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REBUILDING HEALTH AND SOCIAL CARE CANCER AND HAEMATOLOGY TREATMENT SERVICES IN NORTHERN IRELAND

POLICY STATEMENT

OCTOBER 2020

Contents

FOREWORD BY ROBIN SWANN MLA MINISTER OF HEALTH

In March 2019 my Department announced that it would commission a new Cancer Strategy for Northern Ireland. While significant progress has been made over the past 20 years in developing cancer services, the anticipated demographic change in forthcoming years means there is likely to be a significant growth in demand for cancer services, and we must prepare for these challenges. A new strategy would help us do that.

As incoming Minister of Health in January 2020 I was particularly pleased that the 'New Decade New Approach' document, which sets out the priorities for the restored Executive, has given a high priority to meeting the needs of cancer patients by committing to the development of the new strategy and an implementation plan by December 2020. The development of the strategy is progressing under the direction of a steering group led by Northern Ireland's Chief Nursing Officer, Professor Charlotte McArdle, which has brought together healthcare professionals, cancer charities and service users to deliver a strategy which aims to place Northern Ireland at the forefront of providing world class cancer prevention, treatment and patient experience in the years ahead. However, delivering this mission is dependent upon the Executive making available the necessary funding to invest in the development of cancer services.

While we have greatly improved our cancer treatment services with increasing numbers of patients surviving cancer for longer periods, regretfully our waiting times for diagnosis and treatment have been deteriorating in recent years. This is due to both the increased demand for services and the pressure on cancer treatment providers arising from the difficulty in recruiting staff. Unfortunately the pressure on waiting times has been compounded this year due to the adverse impact of the Covid-19 pandemic on the Health and Social Care (HSC) system's ability to sustain services during this difficult period. While every effort has been made by the HSC Trusts to prioritise both red flag and urgent patient referrals it will require some time to return these services to delivering the full available capacity.

Alongside the development of the new Cancer Strategy healthcare commissioners, professional staff and the Trusts have been working to produce short and medium-term plans to rebuild and stabilise cancer services in response to the adverse impact of the initial wave of the Covid-19 pandemic. There is an urgent need to rebuild cancer services and these plans complement each other by providing a strong base for the long-term Implementation Plan to underpin the Cancer Strategy called for in the 'New Decade New Approach' document.

The Rebuilding and Stabilisation Plans for Oncology and Haematology Services are summarised in this Policy Statement. The delivery of these plans will require new investment and the adoption of new and innovative ways of delivering services in order to maximise available capacity.

The high prevalence of cancer across our community means that all of us will at some time experience this condition either as individuals or through the experience of family and friends. The development of the new Cancer Strategy together with the rebuilding and stabilisation plans therefore provide Northern Ireland with a once in a

generation opportunity to develop a world class cancer service. I am fully committed to engaging my Executive colleagues to reach out for this prize by delivering the necessary investment to make this a reality in the years ahead to deliver a new decade and new approach to improving cancer care.

Finally, I want to take this opportunity to thank all of the staff who provide cancer services across the HSC for their dedication to delivering high quality treatment and care for cancer patients and for the solace that they bring to families and carers.

Robin Swann MLA
Minister of Health

Introduction

A population health needs assessment prepared by the Public Health Agency (PHA) in 2019 comments that the "recent pressures affecting oncology services in Northern Ireland have highlighted challenges in sustaining the appropriate level of high quality specialist care in all Health and Social Care Trusts. There are a number of reasons for the existing pressures, including vacancies and sickness absence. In addition, the service is being supported by single handed practitioners and locums, making it vulnerable. The overriding concern amongst clinicians is that the specialty of oncology cannot keep pace with the increasing demand and workload and the increasing need for consultants to concentrate their expertise on a small number of site specific tumour areas".

The PHA's assessment also revealed that the over 65 years population is projected to increase by 65.1 per cent to 491,700 people by mid-2041 i.e. almost one in four people will be in this age category. The population aged 85 and over is projected to increase by 82,800 people over the same period. The risk of cancer increases with increasing age. Between 2007 and 2016 the number of cancer cases, excluding Non-melanoma skin cancers (NMSC), increased from 4,044 to 4,629 among men and 3,885 to 4,817 among women. This increase is largely due to increasing numbers of older people in the population. In 2009-2013 there were 4,347 male and 4,275 female cases of cancer (excluding NMSC) diagnosed each year. This is expected to rise by 43% for men and by 40% for women by 2026 to 6,206 and 5,999 cases per year respectively. By 2035 the number of cases per year is projected to be 7,181 male and 6,967 female cases, a 65% rise among men and a 63% rise among women.

