# AnnualReport 2008/09

Peninsula Cancer Network NHS
Devon and Cornwall

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Chair's report:

# The delicate task of putting guidance into practice

I feel a great sense of responsibility in following Peter Colclough in the chairmanship of the Peninsula Cancer Network Board, when he took on the role of Acting Chief Executive at Royal Cornwall Hospitals NHS Trust.

The Board has benefited from Peter's wide experience and he has provided valuable continuity for the Network through three phases of NHS reorganisation since it was formally established in 2001.

As soon as I took over the chair I was delighted to be involved in the eighth Annual Network Day at Buckfast Abbey and was impressed by the broad spectrum of topics covered and the clear engagement of all our NHS and voluntary partners in the work of developing cancer services in the Peninsula.

One of my early priorities has been to support completion of the implementation of the outstanding Improving Outcomes Guidance. Great progress has been made with the clinical reviews of upper gastro-intestinal cancer services, but the translation of recommendations into service changes is a delicate task and in this I have welcomed the support of my fellow Chief Executives in Trusts and PCTs.

The Cancer Reform Strategy provides a fresh set of challenges to Peninsula health services, and I look forward to working with the Network executive team in developing the policies and processes to turn its ambitious objectives into reality.

The strategy sets out a broad and ambitious scope for our future work. I want to see the Network Board and its constituent members making headway across the primary and community service areas, as well as improving specialist hospital care.

Finally, I thank my colleagues at Torbay Care Trust in supporting me in this new role and providing excellent hosting services to the Network.

**Anthony Farnsworth**
PCN Chairman

**Former Chair's report:**

# The increasing degree of collaboration between clinicians

I find myself reflecting on the eight years I have been Chairman of the Peninsula Cancer Network Board.

We have been fortunate in that the Network has consistently received support from all the original 11 – and now four – primary care trusts, the five acute NHS trusts and the hospices within the Peninsula. Without that support there would be no Network and the public we serve would not have had the benefit of the progress that has been achieved since 2001.

I should like to thank all the Network team led by David Chambers and previously by Sara Aspley. They have maintained the momentum of first the Cancer Plan and most recently the Cancer Reform Strategy, which have helped drive high-quality services and better outcomes for patients and their carers, wherever they may live within Devon, Cornwall and the Isles of Scilly.

It has been reassuring to see the increasing degree of collaboration between clinical colleagues from different organisations, despite the tensions sometimes caused by the element of competition that has flowed from the introduction of market concepts into the NHS.

I am particularly encouraged to see the long-running saga of the implementation of national guidance on upper gastro-intestinal cancers coming to a successful conclusion under the watchful eye of my successor Anthony Farnsworth.

Anthony brings valuable experience to the chairmanship of the Network and I wish him well in his new responsibilities.

**Peter Colclough**
PCN Chairman, 2001–2009

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# The year in focus: Key achievements in 2008/09

## Public health engagement

The Cancer Prevention, Awareness and Early Diagnosis initiatives are well on the way to becoming mainstream policy within Peninsula. PCT Directors of Public Health have become deeply involved in the work of Ian Mackenzie, the Network's Public Health Consultant.

## Bowel cancer screening programme

The Exeter Screening Centre opened at the end of March 2009 and the Network has been instrumental in overcoming the obstacles to the opening of a third centre for Cornwall, scheduled for September 2009.

## Cancer Reform Strategy

The Peninsula has been an early adopter of the CRiS CRoS web-based system charting progress towards the full implementation of the Cancer Reform Strategy, in line with the plan outlined at the beginning of the year. The objectives behind this have been devised and refined using those described in Network's programme. This is now the mechanism by which the four South West Cancer Networks will report their status, along with that of their PCTs and trusts, to the South West Strategic Health Authority.

## New cancer waiting times

The Network has successfully anticipated and managed the transition from the original targets and reporting criteria, in line with the national timetable, whilst supporting trusts in maintaining their performance against both sets of targets in the last quarter of 2008/9.

## Cancer services specification

A service specification was agreed for incorporation into acute trust contracts. This reinforces the need for services to be compliant with national cancer measures, which will be the subject of annual peer review from 2009 onwards. In addition, the specification includes local measures, such as the level of nurse specialist support for patients and the information required from chemotherapy services.

## Local chemotherapy peer reviews

Successful local reviews of all five chemotherapy services have been welcomed; these were being repeated in the summer of 2009. The peer review process has proved invaluable, highlighting the actions that are likely to flow from publication of the National Chemotherapy Advisory Group report, due in September 2009.

## NICE Improving Outcomes Guidance

The Network secured agreement for independent clinical reviews of upper gastro-intestinal, gynaecological and head & neck cancer services to inform the designation of the single centre and second centres respectively.

## Patient information

With the support of Macmillan Fund for Cancer, the Network has recruited a Patient and Public Information Manager to lead the introduction of the patient information prescription programme. They are also coordinating development of the new Network website as a key resource at the centre of cancer information exchange, for patients and professionals alike.

## National skin cancer leadership

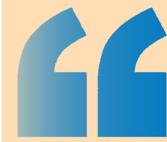
The Network has been endorsed as the national pathfinder network for skin Cancer, with the Director serving on the National Cancer Intelligence Network Clinical Advisory Group developing the next generation dedicated skin cancer dataset. The Network has succeeded in its bid to pilot a Network-wide skin cancer prevention strategy to inform commissioning intentions in 2010/11. This will involve building on the social marketing initiative in Cornwall, which the Network supported with the South West Public Health Observatory in 2008/9.

## Service improvement

Cancer pathways have been audited within each trust to confirm that the protocols agreed with Network Site Specific Groups (NSSGs) are being followed in day-to-day clinical practice. As these pathways have been developed further, they are being uploaded to the Map of Medicine to secure consistent approaches across all healthcare settings within the Peninsula.

## Commissioning

Peninsula Cancer Collective Commissioning Group has ensured the inclusion of significant clauses in the contracts for cancer services between all PCTs and provider organisations. This will underwrite the establishment of services compliant with the national cancer measures, which will be the subject of annual peer review from 2009 onwards.



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**Director's report:**

# Overcoming delays in putting guidance into practice

This year has been one of significant change, as we have seen our long-standing Chairman Peter Colclough passing on the baton to Anthony Farnsworth, following Peter's move to Royal Cornwall Hospitals NHS Trust, where he is now Chief Executive.

Peter has chaired the Network since its inception and given me considerable support as Director of the Network. It is good that he has continued to maintain that link through his membership of the Executive Board, now representing acute services in Cornwall.

Anthony already knows the Network well, having worked closely with us in his former role as Director of Performance with the South West Peninsula Strategic Health Authority. He continues the excellent relationship the Network team have with Torbay Care Trust, where he has become Acting Chief Executive.

The Cancer Reform Strategy has become the main policy driver throughout the year and the Network has been an early investor in the CRiSCRoS progress-reporting website.

Uniquely, the year saw two of the Annual Network Days, in April 2008 at St Mellion and March 2009 at Buckfast Abbey. Both were memorable, with the keynote speakers, Sir Ian Carruthers at St Mellion and Professor Mike Richards at Buckfast, emphasising, in their very different ways, the importance of implementing Improving Outcomes Guidance (IOG) to offer the best-possible results for patients. The events are reported more fully elsewhere in this report.

We are making real progress in overcoming the delays in implementing the outstanding Improving Outcomes Guidance for the rarer cancers. After extensive consideration by Overview and Scrutiny Committees, the single centre for upper gastro-intestinal cancer surgery has been decided. The recommendation from an independent expert clinical review by Professor Mike Griffin and Mr Bill Allum helped gain widespread support from the upper GI clinicians in the Peninsula. The Centre, at Derriford, is due to be operation by January 2010.

The Network has continued to receive support from the acute trusts in making the members of their cancer multi-disciplinary teams available to participate in site specific groups. These have all met at least twice in the year and begun to prepare their policies and guidelines in accordance with the new requirements for peer review.

The Network Board has agreed policies on decision-making and on communications, ensuring that all four Primary Care Trust chief executives, as the commissioners of cancer services, reach a consensus on Peninsula-wide developments.

This new clarity in decision-making has sharpened the focus of all our partners on the delivery of ever-improving cancer services.

The Cancer Local Implementation Groups are now closely linked to the work of the Peninsula Cancer Collective Commissioning Group (PCCCG), which looks to them to monitor progress on the local delivery of Network cancer services policies.

The direct involvement of Directors of Commissioning has not been as great as was originally envisaged, resulting in potential delays in moving proposals into implementation. But the group has been successful is ensuring that the contracts for 2009/10 have included an expanded, detailed set of requirements relating to cancer services.

