Peninsula Cancer Network NHS
Devon and Cornwall

Annual Report

2009/10

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Introduction

1 Review of the year

Chair of the Network Board

This report enables me to reflect on my first full year as chair of the Cancer Network. I want to start by paying tribute to three of the team who left either during the year or early in 2010/11. The excellent work of Dr Simon Rule, Dr Ian Mackenzie and David Chambers has contributed greatly in delivering the objectives of the network during a challenging period.

Last year I set out one of the early priorities as being the delicate task of putting guidance into practice, in particular for upper gastro-intestinal cancer services. The new surgical service completed the first three months of operating in the final quarter of this year. As the service enters 2010/11 we will ensure close scrutiny is in place to provide assurance to patients and the public. Initial results are very encouraging and the service has already demonstrated its commitment to seek out patient views and its willingness to act on them.

I am sure that readers of the report will find the summaries from each of the site specific and cross-cutting groups helpful in describing the progress made in each area during the year. Each group has something to be proud of in terms of its achievements.

As well as saying farewell to colleagues, I have been pleased to be able to welcome Dr Nigel Acheson as Medical Director and John Harrison as our interim Director. They join a highly-committed and motivated team at a period of significant transition within the NHS, and I am confident that they will both play important roles in developing the Network's functions into the future.

Anthony Farnsworth

Medical Director

This is my last Medical Director's report, after three years with the Network. I leave at a very interesting time as far as the politics of cancer are concerned. We are clearly in a transitional phase following the change in Government, with more emphasis on local evidence behind decisions involving service reconfiguration and better engagement with the public, as well as the promise of less bureaucracy.

The philosophy of de-centralisation will be of value in this part of the country in view of the unique geography within which we have to configure services, but the rules around this might prove a challenge where changes are needed. The revision of the Cancer Reform Strategy is eagerly awaited and perhaps there may be, within that, some hint of these philosophical changes. I certainly hope so.

In addition, there is uncertainty about how the new commissioning arrangements will impact on cancer care. In my view these uncertainties provide a huge opportunity for the Cancer Network.

As we move to more local commissioning of care, access for these commissioners to the functions that the Network can provide is likely to be extremely valuable. These include access to independent medical expertise, a national view on how to improve outcomes, and expertise on how that can be delivered locally through service re-design. The Network can provide insights into cancer-specific commissioning and service re-design.

Finally, and perhaps most importantly, the Network can act as a provider of quality control for cancer care through a process along the lines of peer review. I would like to see the peer review measures slimmed down, with a real focus on clinical outcomes and a process that can be managed from within the Network. This is what we have been working on following the successful application of local peer review in chemotherapy, resulting in some very real changes in service provision.

We are extremely lucky in this part of the country to have excellent cancer care, in most cases delivered very locally to the patient. There have been difficulties around service reconfiguration but where this has been done the outcomes have been extremely positive, underlining the rationale behind such moves. It is clear that we need to involve patients from the start as we seek to improve services, whether or not this might involve reconfiguration, and to ensure that we explain clearly what we are doing and why.

Finally, I would like to thank all the very many people who have helped me over the last three years. A network by definition involves the skills of many people pulling together and I have seen this throughout my time. I wish the Network every success and hope that you will support Nigel to the same extent you have me.

Simon Rule

Director

Having joined the Network team in May 2010 I have been on a steep learning curve and, whilst I am aware that the annual report is designed to cover the previous year's activities, I would like to share some of my learning and to set out a few of the priority areas we will be focussing on as a team in 2011/12.

The passion and dedication to the improvement of cancer services and of the experience of cancer patients is evident everywhere I have looked.

The Trusts in the Peninsula have been kind enough to invite me to look around their services, and commissioners and the Network team have also been very welcoming. There are already some excellent services in the Peninsula and the teams in every organisation are seeking to improve services still further. The function the Network provides, coordinating and facilitating the relationships, can be instrumental in helping to achieve this and I have been very pleased to hear this view reflected back from outside the Network team.

In addition to keeping the usual operations of the Network running, the team are supporting the implementation of a revised approach to improving care throughout the 'pathway' that patients follow, developing our processes to ensure more effective engagement earlier in the process from clinicians and patients.

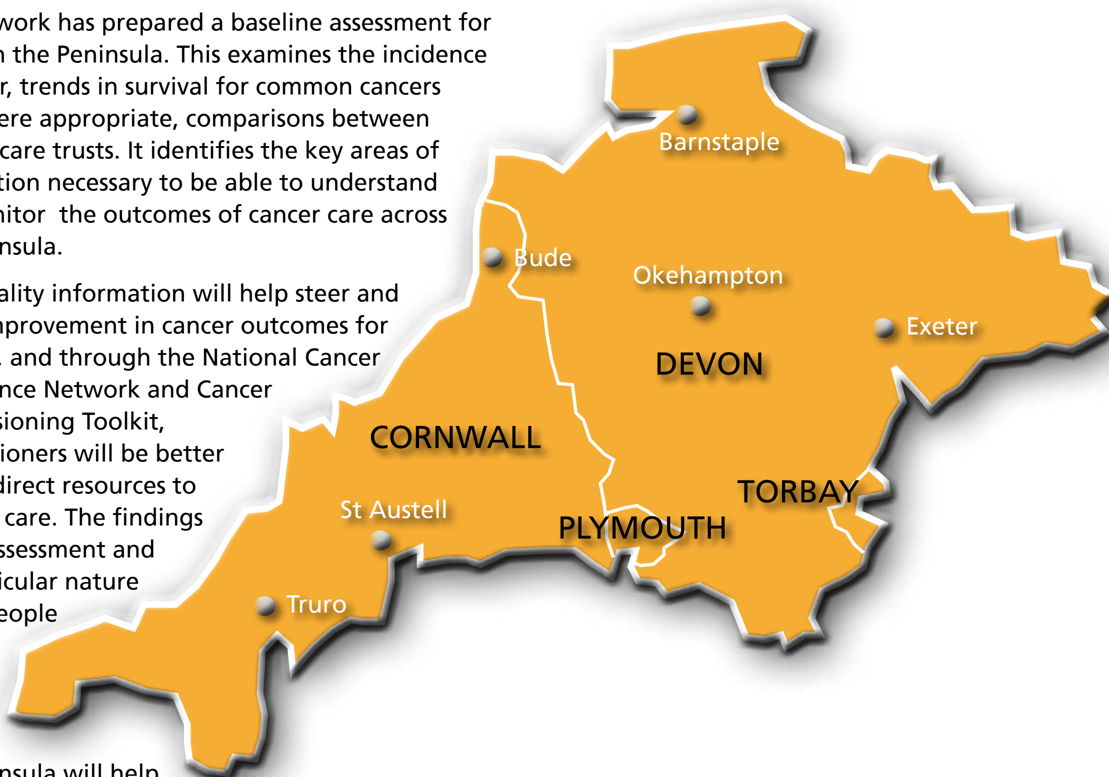
The transitional phase that the NHS is currently going through also requires us to think carefully about the development of the functions of a cancer network. In this respect we have been asked by the commissioning chief executives to consider how clinical networks across the Peninsula could work more effectively. A consensus has developed within the Heart and Stroke and Cancer Networks that there would be a benefit to working in this way.

With this in mind we are now in the process of managing through the NHS transitional phase, taking account of the clustering of PCTs and the establishment of GP consortia, but at the same time not losing sight of the need to deliver the core functions of networks.

John Harrison

2 The challenge of cancer

The Network has prepared a baseline assessment for cancer in the Peninsula. This examines the incidence of cancer, trends in survival for common cancers and, where appropriate, comparisons between primary care trusts. It identifies the key areas of information necessary to be able to understand and monitor the outcomes of cancer care across the Peninsula.



High-quality information will help steer and direct improvement in cancer outcomes for patients, and through the National Cancer Intelligence Network and Cancer Commissioning Toolkit, commissioners will be better able to direct resources to improve care. The findings of this assessment and the particular nature of the people and health services across the Peninsula will help shape the Peninsula strategy for prevention, awareness and early diagnosis of cancer.

