Update on non-surgical oncology outpatient transformation in the North East

December 2023

Current challenges

Workforce challenges in oncology services are being felt across the entire NHS and nationally there is a predicted consultant oncologist workforce shortage of 28% (401 whole time equivalents) by 2025. We expect to feel the impact of this even more within the North East region in the years ahead.

The immediate workforce pressures being faced regionally are within the specialties of breast, lung and colorectal (bowel) cancer and since June 2022 NHS England Specialised Commissioning has seen a shortage of whole-time equivalent consultant oncologists. This is due to a combination of vacant posts (compounded by an inability to recruit) and planned retirements. This is coupled with a growing demand and complexity in non-surgical oncology treatments with for example chemotherapy use increasing significantly.

NHS England Specialised Commissioning are currently discussing the best way to address these immediate workforce challenges to ensure the continued safe delivery of specialist oncology services. As we manage this difficult position, we want to ensure that key stakeholders are well sighted on the issues being faced and the transformational programme of work that is being taken.

Background

Consultant oncologists from Newcastle Hospitals and South Tees Hospitals travel across the whole of the North East and North Cumbria region to deliver specialist outpatient clinics at several local hospital sites.

Given the scale of the immediate challenge and gaps in the consultant oncologist workforce, it was necessary in 2022 for the North region to change the number of local outreach outpatient clinics on a temporary basis to ensure that all patients still have fast access to staging diagnostics and treatment. At the time, this was in relation to breast, lung and colorectal (bowel) cancer only.

This involved a phased approach to establishing fewer outreach outpatient clinics, that allow the consultant oncologists in post to see as many patients as possible who are on a breast, lung or colorectal (bowel) cancer pathway. This interim approach has increased resilience within the existing workforce as it has meant there are no longer lone workers which makes recruitment to vacant consultant oncologist posts more attractive.

Without consolidating the number of outreach outpatient clinics, patients in some areas would have been disadvantaged in how quickly they could be seen by the appropriate specialist consultant oncologist compared to other parts of the region. This means they would have waited longer to agree their initial treatment plan and their cancer treatment would have been delayed. This was not an acceptable position and the NHS worked as swiftly as possible to ensure there was no detrimental impact on patient care as a result of these difficult workforce challenges.

Lessons have been learnt from the interim services changes, and the wider region (including the South region) is now at a point of establishing a new service model that builds on the work to date.

Principles for the strategic review and preferred model for taking forward

The principles adopted for this programme of work ensure the future model is patient focused, clinically led, delivers care as close to home as possible with a view to reducing inequality in current service provision across the region. The view of patients or patient representatives has been integral to consideration of the proposed options.

It is the intention to ensure oncologist time is used to maximum efficiency recognising that the gap between supply and demand for the regional oncologist workforce is forecast to widen further in the next five years. There has been an increase in doctors training in the specialty (national training numbers) and seven additional trainees were secured in the region. These numbers do not close the gap and it takes 5-7 years to complete training. A broad range of alternate workforce options has been considered along with role allocation, training needs and skills required. However, there is a shortage of all staff groups that provide care for cancer patients including clinical nurse specialists as well as pharmacists. This means workforce shortages in these areas also need addressing as part of the long term plan. Future plans will see oncology teams' working arrangements designed in a way that ensures safe levels of specialised cover coupled with opportunities to enhance resilience through peer support and learning.

A number of strategic options have been taken through the relevant NENC boards including the Northern Cancer Alliance board, the Provider Collaborative, the Combined CCG forum (now the ICB) as well as the newly established NHS England and ICB Joint Committee. This has allowed an opportunity to model, travel, health inequality impact and co-dependencies.

The current phase of the project is focussing on further engaging on and developing the preferred model in detail prior to final sign off by March 2024. This preferred option will see the establishment of clinical teams working in tumour specific hubs for outpatient appointments with treatment as close to home as possible, delivering the following model of care:

- Tumour specific teams (multidisciplinary) across NENC for the major tumour groups (Breast, Lung, Colorectal, Urology). Every trust has at least one hub – therefore visiting oncologists.
- Centralisation of intermediate tumour groups to the two cancer centres and more collaborative working to build resilience in the services especially for the rarer tumour groups, supporting services and workforce.
- Hub sites chosen to reduce patient travel impact as much as possible, no immediate changes to co-dependencies such as the Multidisciplinary Teams (MDT), surgery, diagnostic services.

- Ensuring all chemotherapy can be delivered locally with increased services required at some sites thus reducing patient travel.
- Supporting new ways of working, digital solutions, new workforce models.
- Reducing inequity in waiting times, clinical trials access, supporting services.
- Improving patient safety and quality – communication, wrap around tumour specific model of care, acute oncology services and out of hours access to advice, guidance and support (professionals and patients).

The model will benefit the workforce by reducing single-handed clinicians – with a minimum of three oncology consultants per hub, resulting in improved cross cover and resilience. There will be wider multidisciplinary team support from prescribing pharmacists, clinical nurse specialists, care coordinators and administrators as well as new roles of advanced clinical practitioners.