The quarterly newsletter has proved popular with the 800 people who regularly receive it electronically. Such widespread engagement in support of cancer developments is very encouraging and will be further consolidated with the new Network website. Unfortunately the anticipated launch in early 2009 has been delayed until Christmas due to infrastructure issues.

There has been even greater collaboration with the other three South West Cancer Networks. In addition to working together on the Rare Cancers Group of the South West Specialised Commissioning Group (SWSCG), the four Directors are now joined by senior members of their teams in a quarterly meeting hosted by NHS South West.

Dr Duncan Wheatley was appointed as the Cancer Research Network Clinical Lead, taking over from Dr Nigel Bailey in September 2008. Duncan brings a wealth of research experience to the role and is already addressing the recent drop in research accruals.

During the past 12 months the Board has agreed IOG implementation plans for skin, sarcoma, children and young people, and brain and central nervous system cancers. All bring their challenges, but only sarcoma requires a decision on the location of a single service against the two currently provided by the Royal Devon and Exeter Hospital and Derriford Hospital. The two sarcoma teams have worked very positively together to agree a clinical pathway ahead of the tendering exercise, which will be conducted by the South West Specialised Commissioning Group in 2009/10.

In the coming year I look forward to seeing progress on the implementation of gynaecological, and head and neck cancer guidance, with external clinical reviews planned for both in autumn 2009.

Finally, I must thank the excellent team that work with me to meet the challenging agenda we have to deliver with our partners throughout the Peninsula.

**David Chambers**
PCN Director

New clarity in decision-making has sharpened the focus of all our partners on the delivery of ever-improving cancer services.

## Medical Director's report:

# Peninsula leads the way with 'internal peer review'

From my perspective the inevitable headline of the last 12 months has been the re-configuration of upper gastro-intestinal surgery within the Peninsula. I say inevitable for two reasons: firstly because of the amount of public and media attention this has generated, and secondly because the outcome will be a centre of excellence for the region that will rival anywhere else in the country.

The new unit combines the brand new facilities in the cardio-thoracic building in Plymouth with the expertise of experienced and pioneering surgeons from the all three existing departments providing this surgery at the moment. Whilst the idea of re-configuration is uncomfortable, especially for those patients living in the more isolated parts of the region, if the result is a unit that provides improved outcomes but that is also focused on the needs of such patients, then that is an ideal solution.

One of the key lessons that came out of the re-configuration discussions over upper GI surgery was the way the Network engages with the public over changes in healthcare provision. This extends from helping to explain and understand the rationale behind healthcare policy, through involvement in the process where change is needed, discussions with local statutory bodies and, finally, helping to design new patient pathways.

As part of this process, the Network commissioned the independent polling organisation Ipsos MORI to establish the views of the general public about cancer service delivery (not just upper GI). The results showed that the vast majority of people from all parts of the region would be prepared to travel for excellence in cancer care.

While this is an important finding, it is incumbent on policymakers to restrict centralisation to those areas of cancer care where such re-configuration leads to significant improvements for patients. We are fortunate that four of our five hospitals have on-site radiotherapy facilities, which means this can be delivered locally for almost all cancer care; this is not the case for many parts of the country.

Although service re-configuration takes up a disproportionate amount of attention, it represents only a very small part of what the Cancer Network is involved with.

One of the big issues is the change in the process of peer review. This is evolving from an external inspection of a service to an internal validation that peer review standards are being met. A criticism of such a process is that it focuses on paperwork rather than observation. Conscious

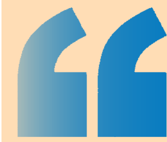
of this, Nikki Thomas and I have visited all of the hospitals to review chemotherapy facilities. Following similar visits last year, we found significant improvements in the areas that we had concerns about.

There are still issues that need addressing, particularly with regard to the physical facilities where chemotherapy is delivered, as the volume of work continues to increase.

The review has also allowed the opportunity to explore with providers how they will address the recommendations of the recently-published report from the National Chemotherapy Advisory Group, which outlines some fundamental changes to service provision.

The Peninsula Cancer Network has led the way in this form of 'internal peer review'. As we have a direct relationship with the commissioners of these services, this seems a very sensible way to evolve. It is possible that the site specific cancer groups could be increasingly involved in such a process as well; this be explored further over the next year.

**Dr Simon Rule**
Medical Director



Whilst the idea of re-configuration is uncomfortable, especially for those patients living in the more isolated parts of the region, if the result is a unit that provides improved outcomes but that is also focused on the needs of such patients, then that is an ideal solution.

### Nurse Director's report:

# Counting the cost of cancer for patients and their families

## Chemotherapy

Internal peer review for chemotherapy continued in 2009, to assure patients, clinicians, commissioners and managers that high-quality, safe services were being delivered. The reviews were completed by the Network Nurse Director, Medical Director, Peer Review Manager and a patient representative. Unlike the national programme, they also looked at governance, local leadership, facilities, workforce and staff development.

The team felt that the clinicians involved were working extremely well as a team and provided patient-centred care to a high level. Areas for improvement mainly involved the clinical environments and facilities. These recommendations will be followed up during the coming year.

The later part of 2009 sees the long-awaited National Chemotherapy Advisory Group report (NCAG), which will see the 'Acute Oncology Team' developed, alongside the management of febrile neutropenia.

## Supportive and palliative care

Supportive care is defined in the NICE 'Improving Supportive and Palliative Care for Adults' Guidance (2004) as care that 'helps the patient and their family to cope with cancer and treatment, from pre-diagnosis, through the process of diagnosis and treatment, to cure, continuing illness or death and into bereavement. It helps the patient to maximise the benefits of treatment and to live as well as possible with the effects of the disease. It is given equal priority alongside diagnosis and treatment.'

The Network Supportive Care Strategy Group has 10 subgroups, working across the five health communities to identify and share best practice, improve patient experience and to ensure compliance with NICE Guidance:

- Survivorship
- Spiritual Care
- Families and Carers
- Rehabilitation and Allied Health Professionals
- Key Worker
- Psychiatric Care
- Complementary Therapies
- Patient Information
- User Partnership
- Advanced Communications Training

## User and carer involvement

The Peninsula Cancer Network Patient/Carer Partnership Group, which draws members from local patient and carer groups across Devon, Cornwall and the Isles of Scilly has been concentrating a great deal of attention during the last 12 months on developing and completing the 'Cost of Cancer' survey.

It is widely recognised that a diagnosis of a cancer will bring many questions for the patient, family and/or carer. Most questions surround the treatment and care that will be required, the long-term effects and the ultimate prognosis. It is not until later that the financial burden is experienced and understood. This survey has been organised for patients, by patients, to examine the costs incurred by cancer patients in the Peninsula to see if there were significant regional variations.

The Partnership Group decided unanimously in July 2009 to disband, so it could be reconstituted with more active representation from the hospital trusts and stronger links with local organisations and patient groups.

The next step was an open event for people interested in helping to shape cancer services, in September. Different ways of working were discussed, with a view to strengthening the input of patients and carers. In the meantime, patient representatives will continue to sit on the series of smaller groups that the Peninsula Cancer Network runs for each type of cancer and for broader issues such as chemotherapy and imaging.

## Advanced Communication Skills Training

The Network training programme continues to be delivered by expert trainers across the patch and I am pleased that many of our local trainees will be accredited during 2009/10. Each individual acute trust has embraced locally-run courses and the waiting list continues to grow. We have more than 150 accredited clinicians from all disciplines, and have received overwhelmingly-positive feedback of the experience.

Funding continues to be a concern, though being able to use local trainers and local-accredited actors will reduce the costs significantly.

## Psychological care

Psychological distress is common among people affected by cancer, an understandable, natural response to a traumatic and threatening situation.

The Network Psychological Care was re-established in September 2008, with clinicians and service users representing all five health communities across the Peninsula. The group aims to map existing cancer psychology services, share good practice, resources and support, provide advice to commissioners on equitable services and agree referral criteria/pathways between acute/ mental health providers.

A bid has been submitted to Macmillan Cancer Support to establish a 12-month project team to work across the Network involving all key providers of psychological support. If successful, it is envisaged that this

Psychological distress is common among people affected by cancer, an understandable, natural response to a traumatic and threatening situation.

team will work across the five localities to identify existing services, capacity and demand; develop outcome measures for service users; improve links with mental health/psychology services; and identify joint opportunities for cancer care clinicians in education, training and/ or research. It is clear from preliminary discussions that greater awareness of each other's services is required. All this will improve the quality of care.

## Lead nurses

Lead nurses across the Peninsula continued to meet, although this was difficult due to vacancies. They are the local leads for implementation of NICE Supportive/ Palliative Care Guidance; much of the programme centred on this work. Guidance has been developed to ensure that each cancer patient has an identified key worker to co-ordinate their care and promote continuity, so the patient knows who to access for information and advice.