Health inequalities are also important in all aspects of cancer treatment, and the baseline assessment draws on local work carried out by the Network Health Equity Audit Group and primary care trusts.

This report was praised nationally for its work on calculating a deprivation score for each GP practice and demonstrating the link between deprivation and the uptake of screening. The report also looks at the influence of practice size and rurality.

Prevention & diagnosis

3 Preventing cancer

The Network established a Public Health & Primary Care Group to steer the Network's prevention and early diagnosis work. The Cancer Reform Strategy identifies a number of risk factors for cancer:

- Smoking
- Obesity
- Unhealthy diet
- Lack of physical activity
- Excessive alcohol intake
- Excessive exposure to sunlight

The first five of these are risk factors for a range of conditions, which means leadership on these is provided by the Directors of Public Health. Excessive exposure to sunlight is a specific risk factor for skin cancer.

The baseline assessment identifies that the Peninsula has the highest rates of skin cancer in the country, with rates of melanoma rising. Therefore the Cancer Network prioritised skin cancer prevention.

The prevention of skin cancer

The Network received funding from the National Cancer Action Team to explore the potential for cancer networks to take a coordinating role in raising the profile of skin cancer and to influence key stakeholders in placing a greater emphasis on awareness and prevention.

The project set builds on the work of the South West Public Health Observatory Skin Cancer Hub and utilises the evidence base of the studies that have been undertaken by the University of the West of England. This includes the identification of a number of audiences that should be prioritised in skin cancer prevention work.

In March 2010, five half-day workshops were held with the local health communities in Devon and Cornwall to explore a more strategic and systematic approach to the commissioning of skin cancer prevention initiatives. Each workshop explored participants' views on strategies and tactics to reach six priority audience groups:

- Parents of young children
- Schoolchildren
- Teenagers
- Outdoor workers
- Sports and leisure participants and spectators
- Older people

Partnership working, particularly between the PCT and local authority, was recognised as vital in order to achieve meaningful outcomes. It was also felt that an important role for the Network was to co-ordinate approaches to national organisations and to help identify local leads for particular activities. Additionally, the development of clear and consistent messaging for each target audience group was seen to be critical.

The local health communities produced a wide range of intervention ideas, covering the short and longer terms, at low and higher costs. Wherever possible, opportunities to capitalise on existing work programmes were considered.

Suggestions include the incorporation of skin cancer into existing service level agreements with providers, influencing the policy of relevant national organisations, marketing activity with commercial companies and a sustained communications campaign. This report provides practical support to organisations wishing to undertake skin cancer awareness and prevention work.

HPV vaccination

A vaccine for human papillomavirus (HPV) was introduced into the immunisation programme in September 2008 for females up to the age of 18 years. The vaccine chosen for use in the programme was Cervarix, which protects against HPV types 16 and 18.

In England, a routine immunisation programme was undertaken, targeting 12-13-year-old girls (school year 8) and a catch-up programme for those aged 14-18 years. The phased catch-up was due should to be complete by July 2010.

The tables opposite show percentage uptake by age group, cumulative to March 2010.

HPV vaccine uptake since 2009: Data for the month ending 31 March 2010

Area	Routine cohort (%) Year 8 girls – 12/13-year-olds		
	Dose 1	Doses 1/2	Doses 1/2/3
Cornwall & IOS PCT	62	51	2
Devon PCT	83	75	34
Plymouth PCT	78	74	1
Torbay Care Trust	84	80	7
South West SHA	80	69	16
England	80	73	20

Area	Catch-up cohort (%) Year 13 girls – 17/18-year-olds			Catch-up cohort (%) Year 12 girls – 16/17-year-olds		
	Dose 1	Doses 1/2	Doses 1/2/3	Dose 1	Doses 1/2	Doses 1/2/3
Cornwall & IOS PCT	68	61	36	70	64	38
Devon PCT	61	55	26	67	59	30
Plymouth PCT	67	53	16	69	60	16
Torbay Care Trust	79	68	4	83	76	1
South West SHA	55	48	20	59	53	21
England	49	42	15	51	44	15

Area	Catch-up cohort (%) Year 11 girls – 15/16-year-olds			Catch-up cohort (%) Year 10 girls – 14/15-year-olds		
	Dose 1	Doses 1/2	Doses 1/2/3	Dose 1	Doses 1/2	Doses 1/2/3
Cornwall & IOS PCT	73	68	46	77	71	44
Devon PCT	75	65	24	77	68	310
Plymouth PCT	71	68	52	72	66	1
Torbay Care Trust	84	79	8	83	76	9
South West SHA	78	67	27	79	68	20
England	74	68	25	74	67	21

Data source:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116311.pdf

4 Diagnosing cancer earlier

The baseline assessment identified lung cancer as the major cancer cause of premature death in the Peninsula, particularly in deprived communities. It also highlighted that a larger proportion of lung cancer patients were presenting at a more-advanced stage in their disease, with the cancer having spread from the original site (distant spread).

	State at diagnosis			
Tumour site	Distant spread	Local spread	Organ confined	Not known
Lung	43	22	29	5
Lymphoma	19	15	38	27
Colorectal	16	20	47	16
Prostate	7	14	72	8
Breast	6	26	59	9

During 2009/10, the Network Patient Information Manager and Public Health Consultant worked jointly to develop a Network approach to raising awareness of cancer signs and symptoms among members of the public. In liaison with communication leads and public health teams, we looked at using targeted approaches, such as social marketing, to ensure that we got the message out, particularly to 'hard-to-reach' groups. Work included:

- Setting up a Social Marketing & Communications Group to review how social marketing techniques could be utilized across the Network to access hard-to-reach groups when raising the signs and symptoms of cancer and highlighting the availability of local information services
- Producing GP and public information for Ovarian Cancer Awareness Month, including a GP algorithm, media release, web-based information for PCT websites, and patient information leaflet on the signs and symptoms of ovarian cancer

The early diagnosis of lung cancer

A number of pieces of work were carried out on the awareness and early diagnosis of lung cancer in the Peninsula, supported by national funding. This involved:

- Meeting with key stakeholders in each of the PCTs
- Identifying key challenges
- Using the national Local Cancer Awareness Measure with a sample of people in the Peninsula
- Holding focus groups in four key target communities
- Making recommendations for development and implementation
- Running a significant event audit of lung cancer within Plymouth GP practices (see section below on primary care audit for more details)

The outcomes of this work were summarised in a report, 'Early diagnosis of lung cancer social marketing project'. The key recommendations are set out below:

The profile of lung cancer as a whole needs to be raised

- Cancers such as breast and bowel benefit from having a screening programme
- Need to ensure non-screened cancers are also promoted
- Opportunity to dovetail with screening communication to provide overview of all common cancers?