Increasing capacity within cancer treatment services has been a priority for the Department of Health for some years. Increased capacity is needed to address the underperformance in meeting waiting time targets and to address the increasing demand for these services. In recent months the Covid-19 pandemic has also contributed to the capacity constraints within the service including a significant fall in red flag referrals during the pandemic surge. Consequently it is anticipated that the service is likely to see a surge in referrals over the coming months, with the potential for an increase in late stage presentations of patients experiencing symptoms. The HSCB working with the HSC Trusts has therefore developed: a Rebuilding Plan for Cancer Services to take immediate action to increase capacity and ensure that the service is sustained over the weeks and months ahead as we face the potential for a second wave of Covid-19; and, an Oncology Stabilisation Plan to sustain the rebuilding of services over the next 2 to 3 years. The HSCB has also developed a similar stabilisation plan for Haematology Services given its close association with Oncology to address the capacity pressures also faced by this service. These plans provide an integrated approach to increasing capacity within cancer services.
The key aspects of these plans are summarised in the following three sections in this Statement. Section 1 covers the Rebuilding Plan for Cancer Services over the Short-term, Section 2 covers the Oncology Services Medium-Term Stabilisation Plan and Section 3 covers the Haematology Medium-Term Stabilisation Plan. The full plans can be accessed on the Department's website at : https://www.health-ni.gov.uk/publications/rebuilding-cancer-services.

The steering group developing the new Cancer Strategy will continue the work on the development of the long-term implementation plan to transform the delivery of cancer services in order to better need the needs of Northern Ireland's population.

In conclusion, both Oncology and Haematology services are under unprecedented pressure as a result of continued growth in demand for services and the adverse impact of the Covid-19 pandemic. It is therefore essential that we invest now to both enhance our consultant numbers and to create sustainable teams that, through increased capacity, skills mix and transformation, can provide high quality and timely care.

Section 1: Rebuilding Plan for Cancer Services over the Short-term

Introduction

1. The rebuilding of Cancer Services will be a particular challenge for the HSC system given that the 2 week waiting time target for suspected breast cancer referral and the 62 day waiting time target for treatment of all cancers were already challenged pre-COVID-19. There has also been a significant fall in red flag referrals during the pandemic surge so it is anticipated that the service is likely to see a surge in referrals over the coming months, with the potential for an increase in late stage presentation. The implications of the restart of cancer screening services will also need to be considered in terms of its potential impact on increased numbers of patients referred for further diagnosis.

2. The Department of Health has established a Cancer Services Rebuilding Cell to set out the approach to implementing the reset of cancer services (assessment and treatments), taking into account the potential need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC.

3. While the group is only recently established and a detailed work plan is yet to be finalised, a number of key actions / areas of focus for the Rebuilding Plan have been identified as follows The full plans can be accessed on the Department's website at : https://www.health-ni.gov.uk/publications/rebuilding-cancer-services. The total new investment required to implement these actions, excluding the Oncology and Haematology Investment Plans, is estimated as £2.5m revenue expenditure and capital investment of £151K.

Treatment Pathway redesign

4. The availability of new technology, the willingness to embrace this technology and the challenges presented by the Covid-19 pandemic have provided the key opportunities to change clinical pathways. The clinical teams had already started adopting the virtual triage model and the embedding of this new pathway was reinforced further when traditional face to face clinics ceased due to Covid-19. Collaborative working across the Northern Ireland Cancer Network (NICaN) Clinical Reference Groups has created opportunities for cross-Trust working which is helping to equalise waiting lists across Northern Ireland.

5. The Upper and Lower Gastro-Intestinal (GI) teams, working through NICaN, have continued to share learning and refine and make improvements to the pathways. Improvements in the Upper GI pathway have included putting processes in place to increase the use of e-triage and sending suitable patients straight to diagnostic endoscopy therefore speeding up the pathway by eliminating time spent waiting for an outpatient appointment. They have also established fast track mechanisms for staging elements of the patient pathway.

Action 1: *Learning from the pathway changes should be shared across Trusts and other tumour sites via NICaN.*

Cancer Patient Referral & Triage

Breast Cancer Assessment

6. One of the key recommendations of the breast cancer assessment service transformation review was the need to establish a single point of referral and to equalise waiting times for breast assessment across Northern Ireland. It is proposed that this work should be progressed as a priority.

7. The HSCB has recognised the capacity gap in the Northern Trust breast service and has funded a fourth consultant post – this post has now been appointed with the consultant due to take up post in August 2020.

   Action 2: *Undertake scoping of infrastructure requirements and governance processes required to support the introduction of a single point of referral for breast assessment across Northern Ireland*.

FIT Testing

8. In accordance with the British Society of Gastroenterology (BSG) guidance, all endoscopes, with the exception of emergency scopes, were paused from 2nd April 2020. In response to this the NICaN Colorectal Clinical Reference Group (CRG) has developed pathways and protocols to support the introduction of FIT testing in secondary care. The testing, introduced in mid-May, has been made available to all urgent and red flag patients awaiting an outpatient appointment, scope or CT colonography and has enabled colorectal teams to risk stratify patients, ensuring that high risk patients were prioritised. While scoping recommenced at the end of May 2020, ongoing requirements with regard to use of PPE and enhanced decontamination processes have significantly impacted on capacity, with a reduced throughput per session of approximately 50%. Clinical teams have advised that the ability to risk stratify patients will be essential going forward. A rapid options appraisal and costing is being undertaken to inform how best to take this forward looking at provision in primary care as a potential option.

   Action 3: *Complete rapid options appraisal for extension of FIT testing and secure funding for its continuation.*

Phototriage Dermatology

9. Dermatology demand has fallen sharply during the Covid-19 period including cancer referrals. Given the backdrop of very lengthy waiting times into Trust Dermatology services there are clinical concerns with regards to timely access for cancer assessment and treatment. There is an acknowledgement that referral demand could increase sharply, as we potentially move beyond

the societal lockdown and HSC Rebuilding gathers pace. This would further exacerbate the challenges the service is under.

