services at some sites thus reducing patient travel.

- New ways of working, digital solutions, new workforce models and virtual consultations will continue to be supported.
- Greater access to clinical trials can be supported through a unified protocol that offers more patients access clinical trials in a timely way.
- More standardised access to supporting services within the hub and spokes to provide equitable access for patients.
- Service Level Agreements can be reviewed to enable a more unified approach and facilitate equity across the system.

The current proposed clinical models for the Stabilisation Phase are proposed as follows:

Stabilization Phase	Clinical Model	Rationale	Team Model	Proposed Location
Specialist cancers	Centralised model	Patient outcomes, volume of activity and NICE guidance	Link with regional and supra-regional teams	• Sheffield
Breast	2 site model	• Patient outcomes. • Patient choice and access, provides safety. • Team configuration and resilience	2 teams	• Sheffield • Rotherham
Urology	3 site model	• Patient outcomes. • Patient choice and access, provides safety. • Team configuration and resilience	3 teams	• Sheffield • Doncaster • Chesterfield
Lung	4 site model	• Patient outcomes. • Patient choice and access, provides safety. • Team configuration and resilience	3 teams	• Sheffield • Doncaster • Chesterfield • Barnsley /Rotherham
Colorectal	3 site model	• Patient outcomes. • Patient choice and access, provides safety. • Team configuration and resilience	3 teams	• Sheffield • Doncaster • Chesterfield

Some of the clinical teams have proposed locations for the services based on existing facilities, which have been crossed referenced with other co-dependent services, deprivation/demographic data and further impact assessments.

There is recognition that there are capacity issues with some of the Estate, including Weston Park which will need to be considered in the implementation of the model(s)

Currently none of the clinic sites meet all the requirements for a hub or a spoke.

6.1 Stabilisation Phase Risk Assessment

As part of the Case for Change there were risks identified that we are mitigating through the stabilisation phase:

1. **Workforce resilience:** the developing proposals support the need to help stabilise the current workforce pressures providing staff and organisations the clarity to plan services over the next 2-3 years. 'Do nothing' until the longer - term model is agreed, puts further workforce retention risks into the system.

2. **SLAs:** the stabilisation phase will allow the SLAs to be revised to support a model which will provide the foundation for future commissioning as Specialised Commissioning is more established by the ICB.

3. **Longer-term model**: the stabilisation phase allows us to plan in parallel for a longer-term solution, factoring in digital solutions, new technology and the wider strategy for the future of outpatient services.

6.2 Risks

There are risks with the models being proposed for the stabilisation phase:

1. **Oncologist presence**: The potential reduction of oncologist presence at each site. Work is underway to ensure that the overall impact at each site is fully defined to enable appropriate mitigations e.g. with relation to the impact on Acute Oncology and supporting services. There is also work underway to define and scope virtual consultations with local team members on site and remote oncologist support which will initially be focused on those sites with reduced oncology presence.

2. **Estate**: currently no site meets all the requirements for a hub or a spoke, and there are estates risks with existing locations. These discussions form part of the wider SYB estates strategy.

On the 20th October 2023 a briefing session was held to talk through the proposed clinical models and brief an Evaluation Panel. The Evaluation process has been established to assess the viability of the clinical models for the stabilisation phase of the programme.

7. Assurance Process

As part of our approach, we have sought review and assurance from NHS England and independent scrutiny from external stakeholders.

Papers have also been presented to the SYB Cancer Alliance Board on the 3rd November and the SYB Acute Federation Board on 6th November with support to the approach and stabilisation phase as an approach towards developing a longer-term model.

8. Next Steps

Due to the complexity of non-surgical oncology as a service, the co-dependencies with a wide range of supporting services and the fact that many of the challenges we are facing are national long-term challenges, a phase of stabilisation is required to support patient outcomes, team working and revise the commissioning arrangements to reflect a new starting point.

During the stabilisation phase we will continue to:

- Understand the strategic direction of each place in relation to outpatients and potential estate facilities that meet the service specification for a hub and spoke.
- Determine localities that could provide a hub or spoke for the longer-term model.
- Scope further Advocacy support into the design of the future model.
- Transform the existing operational processes to deliver a standardised and equitable offer and organisational development for the teams.
- Further develop the virtual offer with an emphasis on enhancing in the site where oncologist physical presence has reduced.
- Maintain engagement to ensure co-production of the future state.

9. Recommendations

The JHOSC is asked to**:**

- **Note** the approach to co-production of the service model, assurance process and progress to date.
- **Support** the proposed service model for the Stabilisation phase of the programme
- **Support** the need for consolidation of some on site locations to support workforce capacity and provide service resilience.
- **Note** the high level of patient and public involvement already achieved by the programme and the role it has played in the decision making and indicate if it expects further consultation to take place in this stabilisation phase of the programme.

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