This will support standardisation of clinical ways of working with more access to clinical trials, standardisation of clinical protocols and face to face appointments and an agreed regional model for out of hours access to advice, guidance and support (for professionals and patients).

The preferred model has been subject to an external peer review by two other systems, (South and North Yorkshire) with a senior external clinical chair to facilitate. The panel members were peer experts in non-surgical oncology – including patient representatives. The review team has fed back support in principle for the model, and suggested some further work to mitigate for the planned changes which is now being progressed.

Communications and engagement

All engagement activity to date regarding this programme of work has been conducted in line with the Cancer Alliance co-produced public engagement strategy.

Initial work adopted a three staged approach to understand what matters most to oncology patients, their families and their carers as well as potential future patients. This has focussed on:

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

Stage one involved developing a framework for speaking to people with lived experience, members of the public and representatives from community

organisations who understand the impact of health inequalities on people living in some of our most vulnerable communities.

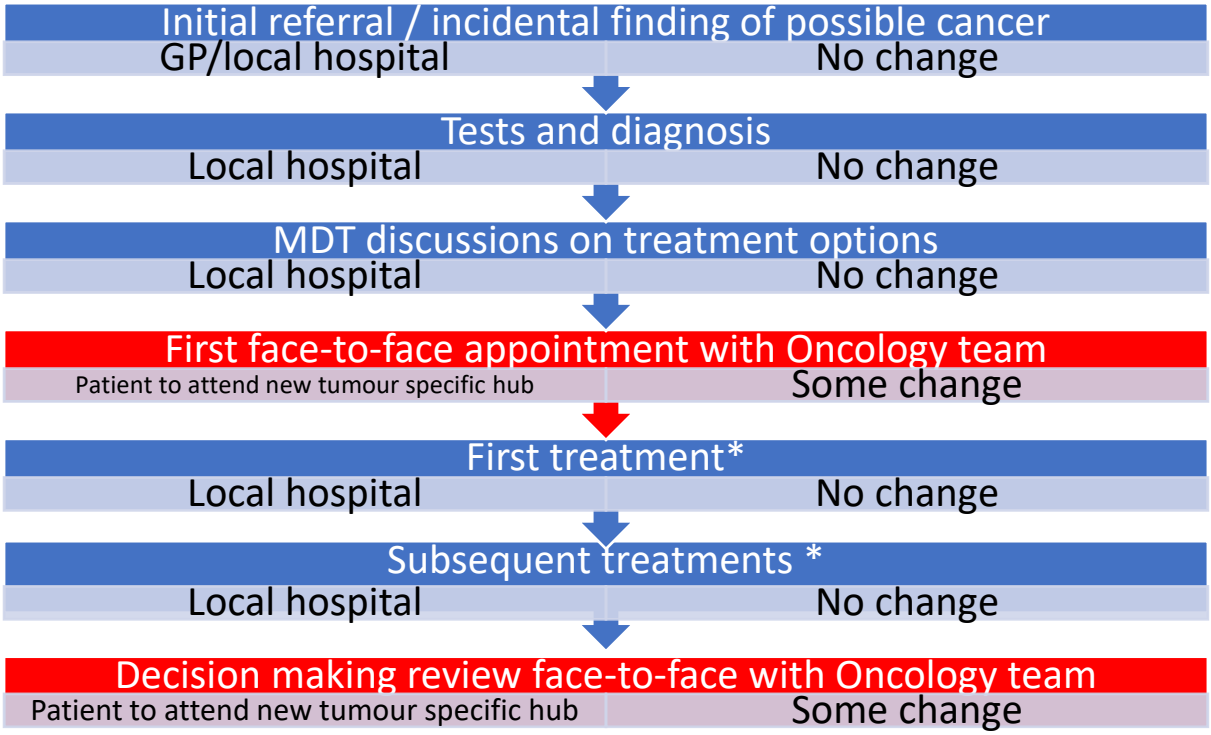
Stage two of the engagement process involved holding three focus groups to explore the key themes identified in the data analysis along with the risks and benefits of the current service model and the pros and cons of any potential service changes.

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

All engagement continues to be conducted in line with the Alliance co-produced public engagement strategy The NCA Framework for Public Involvement - Northern Cancer Alliance Northern Cancer Alliance. There are lay representative on all strategy groups and the Alliance Involvement Forum participation continues. A task and finish group has been established – to consider the proposed model and there are questionnaires in circulation as well as planned focus groups.

Expected impact for patients

Under the temporary arrangements in the North region the vast majority of patient care has continued to happen locally with no impact on the initial diagnostic pathway, local MDTs, local surgery and chemotherapy continuing at local hospital chemotherapy units.The example patient pathway under the preferred model of care for the wider region, highlighting the areas of potential change, is set out below:



For some patients the first face to face outpatient appointment with the consultant oncologist and any necessary face to face follow up appointments may be offered at a different site from their local hospital. The oncology service has continued to offer and maximise the use of virtual appointments where this is appropriate.

