Opposition costing – target of one week wait for all cancer diagnostics

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Description of policy
Labour Press release: "Ed Miliband tomorrow (Sat) pledges that a Labour government would guarantee that NHS patients in England will wait no longer than one week for cancer tests and results by 2020." Source: http://press.labour.org.uk/post/100266704979/ed-miliband-commits-labour-to-a-one-week-cancer-test

Additional policy assumptions
1. All diagnostic tests that may diagnose cancer must be completed within one week. 2. The one-week clock runs from referral specifically for a test, rather than to a specialist who may then request a test, to the point at which the test result is received by the patient. 3. Diagnostic tests included are: Flexible Sigmoidoscopy, MRI, Chest X-Ray, Non-obstetric Ultrasound, Cystoscopy, Gastroscopy, Colonoscopy, and CT 4. The policy would be rolled-out on a gradual basis, with full capacity being reached in year 5 5. The performance standard for this target is assumed to be 95%.

Additional technical modelling assumptions or judgements required
This modelling is extremely sensitive to the underpinning assumptions, and even small changes to these could result in large changes in the final totals. **Definition of 'cancer test'** In consultation with NHS England clinical leads, we have assumed the 8 types of diagnostic test outlined above may be reasonably assumed to be tests which diagnose cancer. The exception to this is 'planned activity' which is usually surveillance or follow-up of an existing medical condition. 'Cancer activity' is therefore defined as total activity minus 'planned activity'. Defining 'cancer tests' in this way is in line with a previous policy costing carried out in 2009. It is worth noting that although the term 'cancer tests' is used, in reality a specific diagnosis prior to the test would be very difficult to define. Therefore the only way to enact this policy would be to extend it to all diagnostic tests within the 8 categories of test which may diagnose cancer. Patients with symptoms highly predictive of cancer should already receive an "urgent GP referral for suspected cancer," which requires them to be seen by a consultant within two weeks. Should further testing be required this will usually take place as a matter of urgency. **Demand in absence of the policy** In the absence of the policy being introduced, there would be some rise in the cost of providing diagnostic tests as a result of increasing activity. These costs are not included in the cost of this policy as they do not arise from it but from underlying demographic changes and other factors.

As a baseline assumption, demand for all cancer diagnostic tests aside from flexible sigmoidoscopy and colonoscopy is assumed to continue rising (in the absence of this policy) at the average rate of the last 5 years.

Demand for flexible sigmoidoscopy and colonoscopy has been assumed to increase such that the number of these tests performed will equal the number in Scotland in 5 years time. This is an increase above the underlying trend and has be assumed due to an acknowledgement that capacity for these tests will have to increase quickly to keep up with demand.

To exclude the costs of the demand increase that would occur without this policy, it has been assumed that underlying capacity will increase at the same rate as demand. It is therefore assumed that waiting times would remain constant in the absence of this policy.

Definition of 'receiving tests and results within one week'

We have assumed that 'one week' represents six days, as most diagnostic services are open a minimum 6 days per week.

The time from referral to patients receiving results is comprised of

a) time patients wait for test to be performed

b) time from test being performed to patients receiving the result

This analysis assumes the time from test to result is fixed at current levels for each test. The target waiting time for patients to have their test performed is 6 days minus the test to result time.

Test-to-report times have been estimated from the Diagnostic Imaging Dataset (DID).

Analytical assumptions required

To find the size of waiting list consistent with the target 95th percentile waiting time, the analysis first calculates the clearance time (the length of time it would take to clear the waiting list in the absence of new activity) associated with the 95th percentile patient receiving their result within 6 days. A maximum waiting list size is then calculated from this clearance time.

Practical assumptions applied

Lower GI endoscopy tests (colonoscopy and flexible sigmoidoscopy) are assumed to require a minimum of two days on the waiting list to enable pre-operative prep to take place. Similarly, upper GI endoscopy (gastroscopy) and cystoscopy are assumed to require a minimum of one day on the waiting list.

We have made no attempt to account for the **feasibility** of implementing this policy from a patient perspective. In many cases this policy would require patients to begin pre-operative preparations or undergo diagnostic tests on the day of referral.

We have made no attempt to account for the **feasibility** of recruiting the additional staff required to provide this capacity. We have assumed that in the short term trainees could be recruited away from other specialisms, with additional trainees recruited to back fill those roles in future. However, this may not be achievable within the time-frame required.

For detailed costing assumptions, please see the attached annex.

If needed, information required on distributional effects of the policy

N/A

Cost/Revenue to the Exchequer over five years

We present a number of scenarios. We estimate the minimum, central and maximum[1] cost estimates of ensuring 95% of patients receive the results of their diagnostic test within a week to be:

1. Minimum

	DEL (£ms) to nearest £10m					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
TDEL Minimum	100	130	110	110	50	**510**
TDEL Central	280	350	210	210	150	**1,200**
TDEL Maximum	500	640	330	330	270	**2,060**

This modelling is extremely sensitive to the underpinning assumptions, and even small changes to these could result in large changes in the final totals.

All expenditure is assumed to fall under DEL.

Distributional effects (if none requested, any significant):

Comparison with current system (if applicable):

The current system does not mandate differential waiting times for 'cancer' diagnostic tests and other tests. The NHS constitution pledges that patients will not wait longer than 6 weeks for a diagnostic test, and an operational standard is set at 99% of patients being seen within 6 weeks.

Clinical advice is that this commitment is not supported by clinical evidence that this would lead to any significant improve outcomes.

To be completed by Permanent Secretary's Office Date costing signed off:	18 December 2014
[If applicable] Date revised costing signed off:	

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[1] For more detail on calculation of minimum, maximum and central estimates please see Part B of the Annex.

ANNEX

Annex A – Detailed costing assumptions

Costs for equipment and carrying out diagnostic tests are assumed to remain constant over the duration of this policy and we have not accounted for inflation or discounting. These costs have been provided by NHS supply chain and clinical leads

We have assumed that the current cancer diagnostic service is at capacity, so any additional tests will require new machines, staff and estate investment to be carried out.

The length of time taken to carry out one test, working day and working week length, and staffing requirements to maintain a diagnostic imaging service at full capacity have been estimated in consultation with clinical leads

The cost of training new staff members is taken from the Personal Social Services Research Unit report 'Unit costs of Health and Social Care 2013' http://www.pssru.ac.uk/archive/pdf/uc/uc2013/full-with-covers.pdf

Where spare capacity is required we estimate the cost of maintaining this to be 50% of that for fully utilised equipment. This was agreed in consultation with the reference costs team.

It is assumed that the first two years will be spent building up capacity, the backlog will be cleared over years 3 and 4, and that the the policy will be fully rolled-out in year 5.

We have made no attempt to quantify additional capacity or equipment to train additional staff required.

Annex B – Calculation of minimum, maximum and central estimates
Once a 'steady state' has been reached there are two ways that the system can provide 'headroom' to deal with natural daily fluctuations in the number of referrals:
- Decrease still further the target waiting list so that fluctuations still fall within target waits
- Increase capacity to ensure spare capacity at all times

In reality it is likely the health system would use a mixture of these two approaches. Reducing the waiting list would be cheaper but is very likely to hit the practical limits of how short the waiting list could become. Practical considerations therefore mean headroom would have to be partly provided by spare capacity.

The minimum estimate assumes all headroom is provided by further reductions to the waiting list.

The maximum estimate assumes all headroom is provided by spare capacity.

The central estimate assumes a 50:50 split between these two approaches.