Review to assess the quality, sustainability and cost effectiveness of cancer services for the Cumbria population, and to make recommendations for changes to improve sustainability.

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June 2011

Introduction and Recommendations

I was asked by NHS Cumbria, the counties Primary Care Trust, to undertake a review of county wide cancer services.

Terms of Reference for the review

Purpose: to assess the quality, sustainability and cost effectiveness of cancer services for the Cumbria population, and to make recommendations for changes to improve safety and sustainability.

Scope:

- To review the models of cancer care provided in both University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) and North Cumbria University Hospitals NHS Trust (NCUHT) and in the community, both within oncology and within the services for each tumour site;
- To review care standards;
- To identify areas of care which are at risk of being unsustainable e.g. due to small numbers of patients or dependent on individual clinicians with relevant expertise;
- To suggest ways of improving the overall sustainability of local services;
- To consider progress towards achieving National Radiotherapy Action Group (NRAG) recommendations;
- To recommend service models which would enable implementation of an acute oncology model across the three relevant hospital sites in Cumbria (Furness General, West Cumberland, Cumberland Infirmary).
- To suggest models for reducing unnecessary hospital admissions, in particular emergency admissions;
- To suggest models for further developing community based cancer services.
- To recommend approaches to improve integration and coordination of clinical and non-clinical support across community and hospital services
- To assess the effectiveness of management support to clinical services
- To recommend approaches for effective commissioning of services within the new NHS structures.

The National Cancer Director Mike Richards has previously commented: **'It would appear there are no *major* (the author's italics) concerns in Cumbria services''**.

He based his statement on information from the cancer peer review system and from the second annual report on the Cancer Reform Strategy.

For many the obvious response therefore is 'if it isn't broke why fix it?'' A more valid question would be "it may not be broke, but how can it be made better?'. The context being Britain's' poor cancer outcomes when compared with comparable international health care systems.

This is what this report will review.

I also look at the full draft review that was presented to the Cumbria PCT Clinical Senate on 24 March 2011. It is a review of the whole cancer pathway, which for our patients may seem more like a journey often rocky. A journey encompassing prevention, awareness raising - amongst public and professionals, early diagnosis with a particular emphasis on primary care, hospital quality issues, co-ordination of care by primary and community health services, survivorship, end of life care and sustainability of services.

I recommend a service improvement programme informed by the existing plentiful national and local information (annex 4). All the information available for this review is in the public domain but for some aspects of service are already out of date. All reviews are a snapshot in time and progress and improvement will have been made to some of the reviewed services. There needs to be on-going communications to update NHS staff and professionals and most importantly the public when progress is made.

This report concludes that the main responsibility for setting improvement standards and delivering improved outcomes must lie with all providers of services whether primary and community or hospital services; NHS Cumbria and providers working together to ensure a better system approach to improvement of care rather than one based on a focus on individual organisations alone. The challenge will be then to construct system wide indicators that all must contribute to achieve.

Continuous service improvement will be achieved if a more reflective and never satisfied culture can be instilled amongst all health care professionals. A culture that recognises the evidence base behind peer review, and emphasises audit and the use of benchmarking. Improvements will be made if the underlying principles of community involvement, transparent accounting to the public and patients and wherever possible devolving budgetary responsibility to front line clinicians is imbedded in service delivery.

I have constructed this review so ideally it will be read as a system approach but for ease of reference can be read as self-standing sections. The report goes beyond local information to place Cumbrian issues and services in a wider context. It also incorporates the many excellent ideas and suggestions received from local clinicians. This review is a participatory review whose recommendations I believe can improve outcomes for the people of Cumbria.

Finally there is a glossary at annex 3 detailing some of the cancer specific acronyms.