10. Following the scoping and piloting of dermatology phototriage utilising Confidence and Supply funding an Outline Business Case (OBC) is being expedited for a regional solution to photo triage and image transfer. The OBC complements the current use of video consultations as part of the 'new normal' for elective care assessments and patient management moving forward. Given the clear interest across Primary and Secondary Care to support this work this would represent a major service transformation for future patient access and the current service backlogs in Dermatology.

    Action 4: The Dermatology service development is in the Primary Care Rebuilding Plan (Phase 2 July-September 2020) and is to be supported by HSC Trust Dermatology Teams

Cancer diagnostics

Imaging Services

11. The Imaging Services Managed Regional Clinical Network (MRCN) have commenced a number of pieces of work aimed at equalising imaging waiting times across the system including:
    - MRCN leads are currently quantifying and assessing trust capacity and backlogs and looking at best practice regarding throughput to maximise patient flow to develop a regional plan for both imaging and reporting;
    - a weekly data download for waiting times (data to be drawn from 3 information systems) is being developed to inform service planning;
    - Looking at regional flags in the Northern Ireland Picture Archiving and Communications System (NIPACs) to identify priority codes to help with stratifying patients according to clinical need.

12. Northern Ireland has benefited from a share of NHS England COVID-19 supplies including:
    - 8 Mobile DR X-ray and 8 Ultrasound carts- allocated across the HSC Trusts; and,
    - a relocatable CT Unit on loan, to be located at Musgrave (COVID-19 green site and accessible to M1 and M2 motorways) for regional use.

13. While this additional equipment is welcome, there are a number of existing mobile scanners funded 'at risk' within Trusts where contracts are due to expire and which will need to be secured to continue to provide service continuity as well as resilience. It is also likely that additional MRI and CT mobile capacity will be required in-year from the Independent Sector (IS) as part of the rebuilding plan.

    Action 5: *MRCN to bring forward a plan for equalising waits which outlines additional capacity requirements in year.*

PET–CT

14. PET-CT is a significant constraint on a number of pathways, in particular upper GI and lung. A second PET scanner has been commissioned within Belfast Trust. The second scanner was due to be operational in April 2020. Unfortunately, the pandemic meant that trainers could not travel from England to provide training to the local teams so "go live" was delayed. Staff training was completed in June 2020 and scanning has now commenced. Activity will be built up incrementally over the coming weeks increasing to 4 sessions per week by August 2020. This should address the immediate capacity gap. Interim arrangements which provided additional capacity through Blackrock Clinic will be stood down once the current cohort of patients with planned dates has been completed (approximately 85 patients). All new patients will be scanned in Belfast going forward.

    Action 6: *Belfast Trust to ensure incremental increase in activity on second scanner as per agreed plan with HSCB.*

Endoscopy

15. The continuation of FIT testing will enable teams to risk stratify patients and enabling high risk patients to be prioritised against the available resource. In addition to this the following actions have or will be taken:
    - An additional £2.7m non-recurrent funding was allocated to Trusts in 2020/21 for additional endoscopy procedures;
    - Recognising pressure on scopes facilities in light of COVID-19, additional capacity will be secured from local IS providers;
    - Endoscopy is one of the clinical services identified for Phase 2 of the Day Case Elective Care Centres (DECCs) programme which will again help reduce the clinical variation in practice, standardise throughput and help equalise waiting times across the region;
    - Recognising the additional challenges posed by COVID-19, it is proposed that a *Regional Endoscopy Reform and Modernisation group* is established to take forward pathway and service improvements;
    - A total of eight additional training posts for nurse endoscopists have been created; the two-year training programme is underway with some nurses having already completed it and taken up posts.

    Action 7: *Health and Social Care Board to establish Regional Endoscopy Network to take forward pathway and service improvements.*

    Action 8*: HSC Trusts to maximise the utilisation of both in-house and IS capacity and work towards the equalisation of waiting times across the region.*

    Action 9*: Explore the continued utilisation and funding for NHSCT Vanguard Endoscopy Unit beyond current contract end~ October 2020 as a regional resource*

Cancer Treatment

Oncology & Haematology Treatment

16. Oncology services were under considerable strain pre-COVID-19 with a number of areas of single-handed consultant practice and Trusts raising concerns that the current service infrastructure was struggling to support the growth in activity with overbooked SACT clinics, increases in waiting times and concerns about recruitment and retention. The stabilisation plans for Oncology and Haematology services set out in the Department's Policy Statement provide the basis for maximising available capacity. The *HSCB will also allocate £1m investment in 2020/21 (£2m full-year effect (fye)) for infrastructure support associated with approved NICE Technology Appraisals.*

    Action 10 *The Department of Health has approved the Oncology and Haematology Stabilisation Plans.*

    Action 11 *HSCB to allocate £1m in year (£2m fye) for infrastructure support associated with approved NICE Technology Appraisals.*

SACT Treatment

17. SACT services report that any patient who, on discussing the risks of progressing with treatment, wanted to proceed with treatment, were supported to do so. Services have put in place a range of measures to enable them to continue to provide services while trying to minimise contact for patients due to the need to ensure preventative infection control. This included the use of virtual clinics, provision of community bloods and home delivery of SACT. Trusts report that this activity was largely supported through the redeployment of staff, with some projects sitting as cost pressures within Trusts. As activity levels approach pre-COVID-19 levels, there are concerns about the ability of Trusts to maintain these measures without some additional funding. In particular, Trusts highlight the need for regional investment in phlebotomy services in order to support the provision of virtual clinics across all elective specialties. While some elements of this work are reflected in the Oncology and Haematology Stabilisation plans, there would be value in undertaking a rapid review of the improvements and the associated sustainability requirements to ensure that all opportunities for improvement have been identified.