A handheld record is being designed by the lead nurses to underpin a common approach. The South Devon model will be adopted, with minor adjustments based on locality. The joint approach, involving all clinical nurse specialists and lead clinicians, will give all patients the same information and improve continuity for those who use more than one trust.

The lead nurses have been influential in a number of key Network and national documents, in particular the Network cancer service specification and the CNSs and various peer review consultations.

A Study Day at Buckfast Abbey was organised for all cancer CNSs across the Network entitled 'Political Awareness for Cancer Nurses'. This saw presentations on the Darzi review and how this links to the Cancer Reform Strategy, how nurses should be involved in the commissioning of cancer services, tariffs, payment by results, and workforce planning.

## Looking forward to 2009/10

There have been many challenges for cancer nurses, yet the biggest will be the economic climate in the NHS over the next few years.

The NICE Supportive and Palliative Care Guidance is due for full implementation by December 2009, so this will remain the top priority for me and for all the lead cancer nurses across the Network.

There is still work to be done on administrative support for clinical nurse specialists, and in chemotherapy and workforce. The Network has funding for a Lead Allied Health Professional (AHP) to take forward work on rehabilitation and access to specialist equipment. We will continue to work with PCTs' end-of-life care leads to share experiences and offer support.

The National Survivorship pilots are also underway; this year the Network will look at these evaluations and consider the best way forward for all cancer patients.

**Nikki Thomas**
Nurse Director

**Public health:**

# The joined-up approach to combating skin cancer

The Public Health emphasis within the Cancer Reform Strategy is on the prevention, awareness and early diagnosis of cancer. Working with colleagues in primary care trusts, the Peninsula Cancer Network has coordinated a range of initiatives relating to the prevention and awareness of ovarian cancer and skin cancer. The Network also participated in the successful launch of the national skin cancer hub by the South West Public Health Observatory.

The Network Health Equity Audit Group, comprising representatives from each of the four primary care trusts, has developed an estimate of deprivation for each of the 243 general practices in the Peninsula. Work is under way to explore the association between deprivation of practice populations and various measures of cancer service provision, including the take-up of breast cancer and cervical screening and the incidence of common cancers.

Work is also under way with colleagues in the cancer registry and information teams in each of the acute trusts to improve information on the staging of cancers and the completeness of data submitted to the cancer audits within National Clinical Audit Support Programme.

The Network continues to support the development of screening programmes across the Peninsula. The Network Public Health Consultant and Commissioning Manager produced a detailed report for the Network breast cancer screening group and PCT commissioners, modelling the impact of the introduction of digital mammography and age extension to the breast screening programme.

The Peninsula Cancer Network is the national Pathfinder Network for skin cancer prevention and early diagnosis, and successfully applied for a funding from the National Cancer Action Team to lead a project exploring the role of a network in coordinating social marketing and commissioning initiatives to implement skin cancer prevention across health communities. The project work will be carried out over the coming year.

The Network has also gained NCAT funding for improving early diagnosis and will be exploring a range of initiatives to work with Primary Care Trusts to identify patients with lung cancer at the earliest possible stage.

**Dr Ian Mackenzie**
Public Health Consultant

The Network has gained funding for improving early diagnosis and will be exploring a range of initiatives to work with primary care trusts to identify patients with cancer at the earliest possible stage.

**Service development:**

# Helping trusts meet the targets for cancer waiting times

The main focus of our year has been the targets and requirements of the Cancer Reform Strategy.

Considerable progress has been made in achieving the new waiting times targets. The Service Development team has been very involved in enabling services to achieve and sustain these targets, in each secondary care trust.

The main features of work during this year have included:

- Stronger connection with Network Site Specific Groups and in particular with the clinical leads for service improvement within those groups
- Improved connection with the commissioning process and with primary care generally
- The development of site-specific pathways of care, which have been uploaded to the Map of Medicine during 2009
- Enabling safe and efficient transfer of patients to tertiary referral centres

## Network Site Specific Groups

Each member of the Service Development team is now taking a lead on each of the Site Specific Network Groups. This means that they can work closely with the clinical service improvement leads for the group.

The development has enabled pathways to be agreed for the benefit of both staff and patients.

Service mapping during 2009 will enable us to build up a robust picture of what each service contains in all healthcare communities.

## Transfer of patients

The necessary transfer of patients with some cancers to tertiary referral centres has been another important area of work for the Service Development Director and team.

Each site-specific transfer potential has been the subject of a workshop, attended by members of the site specific multi-disciplinary teams and by operational managers of acute trusts.

The events have enabled robust communications and administrative pathways to be agreed, so that all patients who need to travel for surgery or complex treatments can be assured of safe and effective care, wherever they receive treatment and follow-up care.

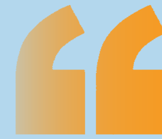
## Improving patient experience

The team continues to be dedicated to improving the patient experience throughout cancer services, with all developmental ideas driven by the need to assure quality of service, as well as improving the efficiency of systems and pathways.

The Network Partnership Group has been kept up to date with service developments and changes, with each trust user group involved in assessing improvements and providing input for the development of patient pathways.

Patient groups also continue to be involved in examining and making recommendations around patient and carer information.

**Liz Alsbury**
Service Development Director



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**Commissioning:**

# Putting quality at the heart of cancer contracting

## Implementing the Cancer Reform Strategy

This year the Network helped commissioners understand the enormous breadth of the Cancer Reform Strategy, culminating in the agreement of 85 PCT objectives with the Strategic Health Authority. This now forms the basis of communications between PCTs and the SHA on progress with implementing the Cancer Reform Strategy, supported by the Network team.

The objectives also form the basis of discussion between commissioners and providers in the Cancer Local Implementation Groups, ensuring a consistency of approach across the Network.

## Cancer services specification

Cancer services are backed by extensive national guidance, from Improving Outcomes Guidance and their associated peer review measures, to NICE appraisal on the use of particular drugs.

However, the standard NHS contract for acute services contains very little detail on the quality of care. This year all the national guidance was collected together into a single service specification for cancer for inclusion into contracts with acute providers of cancer services. In addition, Peninsula Cancer Network clauses were agreed. For example

- Providers need to demonstrate a sufficient level of nurse specialist support
- In the absence of a national minimum dataset for chemotherapy, local providers should collect the information recommended in the draft National Chemotherapy Advisory Group report
- Quality measures were agreed, taken from the range of national professional bodies.

The Peninsula Cancer Collective Commissioning Group was instrumental in agreeing the content of the service specification.

## Clinical genetics

The Network helped the Peninsula Clinical Genetics Service receive a significant investment from the South West Specialised Commissioning Group. This will enable developments to improve patient access and

compliance with Department of Health guidance ('Our Inheritance, Our Future').

## Peninsula Health Technology Commissioning Group

The Network provided support to the establishment of the Peninsula Health Technology Commissioning Group, as a significant amount of the work of the group relates to chemotherapy. We will continue to develop the connection between the clinicians in the Network and this commissioning group, and look to improve the understanding of new drugs and their place in effective treatment

## Local Implementation Groups

The Network continues to support the delivery of the Cancer Reform Strategy by working with Local Implementation Groups for cancer, where providers and commissioners of cancer work out the practical details for implementation for the local healthcare community.

## Radiotherapy

Following the publication of the National Radiotherapy Advisory Group Report, the Network developed a local model for understanding the demand for radiotherapy over the next eight years, which was used to identify developments in both staff and equipment.

The Network also agreed a first service specification for radiotherapy, setting out the key principles that underlie the delivery of a safe and effective service. Further refinements to both the service specification and the demand model will be made in 2009/10.

**Jonathan Miller**
Commissioning Manager

This year all the national guidance was collected together into a single service specification for cancer for inclusion into contracts with acute providers of cancer services.

**Research:**

# New sources of funding to help boost take-up of trials

The work of the Peninsula Cancer Research Network (PCRN) has been helped by the setting up of the National Institute of Health Research (NIHR) and the Comprehensive Local Research Network (CLRN) and by the introduction of new sources of finance, including Flexibility and Sustainability Funding (FSF).

These have supported additional infrastructure, new investigators and additional trials to address some gaps in the Network's portfolio.

During 2008/09 the Peninsula recruited 1,020 patients into 79 trials, covering 13 of the cancer disease sites defined by the National Cancer Research Network (NCRN). Key performance targets set by NCRN of recruiting 6.5% of incident patients with cancer or pre-malignancy to randomised controlled trials was just missed (6.3%), but overall 14.5% of incident patients participated in NIHR cancer trials.