Demonstrate the impact of lifestyle factors on risk of developing cancer

- Develop evidence base and use as basis of messaging

Develop clear, concise and consistent information on symptoms

- Standardised list
- Provided with reassurance
- Communicated by person who has had symptoms and taken early action

Provide information on treatment

- Positive outcome case studies
- Include simple care-pathway information

Provide reassurance from medical professionals that it is legitimate to visit them

- GP-fronted campaign regarding symptoms and taking action for early diagnosis to provide 'permission' for attendance

- Encourage questioning, 'Is there anything else that is worrying you?', when patient does attend
- Professionals must be fully engaged in the intervention – it is a wasted opportunity to 'grant permission' to visit GP, for their concerns then not to be taken seriously

Develop alternative service models

- For example use of practice nurse, life check/MoT, community outreach, non-urgent health round-up sessions

For PCTs to co-operate and produce an interlocking programme

- Promote shared approaches
- Added value from working together

Undertake message and case study development

- Conduct further testing to refine and confirm most effective format
- Identify community 'champions'

Embed campaign messages with key audience-centred groups

- Workplace
- Social: social clubs, training classes

Synchronise and build from smoking messaging

Primary care audit

General practices in Plymouth were invited to take part in the National Cancer Action Team – Royal College of General Practitioners (NCAT-RCGP) primary care audit of cancers in primary care, and also to carry out significant event audits of the last two cases of lung cancer within their practice. Thirty-one practices took part. These were the key findings and issues identified:

- The success of the one-stop approach for diagnosis of breast cancer has been shown, with the main investigations (ultrasound and biopsy) performed at a single visit, leading to rapid diagnosis and specialist treatment. Can this approach be extended to other cancers?
- Where there has been a breakdown in the systems for patient management leading to avoidable delay, should this be classified as a serious untoward incident with hospital and primary care working together as a priority to understand the reasons and prevent recurrence? How could this be achieved?
- Primary care is a multi-professional service, and in some cases described in the audit patients presented initially to a practice nurse. Practice nurses need to be supported and receive education and training on the 'red flag' signs suggesting cancer. How best can this support and training be provided?
- Plymouth GPs are referring appropriately through the two-week wait arrangements but there are a range of patient factors which influence early presentation and attendance for diagnostic test and hospital assessments. How can practices, hospitals and the Cancer Network inform and support patients in this early part of the patient pathway? How can patient groups and Local Involvement Networks (LINks) contribute to this?
- Many patients with lung cancer have co-morbidities, particularly COPD. Changes in the nature of cough, symptoms such as weight-loss, chest pain, or increased fatigue and deterioration in spirometry should trigger referral for chest x-ray. Practices felt that they should lower their threshold for chest x-ray with any symptoms suggestive of lung cancer.
- A high index of suspicion should be maintained even if initial chest x-ray does not show a malignancy. Continuing symptoms or deterioration should be followed up through arrangements within the practice to ensure that further investigation is promptly arranged. This is sometimes described as 'safety-netting'.
- Members of the primary care team need to communicate regarding concerns and all clinical staff should have regular training and reminders of the red flag symptoms for lung cancer.
- Patient factors affecting presentation or agreement to investigation are significant. Continuity of care and good communication with patients, family and carers are important to early diagnosis.
- Rapid and accurate communication from secondary care of the results of investigations and diagnosis is essential to primary care teams. Lack of communication or poor communication can seriously affect the quality of care.
- Clinical guidelines are an important aid to diagnosis and referral within general practice, but cannot completely capture the complexity and variety of presentations in primary care.
- Significant event audit is a useful tool to examine care pathways for people with cancer.

Screening

Breast screening

- The Cornwall Breast Screening Service ran a project to improve uptake of breast screening. The learning from this work was shared with the Peninsula.
- A protocol for the surveillance of high-risk women was developed and commissioned.
- A patient information leaflet to support attendance at screening was developed.

- The link between deprivation and breast screening locally was established.
- The age extension for breast screening has been delayed by national issues. Providers will need one digital mammography machine to proceed.

Breast screening performance 2009/10

Service	Round length (50-70 years) % where first offered appointment is within 36 months of previous screen	Screen to routine recall % of results within 2 weeks	Screen to assessment % of women who attend within 3 weeks of mammogram
Cornwall	98%	98%	87%
North & Eastern Devon	89%	88%	61%
South Devon	98%	96%	93%
West Devon & East Cornwall	94%	93%	85%
South West SHA	95%	95%	81%
Operational standard	90%	90%	90%

Cervical screening

- The coverage of cervical screening continued to compare well with national averages but is nevertheless below the 80% desired.
- The Cancer Reform Strategy recommended that women receive the result of their smear within two weeks. This has been implemented in part of the Peninsula but further work is required to ensure this is available to all women.

Cervical screening performance 2009/10

PCT	Cervical screening coverage % less than 3.5 years since last test, 25-49 years	% of results within 2 weeks
Cornwall & IOS PCT	76.2%	40.1%
Devon PCT	78.4%	92.1%
Plymouth PCT	74.7%	56.1%
Torbay Care Trust	75.2%	94.1%
South West SHA	76.8%	55.3%
England	74.0%	44.6%

Bowel cancer screening

- Bowel cancer screening is now available for the whole population of the Peninsula, following the establishment of the service in East and North Devon, and in Cornwall. The South Devon Service is a national pilot for the age extension from 70 to 75 years. This began in September 2008 but was extended to the Plymouth part of the South Devon Bowel Screening Service in November 2009.
- The Network supported providers in the transition from national to local PCT funding for bowel screening.

Treatment & support

5 Ensuring better treatment

Going further on cancer waits

The Cancer Reform Strategy introduced a number of additional targets for the speed of treatment. Staff across the Network have put considerable effort into delivering against these targets, in particular clinical teams, information staff and the Network Service Improvement Team and Information Manager. The performance in March 2010 is given below.

Performance against waiting times standards – March 2010

Standard	Target period (days)	Operational standard	NDH	SDH	RDE	PH	RCH
Urgent referrals	14	93%	99%	98%	100%	96%	94%
Symptomatic breast referrals	14	93%	71%	98%	94%	96%	92%
Decision to treat to treatment	31	96%	100%	98%	97%	99%	98%
Subsequent treatment							
- Drug treatments	31	98%	97%	100%	100%	100%	100%
- Surgery	31	94%	100%	94%	93%	98%	91%
- Radiotherapy	31	94%	n/a	96%	81%	99%	97%
Urgent referral to treatment	62	85%	91%	89%	91%	90%	91%
Screening referral to treatment	62	90%	100%	90%	100%	100%	100%
Consultant upgrade to treatment	62	not set	100%	100%	100%	94%	100%

The speed of access to treatment from initial referral remains a vital part of the quality of care for cancer patients. However, the Network is approaching the point where these targets are routinely met, and more focus can be placed on the clinical outcome and patient experience of care. The Network will continue to be vigilant to ensure the sustainability of these standards, especially in light of the current financial pressures.

The National Cancer Peer Review Programme for the Peninsula Cancer Network

In April 2009, a new process for National Cancer Peer Review was introduced which incorporated an annual self-assessment process supported by a targeted visit programme. The process was designed to allow more up-to-date information to be available to support the commissioning of cancer services and patient choice.

The National Cancer Peer Review Programme and the Care Quality Commission (CQC) work together to determine compliance with standards of safety and quality. The data collected from the Peer Review process is shared with the CQC on an annual basis.

Within the Peninsula, the 2009/10 round of peer review focused on six site-specific groups across the Network; Breast, Lung, Gynaecology, Upper Gastro-intestinal, Urology and Skin. All of the groups followed a process of:

- Working together to agree the four key documents to evidence their compliance against the peer review measures (clinical guidelines, annual report, constitution and work plan)
- Completing a self-assessment against the peer review measures
- Undergoing an internal validation of the group alongside the Network team

The Breast and Lung groups' self-assessments were subject to external verification by the South West Peer Review team. The robustness of the PCN internal validation process was confirmed and given a 'green' rating. However, the overall compliance thresholds were rated as 'red', which meant the groups fell below the minimum 50% compliance threshold. Consequently the NSSGs will be visited in the 2010 /11 peer review programme.

The lack of agreement on reconfiguration of specialist services for the Gynaecology and Upper GI NSSGs, and subsequent lack of detail in the network clinical and referral guidelines, had an impact upon their compliance which in turn affected all Gynaecology and Upper GI MDTs across the Network.

The Urology and Skin Groups underwent an external peer review in March 2010. Areas of good practice identified across the groups included:

- Good engagement and involvement from commissioners at Network groups, which in turn have input into PCTs
- The Clinical Nurse Specialists, who are working well together across the Network
- Service mapping of the Skin Group
- Malignant melanoma pathway
- Urology recruitment to clinical trails

There were no serious concerns raised. However, it was recognised that the Network had a role in supporting the MDTs with any serious concerns raised within their teams.