    Action 12: *Undertake a rapid assessment of service improvements and sustainability considerations via NICaN SACT CRG.*

    Action 13*: Discussions to take place across primary and secondary care on arrangements for phlebotomy services out with traditional acute clinical settings.*

Radiotherapy Treatment

18. Both Cancer Centres (Belfast and North West) have developed 4-step escalation plans during the Covid-19 surge period. Both centres only had to move to level 1 which required:
    - Delaying treatment for some prostate patients who were already on hormone therapy;
    - Reduced fractionation for breast patients[1]; and
    - Delay / amendment of other treatments in line with national guidance.

19. Changes to pathways meant that both centres saw an increase in referrals from some tumour sites and that treatment activity across the period was comparable to the equivalent period in 2019. Both centres are now working to assign the prostate patients who were paused. While social distancing requirements are impacting on capacity, recent changes to the fractionation for breast patients have created some additional capacity within the system and services report that they are currently able to manage demand.

    Action 14*: Continued reduction of fractionation for breast patients in accordance with national guidance and emerging evidence*

Surgery

20. NICaN CRGs worked to produce regional guidance on the prioritisation of patients during surge. The larger tumour sites report that they have been able to provide treatment to all priority 1 & 2 patients through a combination of in-house and Independent Sector (IS) delivery. However, the impact of the Nightingale hospital within Belfast City Hospital has resulted in delays to some specialist surgery. Belfast Trust is in the process of working through the back log.

21. Requirements for use of PPE and enhanced decontamination measures will to continue to impact on theatre capacity moving forward. In addition, theatre nursing, which was already challenged pre-COVID-19, has been impacted by the COVID response with many nurses redeployed to support ICU. Recognising these constraints, a contract has been agreed across the three IS providers for an additional 30 theatre sessions per week and 25 day procedure lists and 50 scope lists per month. It is proposed that this capacity is prioritised for cancer with a particular focus on breast and urology in the first instance.

22. A surgical oversight group has been established within NICaN and will provide ongoing clinical advice to the Cancer Services Rebuilding Group.

    Action 15: *Maximum throughput of Core and IS treatment capacity to be delivered.*

[1] In line with national guidance and now supported by clinical trial evidence.

Action 16: *Urology cancer surgery to continue to be assessed by Urology CRG to ensure clinical prioritisation and equalisation of waits.*

Action 17*: Surgical oversight group to advise of emerging evidence to shape clinical pathways.*

Section 2: Oncology Services Medium-Term Stabilisation Plan

Introduction

1. Oncology services are facing a number of challenges including increasing patient numbers, related to the increasing older population and improved survival, new and emerging treatment choices and significant resilience issues in regard to the provision of outpatient assessment and the delivery of systemic anti-cancer therapy (SACT). This section provides a summary of the key aspects of the Oncology Services Stabilisation Plan. The full plan can be accessed on the Department's website at: https://www.health-ni.gov.uk/publications/rebuilding-cancer-services. The Plan aims to address the main areas of risk over the next 2 years whilst dovetailing with the longer term implementation of the Oncology Service Transformation (OST) Project recommendations and the development of the future Oncology Service Model. The Plan focuses on service improvements and on increasing the capacity of Oncology teams through a focus on developing skill mix which will optimise the available Consultant capacity. The Plan aims to improve the resilience in local teams and to develop sustainable Acute Oncology Services (AOS), which should support the implementation of the future service model whilst supporting current services.

2. In addition to this investment it is essential that while we await clarity on the future service model, that those Trusts who have an identified requirement to expand treatment chair numbers progress capital bids to support this. A more joined up regional approach to future consultant recruitment may also help to minimise consultant workforce challenges going forward.

3. Following a regional Oncology workshop at the end of February 2020 which had a particular focus on lung / Genitourinary (GU) provision, it is clear that while the consultant body within the Northern Ireland Cancer Centre (NICC) in the Belfast Trust support the need to consolidate vulnerable practices back to the centre, there is a strong feeling from Cancer Units in other HSC Trusts that to do so would destabilise the units and the District General Hospitals within which they are hosted and would provide a lower quality of service for patients. It was agreed at the workshop that, pending agreement of the longer term service model, efforts should be made to enhance the resilience of the current service model through two key actions:

    1) The recruitment of additional consultant posts which would address areas of vulnerable practice; and,
    2) Investment in the wider team infrastructure – It was felt that this was essential in order to increase capacity and create opportunities for skills mix/advanced practice, thereby reducing workload pressures at consultant level and improving consultant recruitment and retention on the longer term. In particular Trusts identified the need to invest in:
        - middle tier doctors;
        - chemotherapy nursing;
        - advanced practice roles within nursing and pharmacy; and
        - robust acute oncology services