At least 67 staff (34 whole-time equivalents) are funded to support NIHR cancer portfolio activity, with 48% funded by NCRN and 52% funded via CLRN sources.

The overall NIHR cancer portfolio includes some 228 trials available to Peninsula sites. Of these, 20 are being set up and 208 recruiting nationally. At present, trusts are either participating in, setting up or have expressed interest in 172 (75%) of these trials.

Dr Duncan Wheatley was appointed as new Clinical Lead for the Research Network in July 2008, bringing much expertise and experience as a member of the NCRI Breast Group and chief investigator.

FSF has given additional support to urology trials in both Exeter and Plymouth, allowing trials such as Boxit, Spare and Radicals to be set up. Increased activity is likely in 2009/10, as well as ongoing support to investigators.

The appointment of a part-time research nurse in Truro helped increased support to radiotherapy trials, and should do the same for trials such as Import Low, Import High, where a strong track record already exists. Truro has expanded its gynaecological cancer trials portfolio, increased activity in the Icon 7 trial and gained EORTC accreditation as a registered centre for gynaecological trials.

A lead oncology research nurse has been appointed in Plymouth. Plans include further strengthening the portfolio of trials and creating additional administrator and research nurse posts.

Torbay's team maintain a stable, effective workforce, delivering good trials activity particularly with randomised controlled trials. The team is now based in the new, purpose-built Horizon Centre, bringing together a larger and bigger research family within a new R&D Department.

North Devon has a good track record in non-interventional studies. Plans include expanding involvement in surgical trials and the haematology portfolio, with greater emphasis on randomised controlled trials.

Exeter continues with a broad portfolio of trials and high levels of activity. A research officer post was successfully piloted to provide additional support to observational and non-intervention studies, identifying a possible model for other trusts. Clinical genetics trials activity has suffered due to consultant workload, but should be addressed in 2009/10.

## Challenges

Capacity issues in chemotherapy, day-case and pharmacy are affecting the ability to undertake some treatment trials. This requires careful consideration and perhaps a more strategic view on supporting trials in other settings, such as surgical breast and colorectal trials if targets are to be achieved for randomised controlled trials.

The continued support of the multi-disciplinary teams across the Network is vital in contributing to the national cancer research agenda, in considering trials for patients and in providing feedback through the peer review process on those obstacles that inhibit trial participation.

CLRN funding has been allocated to trusts to support imaging, pharmacy and pathology, aiding recruitment into interventional trials (including cancer). The effectiveness of this support is vital if future targets are to be achieved for randomised controlled trials. The Peninsula is yet to benefit from any significant increase in commercial NCRN trials activity.

## Plans

Exeter Oncology Centre (EOC) is a national leader in high-dose rate brachytherapy techniques. Participation in these and other radiotherapy trials is seen as an essential element of a major expansion programme. A longer-term strategy includes an increase in Linac machines and IMRT and IGRT capability. However, appropriate radiotherapy/medical physics support will be required to achieve these goals.

We look forward with optimism to 2009/10 to further the achievements in the cancer research agenda. as always, we give thanks to the 8,906 patients, as well as the research staff, investigators and clinical staff who have supported NCRN ambitions and objectives.

**Glyn Rees**
PCRN Manager

*See also Research and Development Group on page 39*

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**Network days:**

# The Wii Fit and its place in the Cancer Reform Strategy

Network days are the annual setpieces that help bring together a huge range of people involved in cancer, from the NHS, charities, national bodies and patient groups, to hear about and discuss pressing issues. They also give people a chance to get to know each other and share experiences, which is not always easy when they might live and work more than 100 miles apart.

Last year saw two events:

## Living with Cancer

***7th Annual Peninsula Cancer Network Day***
***St Mellion International Conference Centre***
***2 May 2008***

More than150 representatives from cancer services and patients across the Peninsula attended the network day, with its theme of living with cancer – one of the key strands in the Cancer Reform Strategy. There was a broad range of speakers discussing topics such as survivorship, the patient experience and the differing perspectives on the role of NICE.

Sir Ian Carruthers, Chief Executive of South West Strategic Health Authority, presented his perspective on taking forward the Cancer Reform Strategy, with particular emphasis on the implementation of the Improving Outcomes Guidance.

Dr Ian Mackenzie, Public Health Consultant with the PCN, presented a range of public health interventions to improve life expectancy. Ed Murphy from Macmillan talked about survivorship and the Cancer Reform Strategy, particularly the background and priorities of the national cancer survivorship initiative, which is being developed in partnership between the DH, Macmillan and other cancer charities.

An energetic presentation followed from Nikki Thomas, PCN Nurse Director, speaking on behalf of Leanne Grose, a cancer patient from Cornwall, who has made an exercise DVD suitable for people with restricted mobility. Nikki also co-presented with Richard Thorpe the priorities for supportive care and a round-up of best practice around the Network.

Afternoon presentations culminated with Alexander Nesbitt, who covered self-management and the expert patient programme.

## Cancer in the Next Decade

***8h Annual Peninsula Cancer Network Day***
***Buckfast Abbey***
***20 March 2009***

This year the event took a different form with a wide variety of workshops between the two main presentational sessions.

The day started with our new Chair, Anthony Farnsworth, describing the recent achievements across the Network and reflecting on the need for partner organisations across the Peninsula to realign themselves to deliver the full benefits of the Cancer Reform Strategy.

The National Cancer Director Professor Mike Richards described progress in the first year of the strategy, acknowledging the improvements there had been through the work of cancer networks.

On the same day figures were published which showed that much still remained to be done. This highlighted the importance of the strategy's emphasis on improving early awareness and diagnosis to further increase long-term survival.

Then the 140 delegates, representing trusts and PCTs, plus patients, clinicians and other health care professionals, chose between workshop sessions on Peer Review, Commissioning, Wii Fitness in Rehabilitation, Art in Cancer Therapy, Bowel Cancer Screening and Social Marketing.

Mike Richards went for a Wii Fit jogging session, followed by slalom skiing and seemed converted.  He was obviously pleased to achieve 'Simmering Fire' status.

The final speaker was Professor Peter Johnson, Clinical Director of Cancer Research UK, who reminded us of the wide spectrum of research currently under way and noted the continuing excellent performance of the Peninsula Cancer Research Network in trial recruitment.

Mike Richards went for a Wii Fit jogging session, followed by slalom skiing and seemed converted.  He was obviously pleased to achieve 'Simmering Fire' status.

## Ipsos MORI research:

# Patients prepared to travel further for best cancer care

Survey and interview work commissioned from Ipsos MORI by the Network shows that around three-quarters of people in Devon, Cornwall and the Isles of Scilly would be prepared to travel further to get the best-possible outcome from cancer treatment.

The figure varies little between the four primary care trust areas:

- 71% in Cornwall and Isles of Scilly
- 78% in Devon
- 79% in Plymouth
- 76% in Torbay

There is also no significant variation between people with experience of cancer in the past two years, involving either themselves or a close family member, and those without. In Cornwall, for example, two thirds (66%) of people with recent experience of cancer say they would be happy in principle to travel further.

The research was designed to find out about readiness to travel further for better outcomes for rarer cancers; what concerns people might have about doing so; and how patients and families might be helped if any changes were ultimately made.

The findings have been shared with Overview and Scrutiny Committees, and were taken into account by the four PCTs when agreeing proposals for the centralisation of upper-gastrointestinal (UGI) surgery at Derriford Hospital.

Ipsos MORI's research involved a telephone survey of 1,003 people, face-to-face interviews with patients, carers and people in 'hard to reach' groups, and three-hour evening events at five locations, each involving 20 members of the public to look in detail at the issues.

Overall, only 29% of people across Devon, Cornwall and Scilly were aware of the UGI reconfiguration proposals and, of those, three quarters said they knew just little or hardly anything about the potential changes (75%). This was despite "considerable media attention".

The research also found many misconceptions, with one of the most common being that proposals were for cancer services as a whole to be centralised, rather than just the surgery for some rarer cancers.

Among MORI's conclusions were that:

- Lack of knowledge about the proposals meant that "people's instinctive reactions towards the proposals are negative: change is not particularly

welcome, and is commonly put down to cost savings – findings that are often associated with change programmes"

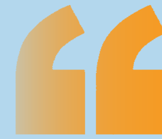
- The principles behind the proposals – travelling further for better outcomes – appeared to be supported
- Many people felt they knew others who wouldn't support the principles, and "struggled with the idea that choice could not be offered"
- People were concerned about issues such as loss of choice, travel and accommodation, continuity of care and information, loss of skills from local hospitals, overloading the hospital infrastructure and rises in waiting times, and the validity of statistics

However, people also put forward a range of ideas to help make centralisation work as well as possible. For example:

- Help with travel and accommodation, focusing on issues such as financial support, public transport and taxi services
- Similar support for relatives visiting their loved ones, focusing on issues such as transport, parking and its cost, accommodation and relaxed visiting times
- Comprehensive travel plans showing what was available
- Plans for contact between patients, local doctors and the central surgical team

The report added: "Both the concerns and the mitigations found during this research show that whilst most support the principle of travelling further for improved treatment and outcomes the same people also have very real trepidations that need to be addressed should reconfiguration be implemented."