The peer review compliance for 2009/10 across both the Network Board and Network groups was variable. It has been recognised that the Network Board and NSSG groups need to ensure they complete the annual process in a timely way to ensure that MDTs are not compromised, and that the good practice of engagement between commissioners and the site specific groups continues.

The Network is committed to ensuring that the Network groups are given the support and assistance required to enable them undertake further assessments in a meaningful way.

Patient engagement at Network Site Specific Groups

- Patient engagement within the Network Site Specific Groups is a requirement of the peer review process. It is recommended that at least two user representatives sit on each group; if this is not possible, then it is necessary to ensure that there is an agreed mechanism by which user representative advice can be shared. Within the Peninsula Cancer Network, this role is undertaken by the Patient Champion, who is usually a Clinical Nurse Specialist within the group.
- The Peninsula is lucky to have user representatives sitting on many of the groups. Their input and unique experience are valued and they consistently ensure that discussions and decisions are patient-centred. It is hoped we will be able to encourage more individuals to become user representatives in the future, as they are an invaluable source of support and advice. A handbook has been produced by the Network for patient members of Network groups. This has been distributed to both existing and new members to aid their understanding of their role and the purpose of the groups.
- A training day was sponsored by the Network for patient/carer representatives to look at the role of the user representative within Network Groups in March 2010. The Network plans to facilitate similar days annually.

Chemotherapy

Key achievements

- The Network undertook a local review against the national peer review measures early in the year. Then, in light of the recommendation from the National Chemotherapy Advisory Group (NCAG), the Network revised these measures so that providers could more clearly identify the local actions required by this report. The assessment against these revised measure will take place early in 2010/11. An overview of the challenges of this report has been shared with the Strategic Health Authority.
- Providers developed top-up payment policies for those drugs administered but not funded by the NHS.
- Electronic prescribing was further embedded at Royal Cornwall Hospitals, and the implementation of a new system began at Royal Devon & Exeter, Northern Devon Healthcare & South Devon Healthcare.
- All providers have a good understanding of their demand and capacity for chemotherapy. This has been achieved without the use of the national CPORT tool, which has proved difficult to use. Further refinements to this tool have encouraged the Royal Devon & Exeter to pilot its benefits again. The outcome of this will inform whether or not CPORT is adopted more widely in the Peninsula.
- NURB course continues to function, a well-established partnership module between South Devon and the University of Plymouth. This ensures that organisations that deliver

chemotherapy have qualified, competent nurses to deliver quality serfvies that are compliant with peer review.

- An audit of the pharmacy workforce was carried out, as the range of new national guidance for chemotherapy has significant implications for areas of pharmacy.
- The Network carried out an audit against the requirements of the National Patient Safety Alert on oral chemotherapy. This highlighted a number of challenges which providers have been addressing.

Challenges

- The sustainability of improved treatments is also reliant on support from chemotherapy nurses and the whole CNS workforce.
- The full implementation of an electronic prescribing system at Royal Devon & Exeter, Northern Devon Healthcare and South Devon Healthcare is taking much longer than anticipated. This is partly due to technical problems, but the project also requires a significant amount of clinical, administrative and information support time. The electronic prescribing system at Plymouth Hospitals is no longer supported by its supplier and a decision on the future of electronic prescribing at Plymouth Hospitals is needed.

Acute oncology

The National Chemotherapy Advisory Group recommended the establishment of acute oncology services at all hospitals that have an A&E. The Network agreed that the implementation of acute oncology needs to focus on delivering care in accordance with agreed pathways, but that each locality will achieve this in different way, given the different services available. Providers have been reviewing what work needs to happen locally to achieve this. This will be the focus of much further work in 2010/11, starting with a workshop in June.

Metastatic spinal cord compression

A group was formed across the Peninsula to examine how the measures for this condition could be met in each trust. Great progress towards compliance with the NICE Improving Outcome Guidance has been achieved. The progress is explained in the chart below:

Progress with metastatic cord compression

Requirement	Completed	Further work
Identify clinical leads	All trusts have named clinical leads	Pathways being written, and completed in most trusts
Information for patients	All relevant patient information shared between trusts	To monitor and audit the use of the documentation and gain patient feedback in 1 year on usefulness of literature
Appoint MSCC coordinator	All trusts have appointed to the post	An audit of the function and success of the posts will be conducted in the next year
MRI within 24 hours for all patients	Available and completed in all trusts	
Develop care pathway for treatment and care	Pathways developed in most trusts, and shared within group	RCHT to complete pathway
Data collection required	Data being collected in PHT and RDEFT. Other trusts to organise data collection as required. First year review of data and case discussion has taken place	To ensure that all trusts are able to collect data. To ensure all information and data available for the next review in mid 2011.
MDT treatment planning	Agreement between all trusts as to how this will operate	To monitor all cases and review 6 monthly
Radiotherapy available as required for patients who cannot have surgery	Available in all trusts. NDDH patients automatically treated at RDEFT	
Surgery available for patients as required – first line treatment preference	Surgery being conducted as required in PHT and RDEFT. Case reviews demonstrate increased number of surgical cases since the guidance. First annual review of outcomes has been completed.	To monitor and review surgical rates and outcomes annually

Radiotherapy

The National Radiotherapy Advisory Group (NRAG) report was published in February 2007, setting out the national ambition for radiotherapy services. This vision was endorsed by the Cancer Reform Strategy (December 2007). The key challenges are:

- Significantly increasing the amount of radiotherapy delivered
- Achieving a 31-day wait for all radiotherapy by December 2010
- Adopting new radiotherapy techniques that allow larger doses of radiation to be targeted at tumours whilst reducing radiation to other tissues
- Introducting a mandatory minimum dataset from April 2009

The Network has continued to respond to these challenges. This culminated in a Network Radiotherapy Event in February that enabled providers and commissioners to discuss challenges for radiotherapy.

The Network Board agreed that it would commission an increase in activity in line with demographic growth. A new linear accelerator was installed in the Royal Devon & Exeter and a new wide-bore CT funded for South Devon Healthcare. Both Royal Cornwall Hospitals and Plymouth Hospitals have business cases for the replacement of their linear accelerators.

All of the providers are developing plans for the introduction of new techniques for the delivery and quality control of new techniques

Providers also began to submit information to the new national dataset. This has enabled a more complete and consistent analysis of activity to be carried out.

Breast cancer

Key achievements

- The Breast Group took part in the new peer review process, carrying out a self- assessment which was validated by the Network team. This was challenging for the Group but ultimately resulted in a greater level of agreement on the clinical guidelines for breast cancer in the Peninsula.
- The Group agreed breast care guidelines, which were written by the breast care nurse members of the group.
- The Group agreed to introduce intra-operative sentinel node biopsy assessment, following its development at the Royal Devon & Exeter.
- Guidelines were agreed for:
  - breast care
  - staging, pathology
  - adjuvant endocrine therapy
- Improvements were made in access to HER2 testing.
- The Group discussed and provided support for implementation of the new cancer waiting times targets, especially the symptomatic breast two-week target.
- An audit of patients against the agreed pathway was carried out. It was noted that, with the exception of one patient, all had met the 31-day target.
- A sub-group was set up to look at follow-up.
- 500 patients were recruited into breast cancer trials.
- An event for users was held on 11 March 2010.
- A service portfolio was developed, outlining the services, personnel and equipment available at each of the five acute hospitals. This is used to identify any gaps in provision for patients in the Peninsula.

Challenges

- At this time, management arrangements for the commissioning of services remain uncertain. It is inevitable that financial constraints will be high on the agenda and service development will require that improvements are achieved by cost-neutral or cost-saving initiatives. It is important that clinical excellence and patient-focused care be achieved and maintained despite the wider pressures.
- A key area requiring particular attention for the coming years will be the management of patients post-treatment and of ongoing reviews. The Group will need to develop a strategy for communicating its purpose to the emerging GP consortia if the vision for Peninsula-wide working is to be achieved.