4. With the advent of COVID-19, virtual clinics and the use of remote assessment has become a necessity and will continue to be so for the foreseeable future. Cancer Units consider that there will always be a requirement for some level of on-site consultant presence. However, there is agreement that targeted use of remote assessment from the centre may enable more effective use of consultant resource (as consultants will not be required to travel for every clinic) and will enable more patients to be "seen", mitigating the impact of COVID-19 on waiting times. However, while units have supported remote assessment to date, they report that it has placed a significant strain on Cancer Unit nursing staff in terms of ensuring appropriate local follow up of actions arising for the remote consultation (e.g. arranging bloods, ECHOs, PICs, pharmacy verification, etc.) and this has given rise to governance concerns. As activity levels return to normal, the consensus view is that for virtual assessment to work on a sustainable basis there are two issues that need to be considered:

    - The first is the need to develop oncology patient navigator/ scheduling roles which would ensure follow up of actions arising from consultations, thereby avoiding an additional burden on an already pressurised nursing workforce, and ensuring robust process and safety netting of patients. The funding to support these posts is reflected in Trust service improvement plans.
    - The second is the need to provide robust phlebotomy services to support the provision of virtual clinics. This issue is broader than cancer. While Belfast Trust has specified additional investment to support phlebotomy provision within cancer services, other Trusts are progressing this issue in the context of their broader plans for the rebuilding of elective services.

5. On the basis of discussions with the service, the proposal for oncology stabilisation includes 5 key elements:

    1) Funding to support development of new consultant posts in the Northern Ireland Cancer Centre (NICC) to address single handed / vulnerable practice and pressures within NICC.
    2) Recurrent investment in the Oncology Service Transformation (OST) early workforce bid / oncology prototype funding.
    3) Funding to support the nursing workforce gap identified within the OST Workforce Plan.
    4) Funding to support the consolidation and expansion of the Acute Oncology Service (AOS).
    5) Funding to support local Trust service improvement plans.

6. The overall cost of the plan is £8.73m. This investment will run across 2 years, through to March 2022.

Investment in Consultant Posts

7. In order to address growth and meet professional standards, the OST project identified a need to recruit an additional 10 medical oncologists and 4 clinical oncologists between 2019 and 2026. To address the immediate issues associated with single-handed practice, it is proposed that 5 additional oncology consultant posts are recruited to the NICC in-year.

8. The nature of the posts are under review but options include:

    1. Clinical Oncologist – Antrim Hospital Breast/Belfast Trust Thyroid
    2. Medical Oncologist – Craigavon Hospital Lung/GU/Belfast Trust GU
    3. Medical Oncologist – Antrim Breast/BHSCT breast
    4. Medical Oncologist – Antrim Hospital Lung GU/AOS
    5. Clinical Oncologist – to provide backfill for loss two academic posts. This would cover 0.5Whole Time Equivalent (WTE) lung and 0.5 backfill for the LGI/Early Clinical Trials service.

9. These posts would address a considerable number of the governance concerns, eliminating several areas of single handed practice and providing much needed resilience. The Belfast Trust has appointed two consultants on a temporary basis and there are a further two trainees coming off programme in year; the Trust is confident it can appoint to all posts.

10. There are a further 5 clinical oncologists and 3 medical oncologists coming off programme before April 2022. It is essential that the system avails of this opportunity to address current vacancies. Feedback suggests that AO consultant posts are not considered to be attractive due to concerns about professional isolation. It is suggested that NICC work with cancer units over the coming months to explore how best to address the above workforce expansion in order to make the posts more attractive. Similarly, there may be value in both cancer centres (located in Belfast and the North West) working together to develop a regional approach to recruitment.

Investment in Advanced Nursing Roles & additional Specialty Doctor Resource within Cancer Units

11. The OST early workforce bid proposed the development of two Consultant Nurse (CN) roles, one in each cancer centre, together with 0.8WTE Advanced Nurse Practitioner (ANP) and 1.0WTE specialty doctor for each cancer unit. These posts would significantly strengthen the infrastructure within the cancer units. In addition, the nursing roles would lead on the implementation of new ways of working and service developments and quality improvements across oncology services.

12. The CNs will be based in Cancer Centres and will provide expert leadership and evidence based direction to ensure service standards and practices related to oncology are maintained and improved across agreed tumour sites

within cancer services locally and regionally. As a member of the multidisciplinary team (MDT), the CN will provide leadership in the provision of high quality nursing care to cancer patients. The role will be at least 50% clinical facing with the remainder of time focussed on quality improvement, service development, audit and research linked to the agreed tumour site.

13. In collaboration with regional CN's and as a member the MDT, the ANP will work autonomously within an agreed expanded scope of practice. The role of the ANP which will be 90% clinical facing across agreed tumour site/s with the remainder of time focussed on quality improvement, service development, audit and research linked to the area of cancer. The clinical aspect of the role will include comprehensive assessment with differential diagnosis, diagnosis, provision of complex care using expert decision making skills, prescribing of treatment and care or appropriate referral and or discharge patients/ clients. Northern Ireland's first two ANP trainees commence training in autumn 2020.