Copies of the report are available from the PCN office. Email: karen.ford2@nhs.net



Both the concerns and the mitigations found during this research show that whilst most support the principle of travelling further for improved treatment and outcomes the same people also have very real trepidations that need to be addressed should reconfiguration be implemented.

**Financial report:**

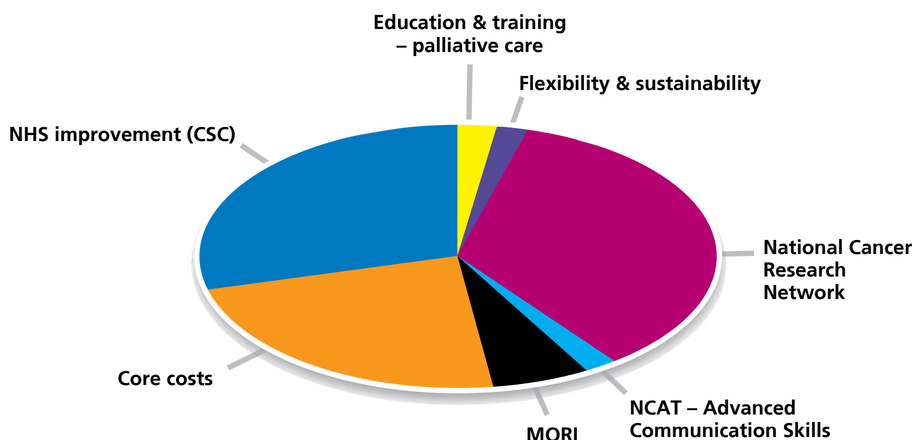
# Where the money came from and how it was spent

The Peninsula Cancer Network is funded by a range of organisations, locally by the four Primary Care Trusts and nationally by NHS Improvement, the National Cancer Research Network and the Department of Health. The Macmillan Cancer Fund continues its invaluable support for our work, directly funding the Network Patient Information Manager and the running costs of patient involvement activities.

This continued support from the local health communities and Macmillan is a valued endorsement of the Network. The flexible use of these resources has enabled the year-on-year local funding requirement to be kept at much the same level for the past two years. As the Network fulfils its commitment to make the Macmillan-funded User Facilitator post substantive and fully funds the new posts of Commissioning Manager and Public Health Consultant, this requirement will increase for 2009/10.

Derek Blackford, Assistant Director of Finance at Torbay Care Trust, continues to provide very helpful support in the management of the Network's finances.

## How the Network's budget was spent:



**Income 2008/09**

| | |
|---|---|
| NHS Improvement (CSC) | 511,000 |
| Department of Health | 40,000 |
| Locally Agreed Funding – PCTs/health authorities | 586,629 |
| Macmillan | 53,394 |
| National Cancer Research Network – DoH | 659,231 |
| Locally-agreed funding – Carry-forward | 111,202 |
| | 1,961,456 |

**Expenditure 2008/09**

| | |
|---|---|
| Core costs | 438,320 |
| NHS Improvement (CSC) | 497,586 |
| Education & Training – Palliative Care | 69,039 |
| NCAT – Advanced Communication Skills | 33,086 |
| MORI | 109,170 |
| Flexibility & sustainability | 52,034 |
| National Cancer Research Network | 577,220 |
| | 1,776,456 |
| | (-185,000) |

The Network is c/f an underspend of £185k to 2009/10

Carry-forward

| | |
|---|---|
| Cancer Reform Strategy | 85,000 |
| Cancer Network | 77,000 |
| National Cancer Research Network | 23,000 |
| | 185,000 |

**Allocations:**

| | |
|---|---|
| CSC – Establishment | 221,000 |
| CSC – Service | 290,000 |
| Network support | 40,000 |
| | 551,000 |

**Income:**

| | |
|---|---|
| Local funding | -384,285 |
| Local funding – MORI | -91,785 |
| Local funding – c/f | -111,202 |
| DOH | -659,231 |
| SHA – reform | -85,000 |
| Other non-NHS income | -25,559 |
| Macmillan | -53,394 |
| | -1,410,456 |
| | 1,961,456 |

**Local funding:**

| | |
|---|---|
| Devon | 170,913 |
| Torbay | 36,512 |
| Plymouth | 63,010 |
| Cornwall | 113,850 |
| | 384,285 |

**DoH income:**

| | |
|---|---|
| Research | 549,443 |
| Flex & Sustain | 109,788 |
| | 659,231 |

| | |
|---|---|
| PCT – MORI | 91,785 |
| | 91,785 |

**Income reconcilliation:**

| | |
|---|---|
| Per above | -1,410,456 |
| Carry-forward | 111,202 |
| SWSHA budget | 121,344 |
| | -1,177,910 |

# Network Site Specific Groups

## Breast

**Chair: Mr Eric Drabble**

### Key achievements

The main achievements of the Breast NSSG during 2008/09 included:

- New surgical appointments at three acute trusts to provide immediate reconstruction
- Establishment of a South West Oncoplastic Breast Surgeons (SWOBS) group to share best practice and to provide educational and networking opportunities
- Completion of a Start training programme for sentinel lymph node biopsy among surgical team members
- Development by the Royal Devon and Exeter NHS Foundation Trust of guidelines for staging of breast cancers, to be adopted by the Network
- Development of a Network-wide guideline for adjuvant endocrine therapy
- Engagement with commissioning representatives to review data-collection requirements and national audit activity

### Key challenges

- Meeting new targets for referrals of all breast patients and for the timings of adjuvant treatments
- Recruiting new patient and carer representatives to the Network group
- Providing advanced communications skills training for all core members of the multi-disciplinary team

### Aims

- Further engagement with commissioners
- Agreement of priorities and aims, in which the whole group can engage. It is envisaged that the Network will devolve more of the decisions regarding targets and priorities; the Chair and the group as a whole must address this task effectively.

- Development of its work plan. New roles are developing and volunteers for these will be found
- Given that the role of the Chair appears to be increasing, his work plan must be addressed accordingly. Network personnel changes will also influence the amount and type of support available.

### Network audit

All acute trusts participated in the National Mastectomy and Breast Reconstruction (MBR) Audit, a project commissioned and funded by the Healthcare Commission to assess and improve the quality of care provided to women with breast cancer undergoing mastectomy and breast reconstruction surgery.

The audit includes all women treated between 1 January 2008 and 31 March 2009. It closed on 14 May 2009; a final report is awaited.

At a meeting of the NSSG in March 2009, members agreed to undertake a locally-defined audit around reconstruction in order to expand on the limitations of the national audit. This will be led by members of SWOBS.

### Patient and carer feedback and involvement

The group continues to look for further recruits to join the sole patient representative. In the meantime, the Network User Facilitator continues to provide a link between the Network and local patient groups. The group will seek to identify a patient 'champion' to help support this area of work.

There are also trust-based patient support groups and initiatives across the Network, including:

- Moving-on rehabilitation groups in two acute trust, helping women post-treatment to come to terms with their survival and to move on in their lives
- The use of 360° surveys to provide feedback on consultations with consultants
- A breast cancer patient support day
- A patient-led Bosom Buddies support group to offer support and advice at monthly meetings
- A support group for younger women with breast cancer

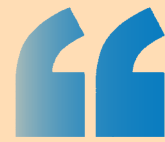
## Colorectal

**Chair: Mr Edward Lloyd-Davies**

The group met twice during the year, with excellent attendance from all five Trust MDTs.

The main topics of discussion have been the formation of a specialist anal cancer MDT and peer review planning.

A central anal MDT has been meeting via teleconference on a monthly



It is envisaged that the Network will devolve more of the decisions regarding targets and priorities.

basis since January 2009. Provisional treatment planning is undertaken by the local colorectal MDT and ratified by the central MDT. Chemotherapy and radiotherapy will be protocol-driven and delivered locally. A named surgeon and deputy, plus an oncology lead, should be identified in each Trust. Timely and accurate data-collection will be required.

The group has been reviewing its patient pathways. A sample audit of patient records showed that in all those cases examined, trusts were adhering to the agreed patient pathway. However, it was noted that CNS contact was not always recorded centrally.