Summary of Recommendations:

Organisational:

- A cancer specific clinical group for Cumbria to be established whose names should be available to the public. Membership to include as a minimum the oncology lead of both hospital trusts, the medical directors of the trusts and NHS Cumbria, the Director of Public Health or their appointed representatives. From the GP commissioners as a minimum the GP locality leads for Cumbria or their appointed representatives and the GP cancer leads. To co-opt other clinicians as members as appropriate. This specific recommendation builds on the NHS Cumbria clinical led internal group, the Cancer Locality Fora and the University Hospitals of Morecambe Bay Cancer Quality Group.

- The group to appoint a Cancer Clinical Director for all Cumbria. The Director will work closely with the clinical group and NHS Cumbria's lead cancer commissioner to ensure implementation of the review and any cancer network or national recommendations. I do not perceive this role as full time as it is essentially a clinical leadership rather than a management role. Maintenance of clinical practice seems essential for such a role and leadership across organisations a prerequisite.

- Develop a communications process to update NHS staff and professionals and most importantly the public where progress is made between reviews.

- More use of video conferencing (VC) as a general policy in all clinical settings particularly in a rural area and not only for cancer services,. Usage to not only aid communication and improve staff productivity but also as an excellent low carbon option. The University Hospitals of Morecambe Bay Foundation Trust currently make extensive use of VC.

Prevention:

- To implement the Asset Based Community Development (ABCD) programme in Barrow in Furness and Carlisle. These two areas have the most significant socio economic deprivation together with poor cancer outcomes in Cumbria. A future focus on Copeland and Allerdale who also have poor cancer survival outcomes, with Copeland having poor cancer outcomes overall and Allerdale poor outcomes for lung cancer specifically.

- Develop direct or indirect incentives for general practices to adopt the Community-Oriented Primary Care (COPC) approach. To initially focus on the four geographic areas described above. This is a a systematic approach to health care based upon principles derived from epidemiology, primary care, preventive medicine, and health promotion.

- For the forming Health and Well-Being Board (annex 3), to prioritise a programme for cancer prevention. It will be necessary to develop a local outcomes framework to assess progress of a multi-agency strategy. Attention should continue to be given to evaluating the empowerment of communities and the changes in the quality of community life that result. Some specific outcomes should continue to include indicators around four week and twelve month quit rates for smoking and assessment of '5 a day' fruit and vegetable intake.

- For future population health, to maintain support for evidence based programmes for the positive health and well-being of children –The Healthy Child, Sure Start and Family Nurse Partnership programmes. The latter being currently piloted in Barrow in Furness.

Early Diagnosis:

- Promote early cancer awareness programmes tailored to local community needs as an integral part of a public health strategy.

- Ensure high uptake of cancer screening programmes by setting year on year stretch targets and devising a multi-agency approach for delivery. There is a specific key role for GPs as the only clinicians currently with a defined population responsibility.

- There is a need to target programmes on deprived communities and groups as they disproportionally have worse cancer outcomes.

- The above three recommendations to be key priorities for the nascent local Health and Well Being Board (annex 3).

- Develop with education leads an on-going cancer awareness education programmes for all clinicians. Programmes must also apply to cancers in children and adolescents where diagnosis can be even more delayed due to their rarity. Educationalists will need to ensure an on-going programme that is varied in approach to lessen the chance of repetition fatigue amongst clinical professionals.

- GP direct access to all mainstream diagnostic facilities to be maintained. It will be necessary to regularly review the opportunity to increase the scope and extent of future GP direct access to diagnostics.

- All clinical organisations which have a cancer treatment or population responsibility to audit all survival rates for cancer.

- To perform a significant event audit for all patients with one year or less survival, and to develop a future programme to audit cancer staging. The numbers of such patients may be small per primary care organisation but should not preclude an audit process. It is essential there is a recognised connection between high level clinical strategies and locally based clinicians.

- Develop a strategy for all providers to take on a defined population responsibility possibly building on GP single or aggregated practice lists. GP lists are already the building block for future GP commissioning consortia populations.

Hospital Issues:

- A key priority for the proposed Cancer Clinical Director supported by the proposed Cancer Clinical Board would be to ensure implementation of these particular recommendations.

