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Introduction

This is largely a narrative response to evaluation of the policies and how they have been fulfilled in Airedale. It is difficult at short notice to give quantitative responses to the questions or to evaluate precisely the benefit or otherwise to service users. I suggest that Cancer Registry data will provide a definitive answer to the questions concerning stage at diagnosis. Further precision will come from the National Lung Cancer Audit, the National Prostate Cancer Audit and potentially the National Ovarian Cancer Audit and, for older patients, the breast cancer audit. It is better to look at the data at the population level and to interrogate the registry data at a local level such as CCG or, ideally, the Health Districts as defined in the late 1980s as they reflect a health service community of primary and secondary care working together with the tertiary function of a cancer centre or larger general hospital used where appropriate. Such geographical issues are known to affect how patients access the service and therefore whether or not a particular patient presents an opportunity for early diagnosis.

In this respect, it is known that GPs in the UK (and The Netherlands) are relatively reluctant to refer patients for a potential cancer diagnosis (Harris et al, BMJ open. 2020;10(10):e035678, Harris et al, BMJ open. 2018;8(9):e022904) and that in The Netherlands the Covid-19 pandemic is associated with healthcare-avoiding behaviour (Splinter et al, PLoS Med 18(11): e1003854). It is likely that the diagnostic and initial treatment cancer services of the NHS are not subject to the level of demand that they should be. We are aware that there were fewer lung cancer and urological cancer diagnoses at Airedale in 2020 and 2021 than in 2019.

This document has been prepared by canvassing the views of staff concerned with delivering secondary care+ services in a facility which seeks to be readily accessible to patients.

In summary, much has been achieved in addressing these national commitments but there are barriers to universal attainment.

- Specialist medical staff recruitment and retention have not been achieved
- Attainment of specialist nursing staff services is variable in establishing an adequate workforce in all areas.
- Covid-19 has had an impact both on demand for services and on their delivery

In all these areas, it has to be recognised that the increase in cases within the community due to the changing age structure of the population and the effect of overcoming factors that delay patients' presentation, which seem to have been exacerbated in the pandemic will increase the required capacity of the service.

Policy Area	Government Commitment

Workforce	1. The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021
Diagnostics	1. A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening 2. By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients
Living well with and beyond cancer	1. By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support
Innovation and technology	1. Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates

Workforce

Medical Oncologists: Following my own retirement in 2015 from this role the doctor recruited to replace me has moved on. Recruitment and retention of a further successor has not been successful. SAS doctors have acted up but this has inevitably been temporary and so without security of status. The consultant pool at Airedale is shared with Bradford Teaching Hospitals NHSFT; issues in Bradford Royal Infirmary have restricted the consultants employed there from fully fulfilling the commitment to the Airedale service. Doctors transiently recruited to Airedale have not continued in post because of the need to work across two sites. Similar issues apply to the recruitment of consultant haematologists.

Diagnosing specialties: The diagnostic process requires the expertise of physicians and surgeons who deal with conditions other than cancer. For example, there is an issue with the recruitment of gastroenterologists at this and other general hospitals. The work that they do is with the whole group of patients which includes those in the process of presenting with cancer alongside those with other conditions and those who need reassurance; it is not centralisable. Where the referral threshold is low enough to facilitate the earliest diagnoses, the proportion with cancer is small (NICE guidance is based on 3% with cancer as an appropriate threshold).

Chemotherapy Nurses: During 2021 it was planned, with funding, to increase the workforce by two nurses on Band 6 and three on Band 5. At present, there is one Band 5 post unfilled despite being advertised. Agency staff have been engaged to fill rotas during the process at extra cost. Nursing staff also work additional hours to cover absences and senior staff members forgo protected time for non-clinical duties to maintain patient care. The effect of the Covid-19 pandemic has been especially apparent in the last 3 months with the omicron variant due to staff isolating because of exposure. One CNS was obliged to be seconded to the “hot” ward for a period.

Cancer Clinical Nurse Specialists:

Lung: With the help of Macmillan Cancer Support funding, it has been possible to recruit sufficient nursing staff and a Care Pathway Co-ordinator.
Breast: The number of CNS posts is stable. The workload is increasing due to increasing numbers; increasing reliance on telephone review and especially rollout of the patient initiated review is increasing demands.
Gynaecology: Staffing is under review because of the impending retirement of one CNS and the return of another from maternity leave. The present establishment was decided in 2017 at 64 hours. Current commitments, as set out in a submission for review, amount to 114 hours; CNS patient contact in Jan-Nov 2021 was 1569 events compared with 1288 in 2020. Including additional tasks as part of the "Living well with and beyond cancer" commitment an additional 30 hours are assessed as being necessary.
Colorectal cancer: This service is under review at present because of a recent retirement and another CNS moving on for career progression. It is felt that when the recruitment and induction process is completed the service will have adequate capacity; this requires separating the stoma nurse role from the cancer CNS role.
Upper Gastrointestinal cancer: This service has adequate capacity at present. It benefits from the skillset of the current post holders as one of the CNSs is an endoscopist with experience as a chemotherapy nurse and another has a background in palliative care. It is felt that this facilitates continuity of care for the patients.
Urological cancer: This service has a particularly large number of new cancer diagnoses (313 in 2021 compared with 234 for breast cancer and 155 for lung cancer). The team currently consists of two CNSs, one of whom was redeployed to intensive care during the height of the pandemic. On her return, workplans were reviewed. One has taken on more of a diagnostic role, see below, and has been trained to do prostate biopsies and urodynamic studies. This has left a huge gap in the cancer CNS service for a very busy discipline. A band 6 CNS has been recruited on a fixed term 6 month contract; it is hoped that this will lead to a permanent role. The cancer care co-ordinator also does the holistic needs assessments.

Diagnostics

Lung cancer: Pathway co-ordination has ensured that more patients referred from primary care have a CT within 7 days (average 5 days, previously 13 days). However, the pre-hospital phase in lung cancer diagnosis is being impaired by the marked reduction in chest X-rays requested by GPs during the early part of the Covid-19 period. (Crawford et al, Clinical Medicine Nov 2020, DOI: 10.7861/clinmed.2020-0638) and which persisted well into 2021 (see BMJ 2021;375:n2549). We are currently analysing the pattern of cancer diagnoses; it seems so far that the number of lung cancer diagnoses was reduced over this period. The pathway for investigation of suspicious radiological findings has been streamlined so these are actively pursued as soon as they are reported. This has resulted in patients seen in the emergency department to initiate the process of investigation; these amount to ⅔ of referrals. On the other hand, delays in the pathway occur in the thoracic surgical service provided in Leeds.

Urological cancer: The team is working on a business case to secure a cancer navigator. The diagnostic cancer pathway has been streamlined, in particular the prostate pathway. The CNS undertakes a comprehensive fast track telephone triage and in making 313 diagnoses in 2021, 901 such calls were undertaken, 99% of the time on day 1 of the referral pathway. These led to 822 requests for imaging - mainly MRI prostate, CT and ultrasound kidney, ureter & bladder. There are

two dedicated MRI prostate slots available which allows most patients to have straight-to-test investigations by day 2-4 but this interval is longer when referral rates are high. This process allows patients to be informed that cancer is not suspected much quicker. It prevents such patients having to undergo unnecessary prostate biopsy.

It should be pointed out that the existing cancer navigator posts in lung and gastrointestinal cancers are only funded until March 2022. Prior to their appointment over April-August 2021 the Trust averaged 68-69% in meeting the 28 day diagnostic pathway target for all tumour sites. After the appointment in August the proportions were: September 72.2%, October 73.3%, November 73.3% and December 75.4%.

The Rapid Diagnostics Centre is currently working with the Care Commissioning Group to look at implementing self-referral and a hot line for advice for GPs.

Living well with and beyond cancer

Delivery of this commitment depends on the specialist staffing issue and in particular the CNSs. West Yorkshire and Harrogate Cancer Alliance has supported this work.

All CNSs have reported the difficulty in managing work load due to Covid-19 social distance working, patients not want to comply with coming into hospital and GPs not examining patients at first contact. This has meant that seeing patients take longer and, in general, fewer numbers can be seen

There is a longstanding issue with specialist clinical psychological support. The wait is 3 weeks but the threshold for patients being referred is high so that probably too few patients are referred.

Similarly, there is a need for other allied health professionals working with cancer patients. This applies to both those cancers where the management is predominately within Airedale NHSFT where dieticians and consultant pharmacists can form part of the wider multidisciplinary team. For tumours where the management is delivered by a remote centralised service the longer-term rehabilitative work could be conducted in the accessible general hospital. An example is speech and language therapy and physiotherapy say for head & neck cancers.

Innovation and Technology

Through the good offices of the charity Hope for Tomorrow Airedale has access to two large vans equipped as Mobile Cancer Care Units. From these the team is able to deliver chemotherapy, blood transfusion and some other services at varying locations around the catchment area. The second vehicle was provided to work within the hospital grounds to deliver these elements when for patients to come into the hospital building is undesirable because of the pandemic and to cover the time chemotherapy rooms within the hospital are out of commission.

The Trust has also implemented colon capsule endoscopy and nasal endoscopy which should improve diagnostic services and reduce the need for patients to have invasive endoscopy procedures.

The breast cancer service was also successful in the bid to secure funding for Magseed (a technology for accurately locating tumours to facilitate surgery) which is currently being purchased.

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