Children and young people

Key achievements

- The providers of children's shared care began assessments against the new peer review measures for children's cancers. This work will culminate in a self-assessment as part of the 2010/11 round of peer review.
- The Royal Devon & Exeter, Plymouth Hospitals & Royal Cornwall Hospitals agreed that they would all like to be designated as shared-care centres for teen and young adult cancer. They have prepared an outline of the developments required to comply with the guidance on such services.

- Shared care arrangements for children living in North Devon are now supported by the Royal Devon & Exeter.
- The referral process and form for children with suspected cancer were clarified.
- A project looking at the support of survivors of childhood cancer was begun, with national funding.

Challenges

- The Group identified issues with the urgent transfer of very sick children, which is being picked up by the Specialised Commissioning Group.
- The absence of a South West Children & Young People's Group remains an issue, as this is the place where the principal treatment centre and the shared-care units need to agree guidelines and discuss service issues.

Colorectal cancer

Key achievements

- A Network Anal Cancer MDT has established where all cases are discussed and data collected. The virtual MDT is be hosted by each of the five acute trusts on a rolling programme. The Royal Devon & Exeter has hosted this meeting for the first year. Feedback from all five local MDTs is that this is an excellent solution for local patients in ensuring high-quality care closer to home.
- All trusts participated in the National Bowel Cancer Audit. The overall aim is to measure the process of care and clinical outcomes, enabling comparisons against specific standards and between hospitals, bringing about improvements where necessary.
- The group agreed to complete an audit of colorectal stenting in the Peninsula, to complement participation in the CREST study, including cases from January 2008 to the end of December 2008.
- The group completed an audit against the agreed pathways to identify areas for improvement within localities.
- An education event was organised by the NSSG Education Lead.
- A Network-wide patient survey was piloted and rolled out across the Network. Individual trusts have presented their local information and the collated Network results were due to be presented in October 2010.
- There was participation in the National Information Pathways & Prescription project.
- There was continued success in laparoscopic training, with the national lead based in Peninsula.
- The enhanced recovery programme was adopted as part of QIPP agenda.

Challenges

- All core MDT members attended the Network Advanced Communication Skills Training programme.

Endocrine and thyroid tumours

Key achievements

- A service-mapping exercise of endocrine and thyroid cancer provision has been undertaken by the service improvement facilitators, which will inform future service provision and new initiatives.
- The Group was able to discuss concerns around the referral of paediatric patients with thyroid cancer with the regional treatment centre.
- In-depth case reviews are shared at each NSSG meeting, which encourages shared learning and good practice.
- Members of the group presented their data for the BAETS audit (British Association of Endocrine and Thyroid Surgeons).

Challenges

- A mapping exercise is being undertaken by the Network to establish the CNS workload for head and neck patients, which will also inform endocrine and thyroid provision. It has been recognised that there may be inequality in the provision of dietetic services across the Peninsula. An AHP lead, appointed by the Network, will be looking at the provision of AHP services, including workforce issues. The Peninsula continues to have difficulty in recruiting into physicist posts.

Gynaecological cancer

Key achievements

- The Network Board commissioned an independent clinical review of gynaecological cancer services in the PCN.
- The concept of NSSG quality circles (QCs) was introduced
- Annual review of NSSG treatment guidelines and pathways was introduced. The pathways for the management of all gynaecological cancers have been broadly agreed but will be revisited following the review of the PCN gynaecological services.

- The clinical guidelines developed by the SW Gynaecology Tumour Panel have been adopted.
- The concept was introduced of commissioning-based thinking in the introduction of Gynaecological Cancer Management protocols in the Network. A current NSSG project 'PET CT and cervical cancer' is being coordinated by Dr Sarah Higgins, SDHCT.
- Lead persons were identified to coordinate and advise on specific NSSG activities and lead QCs.
- Revised FIGO classifications were introduced for the management of vulval, cervical and endometrial cancers and for staging of uterine sarcomas.
- The Group has adopted the audits of the SW Gynaecology Tumour Panel.
- There was participation in clinical trials.

Challenges

- The configuration of specialist surgical services has yet to be resolved. The review that took place in the autumn of 2009 recommended Truro as the second specialist centre in the Peninsula. However, as a result of the Government's new key tests governing reconfiguration and the recommendations from the Independent Review Panel (IRP) into upper gastro-intestinal cancer, the PCN took the decision to review its processes into service improvement where there was the potential for reconfiguration to result. This has resulted in a developmental process, involving patients at a more formative stage and asking clinicians to collaborate on the clinical case for service improvement. Gynaecological cancer services, from diagnosis to follow-up care, will be the first to be developed in this way.
- The increasing workload and lack of funding and clerical support for Clinical Nurse Specialists will have an effect on the potential for nurse-led follow up.
- Support for audit will be needed as the SW gynaecological tumour panel may disappear with the retirement of the lead.

Head and neck cancers

Key achievements

- A mapping exercise is being undertaken by the Network to establish the CNS workload. It has been recognised that there may be inequality in the provision of dietetic services across the Peninsula. An AHP lead, appointed by the Network, will be looking at the provision of AHP services, including workforce issues. The group discussed the reasons why there were difficulties recruiting physicists across the Peninsula, and their concerns were raised with the Network.
- All Trusts continue to participate in the national audit for head and neck cancer.
- The group agreed to carry out an audit of gastrostomies in head and neck patients, which would include prospective and retrospective data and link with data from other published audits.

Challenges

- Following revisions to the way in which the Network develops plans for improving services, the modified process will be used first for gynaecological cancers and then for head and neck cancers. The aim will be to strengthen care along the entire patient 'pathway', including diagnosis, chemotherapy, radiotherapy, surgery and follow-up.

Haematology

- The Group described in detail the issues relating to a proposed reconfiguration of haematopathology diagnostic services, including the drafting of a service specification. This proved invaluable in discussions with the Strategic Health Authority and the National Cancer Action Team to agree the way forward.
- The Haematology Handbook was revised, with further revision expected in 2010/11.

Lung cancer

Key achievements

- All trusts continue to participate in the national Lung Cancer Audit. The Group has confirmed its commitment to this audit and the validity of its nine clinical outcomes. The results from the latest annual report (Jan to Dec 2008) prompted significant discussion in the Network, culminating in agreement at the Network Board that this information should be reported quarterly to commissioners. The importance of ensuring that the clinical teams trust the accuracy of the data was also established.
- The Peninsula mesothelioma audit reported this year. The audit aims to define the demographics of the patients suffering with, and being treated for, mesothelioma in the Peninsula. The ultimate aim of the project has been to aid the creation of a Peninsula-wide mesothelioma specialist MDT. These results and others were due to be presented at the British Thoracic society winter meeting in 2010.
- A lung cancer pathway audit was carried out.
- There was analysis of EGFR mutations in non-small lung cancer (see Research section).
- EBUS experience was reported (see Research).

- A research report was produced.

Challenges

- Establishment of specialist MDTs for mesothelioma.
- Advanced communications skills training for all core MDT members .
- Regular specialist palliative care input into all MDTs.

Brain and CNS tumours

Key achievement

- The Neuro-science MDT is working well, with good attendance.
- A Network brain and CNS tumours MDT is being piloted.
- There are regular pituitary and skull-base MDTs. Spinal cord tumours are reviewed on a case-by-case basis within the neuroscience MDT.
- Timely neuropathology and neuroradiology services continue to be delivered, including image localisation and stereotactic techniques.
- Allied health professional and rehabilitation services within the Peninsula have been mapped.

Challenges

- The role of the designated leads, as laid out in the IOG, has been hampered by the slow development of IT facilities, particularly with regard to external access to the Taunton and Somerset Database, hosted at Derriford. Agreement has now been reached with the IT department in Plymouth, and within the coming months it will be possible for MDT members from the other acute trusts to access data relating to their own patients. This will allow the responsible clinicians to ensure that all patients from within their area are being managed in accordance with the IOG.
- Further work is needed to ensure all patients in the Network with brain or CCNS tumours are discussed at the appropriate MDT.
- There is no regular palliative care representation at either MDT.