In a review of the current primary care referral guidelines, members shared experiences with referral pro forma and direct access to diagnostics by primary care. Such discussions prove valuable in ensuring that good practice is shared and common problems aired, often resulting in constructive help from colleagues.

The benefit of patient involvement in the group was shown when the patient member said he had experienced delayed referral to secondary care but was treated very quickly once diagnosed. The group learned that whilst perceived as a better service for patients, the prospect of several investigations in a single day was very daunting.

The group was delighted to learn that one of its members, Mark Coleman from Plymouth, had been appointed National Clinical Lead for the Laparoscopic Colorectal Cancer Surgery Training Programme. He will undoubtedly reinvigorate the programme around the UK. In the Peninsula, we are well on the way to having full engagement in the training programme in line with the Cancer Reform Strategy.

The group received the previous year's audit into anal cancer management and outcomes. It has supported the development of an audit into stenting across the Network.

The Colorectal Nurses Group has been active all through the year, reviewing CNS workloads and supporting the development of information prescriptions for patients.

Revised terms of reference and work programme have been agreed, which included a review of clinical guidelines.

Members have welcomed the availability of PET-CT scanning within the Peninsula.

## Endocrine and Thyroid

**Chair: Dr Ade Oriolowo**

The Endocrine and Thyroid NSSG comprises clinicians and nurses who are involved in the management of thyroid cancer patients. There is a move to include other endocrine cancers, such as adrenal and pancreatic tumours.

The group meets three times a year to discuss guidelines and pathways for the management of these cancers.

The group's achievements in the past year or so include:

- Implementation of recommendations from the National Cancer Peer Review both at the Network and at all the acute trusts
- Agreement of two main multi-disciplinary teams for the management of thyroid cancer: West Peninsula (Plymouth and Cornwall) and East (Exeter, Torbay and Barnstaple). The hospitals will be video-linked.
- Agreement on a list of nominated thyroid surgeons for each acute trust:
  - Royal Devon and Exeter: D Garth, D Ferguson, J Dunn
  - Plymouth Hospitals: P Cant, T Malik
  - Northern Devon Healthcare: M Menon
  - South Devon Healthcare: S Hickey, D Cunliffe
  - Royal Cornwall Hospitals: A Wild
- Agreement of guidelines for pathology, imaging and GP referral, with discussions under way on multi-disciplinary team referral pathways for each hospital and on the referral pathway for paediatric and complex thyroid cancers

## Gynaecology

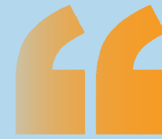
**Chair: Dr Joe Mathew**

The NSSG has had two successful meetings in the last year, though work has been hampered by a lack of progress in implementation of the gynaecology Improving Outcomes Guidance and measures in the Manual for Cancer Services 2008.

In June 2008, there was agreement regarding the configuration of specialist and diagnostic centres within the Peninsula, but the initial proposal was rejected by the National Cancer Action Team. Since then the PCN has, as with the upper gastro-intestinal reconfiguration, commissioned an independent clinical review of gynaecological cancer services. Given these uncertainties, several of the NSSG-related measures are in flux, rather than embedded, and await the outcome of the review.

There has been some success in the last year, including:

- Introduction of the concept of NSSG quality circles
- Introduction of annual review of NSSG treatment guidelines and pathways. Pathways for the management of all gynaecological cancers have been broadly agreed but will be revisited following the review of gynaecological services. The guidelines for management of all gynaecological cancers will also be determined following this review. At present the guidelines developed by the SW Gynaecology Tumour Panel have been adopted.
- Re-introduction of the Map of Medicine to the NSSG for reflection against NSSG pathways
- Introduction of the concept of commissioning-based thinking into protocols for gynaecological cancer management in the Network
- Coordination of a current project, covering PET CT and cervical cancer, by Dr Sarah Higgins at South Devon Healthcare NHS Foundation Trust



Pathways for the management of all gynaecological cancers have been broadly agreed but will be revisited following the review of gynaecological services.

- Identification of leads to coordinate and advise on specific NSSG activities and to lead QCs:
  - Surgical Oncology: not identified
  - Oncology: not identified
  - Radiology: not identified
  - Pathology: Dr Joe Mathew
  - Public Health: Dr Ian Mackenzie
  - CNS: not identified
  - Research: Dr Nigel Bailey
  - Audit: Dr Nagindra Das
  - Patient representative: Mrs J Preston
  - Commissioning: Mr Jon Miller
- Agreement on the introduction and use of the revised Figo classification in the management of vulval, cervical and endometrial cancers, and the staging of uterine sarcomas
- Agreement to adopt and implement audits with the SW Gynaecology Tumour Panel
- Promotion of the Advanced Communications Skills Workshop, especially for core members of local MDTs
- Support for ovarian cancer awareness
- Good attendance for the Network Gynaecology Cancer Day in January 2009, which was a resounding success

## Head and Neck

**Chair: Mr Steve Adcock**

It has been a busy year for the Head and Neck NSSG following Peer Review in March 2008.

The Network has been organising care to comply with Improving Outcomes Guidance (IOG) and taking in to account pressures from the Darzi report.

As with other site specific groups, for head and neck this means being mindful of the geography of the region and yet allowing access to excellence of care.

The Head and Neck Network is split into an East Multi-disciplinary Team (MDT) covering Torbay and Exeter, and a West Multi-disciplinary Team covering Derriford and Cornwall.

Videoconferencing is used to link up the members of each MDT. The technology for this is now quite satisfactory, allowing a full discussion of each patient by a large number of clinicians utilising a wide range of expertise from each trust.

The East MDT has centred its major operative procedures on Exeter, with clinicians travelling from Torbay to operate, yet still allowing other surgery to be carried out closer to the patients home at the local trust.

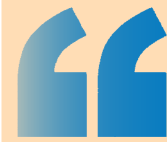
The West MDT is finalising its operative protocol with the aim of agreeing a service model which meets the requirements of the IOG but makes maximum use of the expertise and resources of the local head and neck teams, thereby allowing as many people as possible to be treated close to home.

Over the last year it has been noted at the various meetings that the most important members of the team are the supporting services such as specialist nurses, dieticians, and speech and language therapists. Unfortunately, these are often the under-resourced areas, with staff members at full stretch. This has now been recognised, and we hope trusts will look at further funding in these areas.

Network audit into the patient pathway has shown excellence in speed of diagnosis and decision to treat, once the person has been referred. This can be built upon and re-audited.

Unfortunately, there are still a large number of people who present very late, and public awareness of head and neck malignancy needs further work in the future. The Network would be an ideal vehicle for this.

Finally, emerging newer techniques in chemo-radiation, used by the oncology team, are making it possible to tackle previously-untreatable conditions, which we are sure will also be an exciting development in the future.



Videoconferencing is used to link up the members of each MDT. The technology for this is now quite satisfactory, allowing a full discussion of each patient by a large number of clinicians utilising a wide range of expertise from each trust.

## Lung

**Chair: Mr Nick Withers**

### Key achievements

- Identification of the NSSG Clinical Service Improvement lead identified Dr Stephen Iles, Consultant Physician, Royal Cornwall Hospitals
- Collation of mesothelioma patient information packs by the Lung Nurses group
- Agreement to undertake a 12-month survey of mesothelioma cases
- Appointment of a new clinical oncologist appointment at Plymouth Hospitals
- Availability of mobile PET-CT facility within the Peninsula

### Key challenges

- Recruitment of new patient and carer representatives to the Network group
- Establishment of specialist multi-disciplinary teams for mesothelioma
- Training all core multi-disciplinary team members in advanced communications skills
- Securing regular specialist palliative care input into all multi-disciplinary teams

### Audit

All acute trusts participate in the National Lung Cancer Audit (LUCADA), a project run by the Information Centre for Health and Social Care in partnership with the Royal College of Physicians.

An audit was undertaken to examine oncology practice and survival outcomes across the Peninsula for patients diagnosed with non-small-cell lung cancer stages IIIa and IIIb. All five acute trusts contributed.

The audit demonstrated clear evidence of team-based working, with 96% of patients being discussed by the multi-disciplinary team and 92% of patients having contact with a nurse specialist.

At a meeting of the NSSG in October 2008, members proposed to conduct an audit to establish the number of mesothelioma cases per annum, describe the health of patients and examine the investigation pathways and treatment of this group of patients.

The results of this audit should inform planning for specialist multi-disciplinary teams and provide targets for trial recruitment. It might also help inform the potential set-up of local trials.

### Patient and carer feedback and involvement

Until April 2009, the Lung NSSG benefited from the involvement of two patient and one carer representatives. Their attendance brought a rich and valuable dimension to group meetings and a useful insight into the patient experience.

The group continues to look for new patient representatives to join the group. In the meantime the Network User Facilitator continues to provide a link between the Network and local patient groups.