The attached Appendix A includes a table showing the service delivery model in 2020 when this work commenced (including populations by local authority area in 2018). It also includes a table of the proposed sites of the managed clinical network hubs by tumour speciality under the preferred future model.

Health impact assessments and travel impact assessments have been undertaken for the preferred model of care. These will be kept under review.

Health impact assessment findings

The health impact assessment indicates that the proposed model of care would support compliance with the public sector equality duty in advancing equality of opportunity and fostering good relations. It would also support reducing health inequalities faced by patients in reducing inequalities in access to health care and reducing inequalities in health outcomes.

Travel impact assessment findings

Pre engagement work “what matters to me" considered travel issues – with distance and parking informing the travel analysis.

Work to date has considered travel by car and by public transport - most people travel by car for cancer treatment.

The working group agreed that travel and parking became more of an issue when the other points were not delivered (communication and information, the importance of coordinated, efficient and timely care, knowing who to contact, seamless transfers between hospitals/departments, feeling involved and listened to at all stages of care)

A working group looking at this work considered reducing the number of journeys by using video consultations to reduce unnecessary travel if suitable for the individual and their clinical situation. Further consideration has been suggested for mitigations particularly increasing the use of "daft as a brush” or other voluntary transport schemes.

Next steps

While the temporary changes were requested by Newcastle Hospitals NHS Foundation Trust they were supported in principle by regional NHS England Specialised Commissioners, The Northern Cancer Alliance, the Integrated Care System leadership team for North East and Cumbria and the wider hospital network that are part of this system. The regional Provider Collaborative and the Cancer Board are also briefed regarding the challenging workforce position in non-surgical oncology services and the likely need to consolidate the number of outreach clinics as a temporary measure.

We are at a point when patient feedback to the temporary services in the North region is being carefully reviewed and used to inform considerations for the future model of service delivery.

Given the current workforce challenges we have already described, and which will continue beyond the temporary solution now in place, planning for the future model of service delivery across the whole of the ICS is continuing at pace.

We are seeking support from the JHOSC to progress plans for remodelling of the South region service, in line with the preferred option set out in this report.

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Julie Turner – Head of Specialised Commissioning

APPENDIX A: Service delivery models non-surgical oncology outpatient transformation in the North East

Table 1 below shows the service delivery model in 2020, when this work commenced including populations by local authority area (2018). It should be noted that the 152,000 population from the Hambleton, Richmondshire and Whitby area flow into James Cook Cancer Centre, and the population of County Durham and Darlington flow to both regional cancer centres.

Table 1

Oncologist from	Trust	Site Local Authority Population 2018	Oncology Tumour Sites
Newcastle Hospitals NHS FT	Newcastle Hospitals NHS FT	Freeman Hospital Cancer Centre (300,196)	All tumour specific service provided
	North Cumbria Integrated Care	Cumberland Infirmary (324,000)	In 2020 provision was being reviewed as part of the Newcastle Carlisle work
	Northumbria Healthcare NHS FT	Wansbeck General Hospital (320,274)	Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary
		North Tyneside General Hospital (205,985)	Lung, breast, colorectal, upper gastrointestinal
	Gateshead Health NHS FT	Queen Elizabeth Hospital (202,508)	Lung, breast, colorectal, cancer of unknown primary, gynaecological
	South Tyneside and Sunderland NHS FT	Sunderland Royal Hospital (277,417)	Lung, breast, colorectal, upper gastrointestinal, cancer of unknown primary, head & neck, urology
		South Tyneside District Hospital (150,265)	Lung, breast, colorectal
	County Durham and Darlington NHS FT	Shotley Bridge Hospital	Breast
		University Hospital North Durham (526,980)	Lung, breast, colorectal,
South Tees Hospitals NHS FT		Bishop Auckland Hospital	Lung, breast, colorectal,
		Darlington Memorial Hospital (106,695)	Lung, breast, colorectal, urology, head & neck
		University Hospital Hartlepool (96,242)	Lung, colorectal urology

	North Tees and Hartlepool NHS FT	University Hospital North Tees (197,213)	Lung, breast, colorectal, urology
	South Tees Hospitals NHS FT	Friarage Hospital (91,134)	Lung, breast, colorectal, urology
		James Cook Cancer Centre (277,263)	All tumour groups

Table 2 below shows the proposed sites of the managed clinical network hubs by tumour speciality under the preferred future model.

Table 2

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

Oncologist provision from South Tees Hospitals NHS FT		
Trust	**Hospital site**	**Tumour speciality**
County Durham and Darlington NHS FT	Darlington Memorial Hospital	Head &Neck, lung
	Bishop Auckland Hospital	breast
North Tees and Hartlepool NHS FT	North Tees University Hospital	Breast, lung, colorectal, Urology

South Tees Hospital NHS Foundation Trust	James Cook University Hospital	All tumour groups
	Friarage Hospital	Breast, lung, colorectal, urology