Sarcoma

Key achievements

- The Network supported the Specialised Commissioning Group in its role of commissioning a soft tissue sarcoma service that is compliant with the Improving Outcome Guidance. This included the writing of three service specifications, and supporting engagement with the public and Overview and Scrutiny Committees.
- A poster was developed for GPs on the signs and symptoms of soft tissue sarcoma.

Challenges

- The proposed reconfiguration of soft tissue sarcoma services has been delayed. This uncertainty has hampered the ability to develop the pathway of care for patients.

Skin cancers

Key achievements

- Skin cancer guidelines were agreed, including pathology and imaging.
- Management of community skin cancer was agreed in line with published peer review measures and revised in light of a draft rewrite of the NICE Improving Outcomes.
- The Skin Cancer IOG implementation Plan was revised.
- Arrangements were agreed for specialist MDT discussions of melanomas.
- Development of Mohs surgery at Royal Devon & Exeter was agreed.
- A care pathway for melanoma was agreed and audited. The audit showed good adherence to the agreed pathway and some suggestions for development were made. This audit is conducted by the Network Service Improvement Facilitator for Skin Cancer.
- Network-wide audit of histopathological margins for melanoma was agreed. Prospective data collection has begun.
- Initial service mapping was carried out.
- The Network was selected as lead network for skin cancer, and national funding secured for a project on skin cancer awareness.
- An approach to the management of Mekel Cell tumours was agreed, pending a national update.
- The Group underwent its first peer review.

Upper GI cancers

Key achievements

- Following an extensive review the Peninsula Cancer Network Specialist MDT and Specialist Surgical Service began in January 2010, based at Plymouth Hospitals. The Network put in considerable work to ensure the quality of care and patient experience for all patients across the Peninsula. The outcomes from the surgical team and from patient feedback are monitored quarterly; both are showing promising results. The decision to reconfigure surgical services for Upper GI Cancer was endorsed by the Independent Review Panel.

- The fourth annual Derriford Hepatobiliary study day took place on 25 June 2010.
- An audit of the time taken for patients to have their treatment found that everyone was being seen within the target time. The Peninsula was also active in submitting data for a published audit on the use of PET CT in oesophageal cancer.
- Following implementation of the Plymouth Upper GI service, surgical audits have commenced; these will be presented to the NSSG every six months.
- There has been analysis of patients who have undergone pancreatic surgery from 2006 to the present day; this is an ongoing piece of work which the NSSG will continue to support.
- The Network has continued to input data into National Oesophago-Gastric Cancer Audit. A summary of findings was produced by the Informatics team, fowming the basis of a presentation to the Group by the Network information manager.
- The Group agreed to undertake a three-month audit of management and outcome in deep vein thrombosis and pulmonary embolism among Upper GI cancer patients.
- An Oesophageal and Gastric Patient Regional Support Meeting took place in June.
- A survey of patient satisfaction one month post-operatively has been completed.

Challenges

- The workload is increasing in the areas of speech and language and of dietetics across the Network; although there is no extra funding for this, the Network will monitor the issue and make recommendations through commissioning if necessary.
- The group recognised a need for additional resources to be made available to CNSs. It was suggested that a Band 4 clerical post was required together with a Band 5/6 CNS post at Plymouth. Commissioners were to be advised that more resources were needed.

Urological cancers

Key achievements

- Urology cancer guidelines were agreed, covering testicular, bladder, prostate, renal and pathology.
- There was a submission to the BAUS dataset.
- Audit of Taxotere in hormone-refractory prostate cancer was carried out.
- The timing of testicular prosthesis was audited. This audit highlighted improvement in the way prosthesis is offered and discussions detailed in the notes. Patient satisfaction surveys indicate a good level of satisfaction amongst those given a testicular prosthesis.
- An audit of the care pathway for urological cancers was carried out. The audit showed good adherence to the agreed pathway. The exercise highlighted consistent contact with nurse specialists, including the use of telephone follow-up. Documentation is improving – for example, detailing research trial information. Recent patient transfer events revealed some issues around capacity, not just around the number of patients being transferred between trusts but the movement of complex cases and the impact this has on resources.
- Initial service mapping was carried out.
- Charitable funding for CNS posts was picked up by acute trusts.
- Recommendations were made on the role of High-Intensity Focused Ultrasound (HIFU) for prostate cancer.
- The role of LHRH antagonists for patients with prostate cancer was agreed.
- A working group was set up to look at robotic surgery.
- Plymouth Hospitals and Royal Cornwall Hospitals began holding joint MDT meeting via video conferencing.

6 Living with and beyond cancer

Much of the work involved in this service is being conducted through the supportive care agenda. Ensuring information and advice for patients are maintained is a pivotal part of ensuring achievement in this area.

- Cornwall Libraries Project: The Network has secured a Macmillan-funded post to support patient information improvements in Cornwall, alongside health through existing library facilities. The aim of this project is to work with Cornwall Libraries and its staff to improve patient and public access to cancer information across the whole county, using the infrastructure of Cornwall libraries and their mobile facilities. This project is unique for Macmillan, Cornwall Council and the Peninsula Cancer Network, and will certainly draw great attention nationally from those looking at how to deliver information in rural communities. A project manager has been appointed and the project should come to fruition in the summer of 2011.
- The Mustard Tree in Plymouth has also been awarded a significant grant from Macmillan to support expansion of its operations, focussing on delivering the survivorship agenda to patients during and after treatment.
- Advanced Communication Skills Training continues for all core members of a cancer MDT. More than 120 people have been trained in 14 courses during the year, feedback being positive and of benefit to clinical care.
- Specialist Palliative Care NSSG worked together to produce a Network-wide service specification in June 2009. Following a RAG assessment, the outcomes of these were presented to the Network Board.
- A Holistic Needs Assessment tool has been agreed by all the lead cancer nurses, which will allow all cancer patients to be assessed at key stages of their cancer journey. The rollout of the tool will continue across the trusts in the coming year.
- A Key Worker Network-wide policy, which outlines the key worker roles along the pathway, has been agreed and disseminated. Each MDT operational policy includes local implementation processes for the Network key worker policy. The implementation of a patient key worker has been subject to peer review; the Network performed well against this standard.
- Rehabilitation funding for a Network Lead Allied Health Professional has been received from Macmillan for two days per week for three years.
- General Palliative Care and End of Life Care continues to be led at a PCT level with input from the Network as required.
- Macmillan has again shown immense support for the Peninsula, with funding now reaching over £2.5 million in the last two years. In addition to the Cornwall Libraries project and the Mustard Tree, Macmillan funding includes North Devon welfare benefits advisor, Network lead AHP post, Network psychology project manager post (to be filled), and GP facilitators in Devon. It is anticipated that over the next 12 months this will continue to rise as applications and project ideas continue.

Patient information

Patient Information Prescriptions

Ensuring that patients receive written information which meets their needs at all phases of the care pathway is a high priority within the Cancer Reform Strategy.

The National Cancer Action Team has undertaken a programme of work since 2007 to drive forward the implementation of patient information pathways and prescriptions for cancer patients and their carers. This has involved developing tumour-specific National Information Pathways for all common cancers by the end of 2010 to:

- Develop a training and support package for cancer information prescriptions delivery
- Develop, in partnership with Macmillan Cancer Support and Cancer Research UK, an electronic web-based information tool to support healthcare professionals in delivering tailored information prescriptions to cancer patients at the point of need
- Develop an e-learning tool to support healthcare professionals in using the web-based information tool
- Pilot the electronic information tool in a number of NHS settings to inform the development of the web-based information tool

What is happening across the Peninsula?

During 2009/10, three out of the five acute trusts in the Peninsula undertook pilots of the National Information Prescription delivery system. The aims of the pilots were to test the information provided on the national pathways, look at the functionality of the online system that delivered the patient information prescription, provide feedback on the concept, and provide a greater understanding around future staff support and training requirements.