14. Specifically, the CN and ANP will support the development of the cancer nursing workforce enhancing the contribution of the nursing workforce within SACT services through supporting the development and delivery of:
    - Nurse Led Pre SACT assessment and review clinics;
    - SACT delivery to cancer patients in a range of settings across secondary and primary care;
    - NMP roles for cancer nursing workforce across cancer services;
    - Inform Clinical Nurse Specialist (CNS) workforce and educational requirements in collaboration with CN's to facilitate and support changes in nursing contribution to the entire cancer patient pathway across agreed tumour sites; and,
    - Support cancer nursing workforce to contribute to the emerging immunotherapies agenda within cancer care.

Investment in Radiotherapy Skills Mix

15. The OST project identified an opportunity to invest in radiotherapy skills mix in order to optimise consultant capacity. The investment would support the development of advanced practitioner roles in both Therapeutic Radiography and Medical Physics across both cancer centres. These roles would allow some of the tasks currently undertaken by consultant clinical oncologists (e.g. consent, palliative mark up, treatment planning, organs at risk outlining and on treatment reviews) to be undertaken by others thereby releasing valuable consultant time for the management of more complex patients in the radiotherapy pathway. This prototype importantly also provides robust support to the oncology system as a whole through skill mix development at a time when recruitment and retention to consultant clinical oncologist posts is difficult across both cancer centres due to the national shortage.

16. During the COVID-19 response, both risk to patients and service capacity issues have necessitated a number of changes to usual cancer treatment pathways so that patients who may previously have received surgery are now being treated using radiotherapy. Patient volumes for radiotherapy have

increased as a consequence. Given that the risks and constraints associated with surgical provision are unlikely to change significantly throughout the pandemic response the increased use of radiotherapy treatment is likely to continue, subject to review. Early investment in this skills mix initiative would help to mitigate some of the additional service pressure this will create.

Investment in Chemotherapy Nurses

17. The oncology workforce plan identified a gap of 14.1WTE Band 5 chemotherapy nurses in 2018/19. Trusts advise that these posts are vital to improve resilience and to enable the service to cope with the increasing number and complexity of regimens and the increasing volume of patients. When the 6% annual growth rate for SACT is included the number of nurses required increases to 15.9WTE in 2020/21.

Investment to support the consolidation and expansion of the Acute Oncology Service

18. The development of the acute oncology service (AOS) commenced in 2013 and became operational across all Trusts from March 2016. Current service provision has been funded at 1.0WTE AO consultant in each unit (0.5WTE in AO and 0.5WTE to support a tumour site), 1.0WTE AO Consultant in each cancer centre, plus two Band 7 AO nurses at each unit/centre. Current staffing levels allow Trusts to provide a service on one site, 9am-5pm Monday to Friday. The size of the teams means that when staff are on leave there is no cross-cover. The consultant posts have been vacant in both Northern and Southern Trusts for more than 18 months. Despite these constraints the service has demonstrated measureable impact in terms of admissions avoidance and reduced lengths of stay and has become a core part of oncology services. Cancer Units in particular see them as an essential support to local services in the absence of locally employed consultant oncologists. In addition, one of the proposed long term future service models for oncology is likely to include some degree of central assessment and local delivery of chemotherapy. Units contend that a resilient AOS will be a prerequisite to the delivery of any such model.

19. Acknowledging the ongoing challenges with consultant recruitment, the NICaN AOS Clinical Reference Group, has agreed expansion plans which focus on enhancing the nursing contribution to the service through the development of advanced nursing roles. Plans vary by Trust depending on their own intelligence of when and where patients are presenting. Some trusts are opting to move to extended days Monday – Friday or to expand to weekend provision on their current site, while others are moving to make the service available on new sites in response to patient demand. A breakdown of the proposed posts and costs are presented in Table 7 in the full Oncology Stabilisation Plan. Table 8 in the Plan provides an overview of the expansion priorities by Trust area. The full plan can be accessed on the Department's website at: https://www.health-ni.gov.uk/publications/rebuilding-cancer-services.

20. AO services have become increasingly important in the context of the service response to COVID-19. Given that some of the symptoms associated with complications of treatment are similar to those of COVID-19, Trusts have seen an increase in the number of patients presenting and considerable work has had to go into the development and maintenance of rapid access green pathways for this group of vulnerable patients. AO services have also played a fundamental role in supporting enhanced communication for patients and families at a time when hospital visiting has been restricted and appointments/ investigations may have been postponed. The need for a resilient 7-day AO service has never been more critical.

Investment to support HSC Trust local service improvement plans

21. Each Trust has developed service improvement plans. These plans focus on a number of areas, many of which were tested within the OST oncology prototypes and which would underpin the delivery of any future service model. These plans also incorporate some of the learning from the service response to COVID-19. Common themes include:
    - Continued delivery of virtual clinics;
    - Increased use of nurse led assessment, review and prescribing within oncology services;
    - Increased use of a two stop approach to SACT assessment and delivery with increased use of telephone assessment to reduce patient time at clinic, improve patient experience and reduce pressure on clinics;
    - Extended days for pharmacy to improve clinic flow;
    - Pharmacy dispensing of oral SACT at clinics to reduce patient waits and pressure on clinics;
    - Increasing skills mix within pharmacy (e.g. investment in technician resource to free up higher bands to undertake more advanced roles such as non-medical prescribing, clinical verification and support for management of unscheduled patients); and
    - Provision of phlebotomy services in the community / community bloods.