The NSSG will look to identify a patient 'champion' to help support this area of work.

Group members have also agreed to undertake a Network-wide patient experience survey. This will help identify common issues across the Peninsula and inform the NSSG and multi-disciplinary team work plans.

There are Trust-based patient support groups across the Network.

## Sarcoma

**Chair: Mr Chris Stone**

The Network sarcoma group has made progress in a number of areas this year, in line with its annual work programme.

Items that have come under review include data-collection systems, chemotherapy guidelines and protocols, participation in EORTC trials and service improvement. Management pathways have been examined and changes made to ensure greater alignment between pathways in Exeter and Plymouth.

Particular emphasis this year has been placed on raising awareness in

primary care, including the development a poster campaign for GPs, which will be launched in early 2010.

In parallel, preparations have been ongoing for the centralisation of surgical services to a single site for Devon and Cornwall. The Specialised Commissioning Group is hoping to complete the designation process in spring 2010, and is inviting bids from potential providers. Several public meetings have been held throughout the region, providing provided useful feedback, and a clinical stakeholders' meeting was convened so members of the NSSG could express their views and concerns.

## Skin

**Chair: Dr Karen Davies**

The NSSG for skin cancer met on three occasions in 2008/09, with representation from dermatology, plastic surgery, maxillofacial surgery and oncology from all five acute trusts, from PCT commissioners and from the PCN itself.

The major topic of discussion remained the implementation of the NICE Improving Outcomes Guidelines for skin cancer, which have had significant implications for service delivery in the Peninsula.

Three specialised skin multi-disciplinary teams (MDTs)s are now well-established, in Exeter, Plymouth and Truro. All three also now have clinical nurse specialists in post.

Organising service delivery in primary care that is compliant with NICE guidance has been more complex to oversee, partly because of various interpretations of DoH guidelines. Progress has been made and we are nearing agreement on accreditation arrangements for GPs with a special interest in skin cancer, although some hurdles still need to be overcome. We have had little representation on the skin NSSG group from primary care practitioners, which is an area we hope to improve upon.

We continued to work on drafting clinical, referral, pathology and imaging protocols for skin cancer patients over the year. With the added impetus of forthcoming peer review in 2009/10, these have now been finalised.

The role of sentinel lymph node biopsy (SLNB) and subsequent completion lymphadenectomy was discussed throughout the year, with opposing views put forward. The service in Exeter has been running successfully for some years and, although not part of a clinical trial, it was strongly felt that decommissioning this service would not be in the best interest of the region.

By contrast, we expect that definitive evidence supporting SLNB will emerge and that the procedure will become the expected standard of care. This would then necessitate offering SLNB to all eligible patients across the Peninsula.

In April 2009 Toby Chave passed on the role of chair of the group to Karen Davies from Barnstaple, who will steer the group forward for the next three years.

Particular emphasis this year has been placed on raising [sarcoma] awareness in primary care, including the development a poster campaign for GPs, which will be launched in early 2010.

## Upper Gastro-intestinal

**Chair: Dr John Isaacs**

There have been significant developments over the past year within the Peninsula in upper gastro-intestinal cancer.

In line with Improving Outcomes Guidance, there is support and agreement from trusts, PCTs and the Network Executive Board for a single surgical centre for Upper GI cancer, based at Derriford Hospital. The expected 'go live' date is 1 January 2010.

Getting agreement for this has been a long and protracted process. However, now that this has been achieved, the benefits should start to flow for all surgical patients with these conditions.

In parallel, there has been considerable work to establish a Peninsula-wide multi-disciplinary team (MDT), in line with the recommendations of the clinical review of upper gastro-intestinal cancer services. Meetings with a large number of health professionals and patient representatives have paved the way for a first meeting, which should at the beginning of November 2009. However, there is a considerable amount of work still to do.

The hepatobiliary service will be strengthened by the appointment of a second surgeon at Derriford Hospital, anticipated in September 2009.

Considerable work is currently under way in preparation for peer review next year.

A recent audit of the time taken for patients to have their treatment found that everyone was being seen within the target time.

The Peninsula also was active in submitting data for a published audit on the use of PET CT in oesophageal cancer.

## Urology

**Chair: Mr Seamus MacDermott**

The urology network has continued to work as a co-ordinated group.

The multi-disciplinary team on the east side, bringing together Torbay, Exeter and Barnstaple, meets by videoconference on alternate Monday mornings.

Radical pelvic surgery is conducted at the Royal Devon and Exeter Hospital, with surgeons visiting from Torbay and Barnstaple. There is a partial cross-trust on-call arrangement, supporting the close working relationships.

Videoconferenced multi-disciplinary team meetings between Derriford and Royal Cornwall hospitals are starting in 2009, while radical pelvic surgery is performed at Derriford. Service development events have facilitated the smooth transfer of patient care between trusts across the network.

Laparoscopic pelvic surgery is being developed to provide the widest-possible patient choice in surgical technique. A daVinci surgical robot has recently been commissioned at Torbay Hospital, the first new Si unit in the

UK, and is intended to improve patient care across multiple specialties, including urology.

Both high- and low-dose brachytherapy are available at Exeter and Plymouth respectively. The group are satisfied that the smaller number of patients suitable for other techniques for prostate cancer, such as High Intensity Focused Ultrasound (Hifu) or cryotherapy, are referred mainly to Southmead Hospital. There are no plans to develop these in the local area.

Two major papers in 2009 addressed the value of screening for prostate cancer. Although the US- based study did not fully reflect the possible benefits found by the European group, the strength of the former paper was affected by a large element of previous PSA testing.

The UK National Screening Committee has commissioned a study of the evidence on prostate cancer screening, which is expected to be open for consultation in mid-2010. The introduction of such a programme would have major service implications.

Laparoscopic pelvic surgery is being developed to provide the widest-possible patient choice in surgical technique.

# Cross-cutting Groups

## Chemotherapy

**Chair: Dr Ann Hong**

### Achievements

- Network-agreed policies:
  - Anti-emetics
  - Minimum service specification for 24 hour patient advice service
  - Management of chemotherapy- induced nausea and vomiting: specialist knowledge and skills for practice competency portfolio
  - Management of the neutropenic patient
- Electronic prescribing functions in all five acute trusts (pan-network across three trusts)
- Clinical support of the cancer drug submission to the Peninsula Health Technology Commissioning Group
- National Patient Safety Alert (NPSA) – oral chemotherapy, completion of audit and study day.
- Participated in NICE audit on uptake of cancer drugs
- Underpinned governance arrangements for chemotherapy in all five acute trusts.
- Supported Network internal chemotherapy reviews

### Future developments

The publication of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Systemic Anti-Cancer Therapy report (2008) and the National Chemotherapy Advisory Group report (2009) both raise concerns related to quality and safety.

The key recommendations highlight improvements to three key areas:

- The provision of elective chemotherapy services, based around a care pathway approach
- The provision of emergency care not only for cancer patients who develop complications following chemotherapy but also for patients admitted suffering from the consequences of their cancer.
- The leadership, information systems, governance, monitoring and commissioning of chemotherapy services

The delivery of Network-wide agreed regimens has been a challenge for many networks across England, including the Peninsula. This piece of work will be the major focus of 2009/10. Network-agreed regimens will demonstrate collective evidence-based practice as agreed by clinical peers across the Network. A process for the agreement of Network-wide regimens has been ratified by the Network Chemotherapy, Non-surgical Oncology and Collective Commissioning Groups and will be fully implemented by 1 April 2010.

Pilot site for 24-hour telephone support: As part of UKONS, the RD&E was successful in bidding to take part in the pilot for documentation underpinning 24-hour telephone support.

UKONS partner: The Peninsula nurses group will be undertaking work as a partner for the South West workstream for improving documentation for chemotherapy.

Minimum data set for chemotherapy: As part of the introduction of chemo-care it is hoped the system will provide the Primary Care Trusts with the required information to ensure compliance with Network regimes.

The delivery of Network-wide agreed regimens has been a challenge for many networks across England, including the Peninsula. This piece of work will be the major focus of 2009/10.

## Haematology

**Chair: Dr Bryson Pottinger**

The haematology NSSG continues to work closely with the monthly Peninsula 'Blood Club' meeting of consultants, allowing clinical issues to move forward more quickly.

In the past year the group has largely re-written the haematology chemotherapy handbook to ensure that treatments are consistent across the region. This work will also allow for the implementation of protocol-based commissioning for treatments agreed without prior funding.

The group has actively engaged with the newly-formed Health Technologies Assessment Group and has considered the place of a number of newer drugs in routine clinical practice. Where drugs were not recommended for routine commissioning, the opinion of the clinicians has been used to inform requests to exceptional funding panels.