The following people were involved in the pilot:

- Plymouth Hospitals NHS Trust – Urology CNSs Vanessa Wilcox & Jane Gosling
- Northern Devon Healthcare NHS Trust – Colorectal CNS Karen Day
- Royal Cornwall Hospitals NHS Trust – Colorectal CNSs Claire Ferris and Candy Coombe

Patients and clinicians across the Peninsula have been active in supporting the development of the National Information Pathways. More than 20 consultants and clinical nurse specialists across the Peninsula have been involved in the National Information Pathways tumour- specific reference groups, which check the clinical accuracy of the information on the pathways. Two patients from the Peninsula have also joined the National Patient Reference Group, which looks at the accessibility and readability of the information from the patient perspective.

We are now entering the implementation phase for the Information Prescriptions Project and by the end of 2012 it is hoped that all cancer patients and their carers will be able to access information specific to their requirements, via an information prescription.

The Network has been supporting this by:

- Integrating information prescriptions into patient information development plans for the Network
- Participating in a train-the-trainer programme and training colleagues to offer cancer information prescriptions
- Supporting integration of information centres into the implementation of cancer information prescriptions
- Coordinating the production and updating of local content (such as lists of MDT members) for the NHS trusts within the Network to be included in the NHS Choices information prescriptions service
- Liaising with people who are implementing information prescriptions for other long-term health conditions, particularly in primary care
- Developing links in the community (with GPs and libraries, for example) for co-ordinated cancer information
- Supporting the roll-out of information prescriptions in primary care
- Ensuring that materials in non-print formats and languages other than English are accessed as part of the information prescriptions developments

Partnership working

The Network held a user involvement event at Holne Park in September 2009 to promote engagement with patients and carers who had experienced or been affected by cancer. Fifty people attended from Devon and Cornwall, representing local user groups, support groups and interested individuals.

The day provided time to discuss how user involvement could be developed and many different ideas were captured, as well as identifying the different levels of involvement in which people were interested.

The creation of a new Partnership Group was begun. A consensus was reached that engagement with users on improving and developing of specific services should happen through the vibrant local user groups, with the Partnership Group ensuring that the overall approach to engagement was right.

As a consequence it was agreed that the development of a Cancer User Group for Plymouth Hospitals was a priority. The Network Patient and Public Involvement Lead continues to attend all five local groups and facilitates three groups. Improved links with support groups is developing in some areas with some members of support groups joining local groups.

Further developments to engage with patients and carers, cancer charities and LINks were being planned, with a event arranged for December 2010.

Network website

As part of the redevelopment of the Peninsula Cancer Network website, the patient information section for the public and health professionals has been revamped. In the public section, you can now find useful links to both national and local information resources. The sections cover the following topics:

- What is cancer, cancer awareness
- Types of cancer
- Tests, treatments and links to other support, such as help with financial or employment issues

You can also access information about the local cancer information and support centres as well as details of patient and carer support groups across the Peninsula.

The patient information section of the website aimed at professionals working in cancer services across the Peninsula, provides the latest details about local and national work that is taking place.

Building better care

7 Reducing inequalities

The principal aim of the Network is to ensure that all patients in the Peninsula have the same access to high-quality services. This is achieved through the work of Network Groups in agreeing Network guidelines for treatment, the collection of outcome measures and audits, and the mapping of services against agreed pathways of care.

The Network established a Health Equity Group, which coordinated an assessment of the actions being taken by each PCT, as deprivation is linked with diagnosis at a later stage of cancer and hence poorer outcomes. This was felt to be particularly important with regard to screening and early symptom reporting. The Network carried out work in conjunction with a social marketing company looking at barriers to early diagnosis.

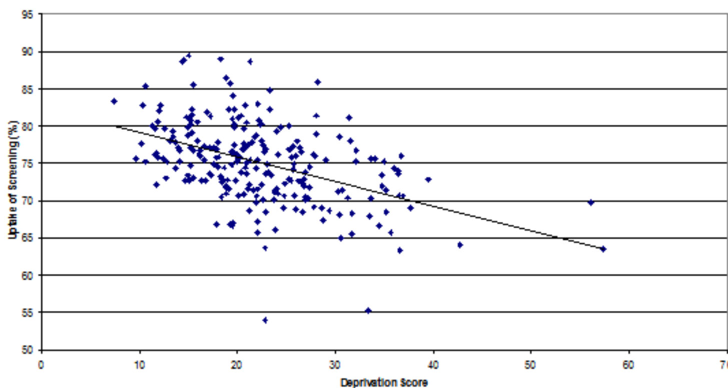
Key findings include:

- Uptake of both breast and cervical screening is inversely associated with increasing socio-economic deprivation; the uptake falls as deprivation increases. The same inverse association holds for all primary care organisations in the Peninsula.
- Practice size and rurality have little influence on this association with deprivation, except for cervical screening in small practices. Small practices achieved a better uptake of cervical screening in more-deprived populations. Only 9.2% of the eligible population for cervical screening is registered with small practices.
- Cervical screening uptake is lower in 25-29-year-old women, but the inverse association with deprivation persists.

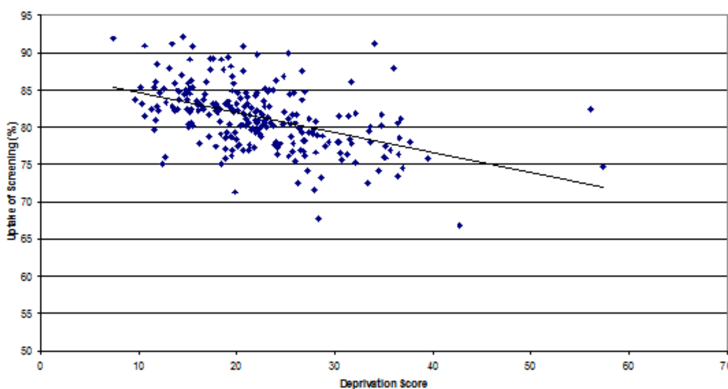
The scatter graphs below show the association between practice deprivation score and the uptake of breast and cervical screening. Each point represents the deprivation score for the general practice population plotted against the screening uptake rate. A full report of this work is available from the Peninsula Cancer Network office.

A similar association has been demonstrated for bowel cancer screening, using general practice uptake rates for people offered screening through the South Devon Bowel Cancer Screening Centre.

Uptake of breast screening (2007/08) across the SW Peninsula by IMD score



Uptake of cervical screening (2007/08) across the SW Peninsula by IMD score



8 Care in the most-appropriate setting

Providing care in the most-appropriate setting features in many of the developments described in this report. The following list highlights the most significant:

- **Follow-up**
  All the NSSGs are in the process of reviewing the follow-up offered to patients after their active treatment has ended.
- **Rehabilitation**
  Ensuring the provision of appropriate rehabilitation in the community.
- **Acute oncology**
  Ensuring cancer patients admitted as an emergency receive the appropriate care, including rapid referral on to hospices.
- **Oral chemotherapy**
  Ensuring the safe delivery of oral chemotherapy in line with the NPSA safety alert.
- **Enhanced recovery**
  The Peninsula has a number of national leaders for enhanced recovery, which supports earlier discharge following surgery.
- **Configuration of specialised services**
  The reconfiguration of surgical services for upper GI cancers, for example.
- **End-of-life care**
- **Cornwall project**

9 Using information to improve quality and choice

Types of information

The Network has identified four key types of information that support quality and choice:

1 Clinical outcomes

The Network Board and the Clinical Advisory Group agreed the importance of robust clinical outcomes. This work is supported by national audit in cancer for lung and colorectal. The Network has agreed to move to quarterly reporting of the key outcome measures for lung cancer, as set out in the National Lung Cancer Audit. The Board anticipates adopting this approach for all cancer sites, beginning with the other three sites where there are national audits (colorectal, upper GI and head & neck cancers). Tumours without national audits will be expected to agree clinical outcome measures locally.