22. Some specific examples of planned service improvements are included in Figure 1 below.

Figure 1 – Examples of planned service improvements

Belfast Trust – Provision of Community Bloods

Many of the GPs in Belfast Trust do not participate in the phlebotomy local enhanced service. The requirement to undertake bloods in SACT clinics means longer waits for patients and puts significant additional pressure on the nursing and physical infrastructure. The Trust wants to invest in a nurse outreach service to be located in health and well-being centres to enable bloods to be undertaken in the community pre clinic.

Northern Trust – extended working day for pharmacy

Northern Trust plans to extend its working day within pharmacy. This would enable SACT to be prepared the previous day for early morning clinics and enable earlier dispensing of oral SACT, significantly improving the flow at clinics and enabling a move to a two-step model for assessment and delivery of SACT.

Southern Trust – In addition to the development of enhanced nursing roles, Southern trust plans to introduce a pathway for medicines optimisation for SACT patients enabling them to understand their medications to increase compliance and concordance visit. We are keen to sustain these improvements to improve efficiency within the SACT service.by ensuring that all relevant patients are seen by a Pharmacist at their pre SACT education

South Eastern Trust (SET)

SET already has a successful nurse led review clinic in place for uro-oncology. The Trust is currently training an ONP to undertake breast oncology review and an ONP and Pharmacist NMP are currently setting up TKI on-treat follow-up (Afatinib, Gefitinib, Crizotinib, Erlotinib). All of these clinics free vital consultant resource to see new and complex review patients. The Trust would like to invest in further expansion of nurse led review in breast and uro-oncology.

Western Trust

Western Trust plans focus on sustainability and further roll out of medicines optimisation ensuring a streamlined pathway for chemotherapy patients by ensuring that all relevant patients are seen by a Pharmacist at their pre-education visit enabling them to be educated about their medication and allowing a review of any unnecessary medications both of which contribute to increased compliance. The Trusts is also seeking funding to support an extension of pharmacy opening hours to allow additional patients to be treated in the afternoon and for SACT treatments to be delivered beyond 5pm. The Trust also plans to enhanced nursing support to provide more nurse led clinics, maximising skills mix and releasing consultant resource for the management of complex patients.

Section 3: Haematology Medium-Term Stabilisation Plan

Introduction

1. Haematology is a clinical specialty encompassing the diagnosis, treatment and follow-up of patients who have blood or bleeding disorders. This includes malignant conditions such as Lymphoma, Myeloma and Leukaemia and benign disorders such as Haemophilia, Thalassemia and Immune Thrombocytopenic Purpura.

2. Haematology services are currently provided by all five HSC trusts, with specialist provision located in Belfast. Local clinical haematology provision includes diagnosis, treatment and follow up care for patients with a variety of blood disease diagnosed with lymphoma, myeloma, leukaemia, myelodysplastic disorders and non-cancerous (e.g. abnormal blood counts, bleeding and clotting disorders). Services also provide an emergency on call service for patients presenting with acute leukaemia, transfusion, haemostatic and other blood disorders.

3. In addition to providing a local service for the population of Belfast, the specialist team also provides the following:
   - A regional service for patients with lymphoma and myeloma who are undergoing autologous stem cell transplantation to include assessment, inpatient care and follow-up for.
   - A regional service for patients who are diagnosed with Acute Myeloid Leukaemia (AML) and those who are undergoing related allogeneic donor transplantation.
   - A regional service for patients with inherited blood disorders such as Haemophilia and Thalassemia and are supported by a small, dedicated nursing team.

4. Belfast therefore supports 3 clinical teams within haematology as follows:
   - Lymphoma/ myeloma
   - Leukaemia
   - Thrombosis.

5. This section provides a summary of the key aspects of the Haematology Services Stabilisation Plan. The full plan can be accessed on the Department's website at: https://www.health-ni.gov.uk/publications/rebuilding-cancer-services. Similar to the Oncology Stabilisation Plan, the Haematology Plan focuses largely on the development of sustainable teams that will create the capacity for skills mix and innovation whilst simultaneously reducing clinical risk and improving the patient experience of care. The plan proposes a £3.63m investment over a 2 year period. This investment would address the immediate risks within the service. In the longer term there may be benefit in undertaking a wider service review which would further support the

reform and modernisation of care pathways and the development of a sustainable workforce plan.

6. All HSC Trusts have brought forward individual plans which provide enhanced capacity to meet the increase in demand for services whilst simultaneously providing a more resilient service through the development of more sustainable teams. For completeness, all posts associated with transformation funding are included in the plans. While the plans vary slightly dependent on Trust's baseline staffing positions the common theme is the development of sustainable teams:
   - Investment in navigator posts to support the continued delivery of virtual clinics;
   - Investment in additional consultant posts to create sustainable teams within both the regional centre and the units (minimum 5.0WTE consultants per unit).
   - Investment in specialty doctors to support clinics, reduce day time attendance at ED and create more attractive rota arrangements in order to enhance consultant recruitment and retention;
   - Investment in CNS and ANP roles to enable more nurse led assessment, prescribing and review; and
   - Investment in pharmacy teams to increase capacity to meet the increased demand for SACT and allow more opportunities for pharmacy staff to undertake advanced roles such as NMP.