### Audits

We continue to adopt the regional South West Public Health Observatory audits for haematological malignancy. For example, the follow-up audit for Hodgkin's Lymphoma shows a clear improvement in many stages of the patient pathway consequent on the setting up and use of appropriate MDT working.

### Research

Recruitment figures for trials such as Myeloma IX, AML 15 and CHOP 14/21 show how actively trusts in the Network continue to participate in national and international clinical trials.

### Progress against the IOG

The group has continued to work towards IOG compliance for reporting haematological malignancy. This will remain the major challenge for the coming year. A major re-configuration of the way in which haematological malignancy diagnoses are made across the region will be required. The group continues to support a tailored solution, allowing for the geography of the area whilst still achieving the quality service intended by IOG.

## Imaging

**Chair: Dr Richard Seymour**

### Key achievements

A significant part of the group's work has been invested in monitoring and sharing information about the new PET/CT service. There were teething problems with the introduction of the service, but it is now working well. The Network was central in planning the use of local radiologists to report the scans, which is seen as a major benefit.

There is continuing input into other Network activity, such as the metastatic spinal cord compression meetings.

The group has had, and continues to have, a role in sharing information between radiology departments, such as the recent RCR Standards for Communications and sharing of best practice in service improvement.

### Key challenges

The group needs to review its terms of reference, membership and chairmanship.

All departments continue to face pressures from increasing demand and the requirement to further reduce waiting times. Out-of-hours services are also not uniform across the Network; for example, interventional cover and MRI for cord compression.

### Audit

There has been discussion about cross-network audit, which is ongoing, and about  including audit requirements for the PET/CT service.

### Research

The group has had a limited role in research matters related to radiology and cancer. There has been some feedback on CLRN issues and on research related to the PET/CT service.

### Service development across the Network

There has been sharing of examples of service improvement in different departments and of wider work, such as the SW Radiology Review.

New equipment has been commissioned within the Network, such as a second CT and a new MR scanner at Torbay Hospital, several new consultant radiologists have been appointed, and there is a new interventional radiology on-call service at South Devon Healthcare.

## Pathology

**Chair: Dr Joe Mathew**

The group has had two successful meetings in the last year. The PCCG board have agreed to have a summer meeting at Lifton and a winter telephone conference.

This group has successfully identified authors to write the Pathology Reporting Guidelines (PRG) for each of the cancer sites represented at the Network NSSGs.

Each author circulates the PRG to the PCNPCCG board members, for sharing with the relevant lead clinician and lead pathologist in their own trust. The lead pathologist then shares this with local pathologists.

All feedback is assessed and a final document produced. This is then sent to the Chair of the relevant NSSG for discussion, approval and dissemination to lead clinicians in the multi-disciplinary team to include in local operational policies.

The PCNPCCG board has agreed that these PRGs should be reviewed annually and formalised in the subsequent summer meeting.

The PCNPCCG Board also defined the Pathology External Referral Guidelines.

## Research and Development

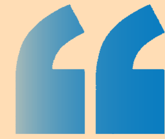
**Chair: Dr Fiona Roberts**

The Research and Development Group, in close collaboration with the new Peninsula Comprehensive Local Research Network (PenCLRN), all site specific groups, trusts and clinicians continues to build on the excellent work to date. This centres on the development of a high-quality research portfolio and on recruitment activity within the Peninsula.

The Peninsula is in the top three best-performing networks nationally, with 1,020 local patients entered into more than 79 studies during 2008/09.

Oversight and management of final transition arrangements associated with the Government's R&D strategy and restructuring programme, including a change to funding mechanisms.

With the shift of funding to an activity basis, it is clear that increased performance review, management of portfolio and recruitment within each trust, and improving links with NSSGs will be instrumental if the Peninsula Cancer Research Network (PCRN) is to maintain its place at the top of the performance agendas and to maximise its funding potential.



The Peninsula is in the top three best-performing networks nationally, with 1,020 local patients entered into more than 79 studies during 2008/09.

Integration of the PCRN into the wider and bigger Peninsula NIHR family has seen increased income via new sessional support arrangements; 'Unblock the blocks – key service support' funding from PenCLRN; and new Flexibility and Sustainability Funding.

This has helped many trusts increase capacity, enabling them to recruit and to develop their portfolios, particularly in areas such as surgical trials that have historically been less active. It has also supported new investigators, further strengthening the trials portfolio and increasing opportunities for local patients to participate in national trials.

The group has started work on improving its communication and information technology strategy, including the use of databases;. This will help support and deliver not only the new NIHR targets but the Cancer Peer Review measures, alongside the service network teams, NSSGs and trust multi-disciplinary teams.

These key developments underpinned the excellent collaboration and work during 2008/09 between the PenCLRN, NHS organisations and academic stakeholders, to ensure that the Peninsula is in the best position to deliver on the new national NIHR research agendas during 2009/10 and beyond.

## Specialist Palliative Care

**Chair: Giles Charnaud**

The Specialist Palliative Care Group began the 2008/09 year by acknowledging the dedication and work undertaken by Dr Richard Scheffer. Richard had chaired the group from May 2001 until September 2007, during which time much progress was made. This included the successful negotiations around the PCN share of the £50m national allocation from the Department of Health relating to the Cancer Plan 2000.

The group tasked itself during the year with delivering key performance indicators for Specialist Palliative Care Services. This work led to the formulation of a service specification for hospital, inpatient and community based services and standards relating to the specifications.

The standards linked to the improving outcomes guidance on Supportive and Palliative Care and the emerging quality markers for End of Life Care. The specification and standards were adopted by the Commissioners Group and the Network Board in early 2009/10.

I would like to acknowledge the energy and work that went into producing what have been regarded as exemplar examples of guidance. In particular I thank Dr Debbie Stevens for driving the process.

The group looks forward to 2009/10 when with the support of the PCN the standards document will be translated into a work/action plan for each health community.

# The Peninsula Cancer Network

## PCN Board

*As at 31 March 2009*

### Chairman (1)

Anthony Farnsworth, Lead PCT Acting Chief Executive (Torbay Care Trust)

### Chief Executives or PEC Chairs of the four Primary Care Trusts (4)

Anthony Farnsworth (Acting Chief Executive) or Phil Green (PEC Chair)
Torbay Care Trust

Ann James (Chief Executive) or Peter Knibbs (PEC Chair)
NHS Cornwall & Isles of Scilly

John Richards (Chief Executive) or Paul Hardy (PEC Chair)
NHS Plymouth

Kevin Snee (Chief Executive) or Nick Darcy (PEC Chair)
NHS Devon

### Chief Executives or Medical Directors of the five acute trusts (5)

Jacqueline Kelly (Chief Executive) or Mike Roberts (Medical Director)
Northern Devon Healthcare NHS Trust

Paula Vasco-Knight (Chief Executive) or Steve Smith (Medical Director)
South Devon Healthcare NHS Foundation Trust

Angela Pedder (Chief Executive) or Vaughan Pearce /Martin Cooper (Joint Medical Directors)
Royal Devon and Exeter NHS Foundation Trust

Paul Roberts (Chief Executive) or James Palmer/Alex Mayor (Joint Medical Directors)
Plymouth Hospitals NHS Trust

Peter Colclough (Interim Chief Executive) or Vacancy (Medical Director)
Royal Cornwall Hospitals NHS Trust

### Network Senior Management Team (6)

David Chambers (Director)

Simon Rule (Medical Director)

Nikki Thomas (Nurse Director)

Liz Alsbury (Service Development Director)

Ian Mackenzie (Public Health Consultant)

Sarah Gray (Primary Care Clinical Lead)

### Research Network

Duncan Wheatley (Research Clinical Lead)

### Patient/user representatives (2)

Fiona Halstead, Chair of Partnership Group (Devon)

Rose Woodward (Cornwall)

### Chair of Palliative Care Network, representing voluntary sector (1)

Giles Charnaud

### Ex officio (1)

Julia Chisnell (South West Strategic Health Authority)

## Peninsula Cancer Network team members

*As at 31 March 2009*

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| **Gilly Beail**<br>Tel: 07825 027605 | **User Facilitator**<br>Email: gilly.beail@nhs.net |

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| **Wendy Maunder**<br>Tel: 01392 406904 | **SIF Royal Devon and Exeter**<br>Email: wendy.maunder@rdeft.nhs.uk |
| **Ruth Card**<br>Tel: 01872 255043 | **SIF Royal Cornwall**<br>Email: ruth.card@rcht.cornwall.nhs.uk |
| **Emma Wheatfill**<br>Tel: 01803 655562 | **SIF Torbay**<br>Email: emma.wheatfill@nhs.net |

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