2 Patient experience

Regular surveys of patient experience are conducted by the clinical nurse specialists for each tumour site and in each acute trust. These take a variety of forms, from questionnaires to patient stories and observations of care. The Network also has access to the national surveys of patient experience.

3 Timely access to care

Timeliness of care is important both to improving clinical outcomes and to good patient experience. Reports set out performance against a range of standards on the timeliness of care, in particular the extension of waiting time standards to new parts of the patient pathway.

4 Productivity

The Network has identify three priority areas for improving productivity in cancer services:

- Enhanced recovery following surgery. The Network has a number of national leaders in this area and will be using their expertise to support the introduction of enhance recovery across the Peninsula
- Follow-up after the completion of active treatment. The Network has begun a project to review the patterns of follow through the Network Groups.
- The use of high-cost drugs. The Network continues to be an active member of the Peninsula Health Technology Commissioning Group, where decisions are made on the commissioning of drugs and health technologies.

The process of collecting information

In recognition of the importance of good information, and of the complex nature of cancer information collection, the Network has carried out a data-mapping project. The aim was to examine how data collection was operated in each trust, with a view to sharing good practice and understanding common problems.

The Service Improvement Team has reviewed the data-collection processes at each trust in considerable detail and highlighted a number of areas where processes could be improved to ensure high quality and timely data. This work will form the basis of a range of improvements in the coming year. The following general issues were highlighted:

- A variety of systems and processes are used across the Peninsula.
- Not every trust has a dedicated audit team or specific time allocation to collect data for audits.
- The varied usefulness of some of the data can at times impact on clinical involvement in data collection.
- Collection of data varies between trusts as to whether prospective or retrospective. If retrospective, this is usually a workforce and time issue.
- Very little cancer waiting time data is collected at the MDT

10 Research

Key achievements during 2009/10

Portfolio

During 2009/10, the Peninsula overall recruited 1,967 patients into 99 trials across 18 NCRI Clinical Studies Groups. Compared to 2008/09, this represents increased activity of 39% in randomised control trials (RCTs), 105% in non-RCTs, and overall an 85% increase for all trials.

There was significant increased activity in breast, colorectal, gynaecological, primary care and upper GI (non-RCTs), with general increased RCT activity particularly in head and neck, lung, haematological and complementary therapy trials.

Recruitment

The Network recruited 8.7% (surpassing NCRN target of 6.5%) of incident cancer patients (including those with a pre-malignancy) into NIHR portfolio RCTs (commercial and non-commercial) during 2009/10.

The Network recruited 24% of incident cancer patients (including those with a pre-malignancy) into all NIHR portfolio RCTs (commercial and non-commercial) during 2009/10.

The year also saw recruitment of 15 patients to seven NIHR commercial trials across 10 sites, with three further trials opening soon and three trials now closed.

Comparative performance

Overall, 1,953 participants were recruited to NIHR cancer portfolio studies (patients and volunteers) during 2009/10, with a further 14 recruited to additional sub-studies, giving 1,967 participants in total. This was the Network's best-performing year overall.

The total number of cancer patients (cancer and pre-malignant) recruited since 2001 is 9,464, with a further 1,394 participants supporting screening and prevention studies (an absolute total of 10,858).

Network resources

Approximately 42.5 WTE individuals are now involved in recruiting or supporting recruitment to NIHR cancer portfolio studies across the network.

The PCRN funds 17.4 WTEs, and therefore financially supports 40% of the workforce. This excludes the many supportive clinicians, investigators and service staff.

Staffing structure

The year saw the appointment of a lead oncology research nurse at Plymouth Hospitals and new Oncology Trials Manager at Royal Devon & Exeter, bringing much expertise and new ideas to the network.

There was significant re-structuring of workforce and skill mix at Plymouth to deliver a broader portfolio of trials supported by both trust and network.

The oncology research team at Northern Devon Healthcare is now supporting haematology trials and increasing RCT trials, and a new R&D Manager is driving forward policies, processes and performance management.

Workforce development

The RNM is the leading Central region (12 NCRN Networks) training and education group. The focus is on delivery of cancer specific training across the region and aims to improve equitable access to training.

The Plymouth Hospitals lead oncology and trust lead research nurses delivered training on: ICH GCP, IRAS, centrifuge, dry ice, CSP, essential skills for new staff, essential and mandatory training, Research Network Forum, archiving, KSF and appraisal. This enhances skills, and improves confidence, credibility and competence in delivering safe research to their patients. There is a proposal for a student nurse placement for three months in clinical research, in collaboration with the Clinical Nurse Education Team.

A senior research practioner was appointed at Royal Devon & Exeter in December 2009 (FSF-funded), leading to the expansion of the surgical breast portfolio. This has led to some very innovative changes, greatly enhancing the support to these trials, with success both in delivery and changing research practice.

There has been similar success at Royal Cornwall Hospitals with lung, gynaecological and surgical breast and radiotherapy studies, with a highly-motivated team, as evidenced by strong recruitment activity.

Consumer involvement

The PCRN has been well-supported by two members on the Steering Committee and support on the FSF funding panel.

An audit is planned looking at topics like patient information and awareness of trials in the region. The aim is to monitor the contributions from the clinical trial team; improve service delivery and identify areas for improvement.

Key priorities for 2010/11 and beyond

- **Support to Site Specific Group (NSSG) Research Leads**
  To lead site portfolio development with better definition of roles and responsibilities. More frequent but simplified research reports.

- **Develop a more-robust centralised approach for peer review measures**
  To fully integrate the multi-disciplinary team (MDT) and Network Site Specific Group (NSSG) Research Peer Review measures so activity is reviewed annually, areas for potential growth/ increased activity are developed and findings feed into the reporting process.

- **Ensure training provision reflects assessed training needs**
  The PCRN identified priorities for training via an online survey. The aim is to repeat this annually and build into the Central regional training strategy. Develop local delivery in tandem with this and other provision by trusts and CLRN.

- **Maintain/increase recruitment**
  Build on successful achievements, in urology, surgical breast, gynaecology and lung trials, for example. To encourage new sites such as palliative care and skin cancer. To work with CLRN to deliver more radiotherapy trials.

- **Maximise potential participation in industry trials**
  PCRN will pilot whether increased data manager support to commercial trial feasibility, costings and set up, results in increased Peninsula site selection, and facilitating recruitment of these trials to time and target.

11 Finance

Peninsula Cancer Network Income & expenditure 2009/10

Description	2009/10 Funding source Total	2009-10 Expenditure Local	08-09 C/fwd	Allocations	Income	Budget	Pay	Non-pay	Income	Variance -fav/+adv
Cancer Network	704,334	479,334	185,000	40,000	-	704,334	505,847	145,184	-29,667	-82,970
CSC	511,000	-	-	511,000	-	511,000	396,384	75,860	0	-38,757
MacMillan	53,393	-	-	-	53,393	53,393	29,316	8,700	0	-15,377
NCAT Projects	295,000	-	-	180,000	115,000	295,000	0	132,422	0	-162,578
Advanced Comm Skills	130,000	-	-	-	130,000	130,000	0	70,923	0	-59,077
PCRN Research	514,596	-	-	-	514,596	514,596	67,791	438,929	0	-7,876
Flexibility & Sustainability	137,232	-	-	-	137,232	137,232	148,768	0	0	11,536
Cancer Commissioning	0	-	-	-	-	0	0	74,897	0	74,897
Pathology	0	-	-	-	-	0	0	1,100	0	1,100
Palliative Care	0	-	-	-	-	0	0	1,116	0	1,116
Network Events	0	-	-	-	-	0	0	5,112	-7,321	-2,209
End of Life Care	24,000	-	24,000	-	-	24,000	0	0	0	-24,000
	2,369,555	479,334	209,000	731,000	950,221	2,369,555	1,148,105	954,244	-36,988	-304,194