7. Table 11 in the full Plan, which can be accessed on the Department's website at: https://www.health-ni.gov.uk/publications/rebuilding-cancer-services, provides an overview of the costs associated with the stabilisation plan, which totals £3.6m. The investment would secure 59 Whole Time Equivalent (WTE) posts across Trusts. Table 12 in the full Plan provides an overview of the WTE posts broken down by professional grouping and Trust.

Consultant recruitment

8. The Plan identifies a need for recurrent funding to support 9.875WTE consultant posts. Three of these relate to new posts, one in Belfast Trust to support the transplant and acute leukaemia team and two in the West to create a sustainable 5.0WTE consultant team. The balance relates to posts that are already in the service but supported through non-recurrent funding. Of these, 3.375WTE are already filled by substantive consultants with a further 3 currently filled by locums. There are also three vacancies in Belfast.

9. There are 6 trainees coming off programme between now and August 2021. Confirmation of recurrent funding may enable the service to secure current locums as substantive post holders. If recruitment of trainees was also successful there is also the potential to recruit to both the new posts in the West and the vacancies within Belfast. It should be noted that there will be a substantial time lag between these trainees and the next group due to come off programme so the timing of this investment is critical.

Summary of Individual HSC Trust Plans'

10. An overview of each Trust's plans is outlined below.

Belfast Trust

11. The Trust plan identifies 3 service improvement projects aimed at reducing pressure on clinics and inpatient beds and enhancing the patient experience of care:
    - Remote bloods – many GP practices within the Trust area do not participate in the phlebotomy local enhanced service which means that patients have to come to clinic to have bloods done. This is contributing to significant overcrowding at clinics and is leading to a poor patient experience. A small investment in nursing would enable provision of community bloods, reducing footfall at clinics and facilitating increased use of a two-step approach to SACT assessment and delivery.
    - Ambulatory follow-up – the trust would like to appoint an Advanced Nurse Practitioner and Specialty doctor to facilitate early discharge from specialist inpatient ward. This has the potential to significantly reduce bed-days in the specialist regional treatment ward, thereby enabling earlier admission for stem cell transplant and complex chemotherapy patients (scoping suggests that equivalent of 2-3 beds could be released via this service model).
    - Provision of supportive treatments in the community – the Trust would like to establish a service level agreement with a private provider for the provision of supportive treatments in the community that are normally in Bridgewater. Scoping has identified that approx. 20-25 procedures undertaken in BWS each month could be delivered in community; would release significant amount of treatment chair time, thereby releasing capacity to meet growing demand for SACT.
    - Support Virtual Clinics– the trust would like to appoint 2.00 WTE Band 4 Navigators who would support the scheduling, and organisation of these clinics. The navigator would work across the Lymphoma, Leukaemia and Thrombosis teams. This investment will facilitate a more efficient, effective and sustainable model of delivering virtual clinics in the haematology service.

Northern Trust

12. In order to meet its demand, Northern Trust routinely overbooks clinics. The Northern Trust plan focuses on the need to secure recurrent funding for its 5th consultant post together with a significant investment in pharmacy and nursing capacity in order to enable the team to staff additional clinics, negating the need for clinics to be overbooked, ensuring an improved patient experience of care and reducing workload pressures on staff. Pharmacy investment would also support clinical verification in clinic whilst investment in navigators will support the continued delivery of virtual clinics.

Southern Trust

13. Similar to Northern Trust, Southern Trust plan focuses on securing funding for the 5th consultant post in addition to a concomitant investment in specialty doctor, CNS and pharmacy support. The development of the multidisciplinary team should free up Consultant time to deal with complex and new patients, reduce/avoid overbooking of outpatient clinics, provide additional capacity for virtual clinics activity, pharmacist and nurse led review clinics and would improve scheduling of procedures such as lumbar punctures, and bone marrow biopsies and the turnaround times for bone marrow aspirate reports. Stabilization of the team should enable further service improvements to benefit patients.

Western Trust

14. With the smallest of all the unit teams, the Western Trust bid focuses on the development of a sustainable team that can continue to transform services and meet growing demand. In particular the Trust would like to recruit additional specialty doctors who could contribute to the middle tier rota, making the on-call arrangements more attractive thereby improving consultant recruitment. Enhanced CNS support within the team would enable the provision of outreach clinics to Omagh and Fermanagh and release valuable consultant resource to see new and complex review patients. Western Trust has an historic arrangement whereby patients from the Southern sector of the Trust are seen by consultants in Belfast Trust (Belfast receives 6PAs of funding which are allocated across its team) – If the Trust was able to secure additional consultant resource and supporting infrastructure it would enable the repatriation of those patients back to Western Trust.

South Eastern Trust

15. South Eastern Trust has appointed a fifth consultant on a locum basis to meet service demand. The trust is seeking recurrent funding to support this post in order to create a more sustainable team going forward. They have also requested and ANP and CNS posts to allow them to expand nurse led assessment, prescribing and review.