- Patient surveys and the innovative PCT-led ‘five senses’ survey need to be publicly available with clear action plans in response to its findings.

- To have a clear goal of delivering accountable services across organisational boundaries.

- To enhance relationships with the specialist centres in Newcastle, Preston and the children's services in Manchester for south Cumbria.

- The whole local NHS system needs to work together to improve one and five year cancer survival and the cancer staging at diagnosis. Each provider should be held to account for their individual performance.

- Both hospital trusts to have a clear public action plan to implement on-going cancer review proposals with regular updates for the public on achievements and progress. Any new services to be 'self funded' by releasing resources from the current local programme budget for cancer. There is much evidence nationally of duplication between hospital and community based services in all disease areas, not only cancer services. Locally clinicians need to explore if duplication or avoidable hospitalisation is occurring in their localities. Devolved budgetary responsibility would ensure a focus on inappropriate and ineffective care delivery.

- There is strong evidence that more complex treatment and treatment of some rarer cancers should be concentrated on fewer sites as clinicians build up and maintain a high level of expertise. Unless there is agreed transparent clarity of which aspects of cancer care can safely be delivered locally, the safe option is to centralise both the running of the service and where care is delivered. The latter in particular could create an unnecessary burden on the people of Cumbria.

- There needs to be several and accountable service federations or partnerships formed to provide comprehensive clinical provision and sustainability of service.;- local hospitals with specialist centres, hospital and primary and community services, the PCT and providers together with the cancer networks.

- One suggestion I promulgated was a Cumbria wide hospital federation, as the travel distance between the trusts will often be less than with the specialist centres. I received support from University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) to consider the feasibility of the proposal. Given this proposal for many is new territory or induces a feeling of *déjà vu*, my recommendation is to actively explore possibilities. The suggestion emanates from recognition that any Cumbrian cancer services can quickly become non functional when unexpected events such as illness to staff occurs. Furthermore numbers treated per individual trust e.g. gastro intestinal cases, can be too small to ensure high quality continuity.

- There must be a fresh focus on how to prioritise more local cancer services for isolated communities which concomitantly have socio-economic problems. In particular for the residents of Barrow and the surrounding Furness peninsula.

- The two week cancer wait patients must have their services reviewed as I have received several complaints that even if patients are seen within that time frame, there are then longer waits in particular for ensuing investigation. There are of course three cancer related indicators; 2 week target /31/62 day standards (see annex 3 for details). These targets are being met, but the whole healthcare system - of which hospitals are a key component - hasto improve earlier cancer diagnosis.

- All the major NHS organisations need to develop a community focus such as recruiting a membership, organising deliberative events for the local public and by defining a population of patients for which they are responsible. A clear community focus will enable all providers to view themselves as a resource for their communities, for instance identifying themselves as a 'health promoting hospital'.

- For the individual hospital clinicians to be a population defined specialist resource for the public and specifically primary care professionals. The tariff system does not preclude such approaches, as frequently claimed.

- A population proactive responsibility must not prevent patients or their GPs outside that population having access to services.

- Nationally there is a focus on avoiding 'never events' which are aspects of care that should never occur. One of the suggested national topics is wrong route administration of chemotherapy. It is also well evidenced that chemotherapy delivered by well trained staff and with rigorous process measures can be delivered locally even in the patients home.

- Diagnostic facilities in many technologies can also be delivered locally-a clear developing role for local hospitals. Furness Hospital for instance currently provides access to Magnetic Resonance Imaging, Computerised Tomography, Endoscopy, Bronchoscopy, and breast screening.

Radiotherapy:

- To ensure implementation of the recommendations of the National Radiotherapy Action Group (NRAG) report. In particular by working with the cancer networks and with the nationally led work for a future cost effective expansion of radiotherapy services.

- To provide a satellite radiotherapy service at the Westmorland Hospital in Kendal to help the local population with access, particularly the Barrow-in-Furness area.

Primary care services: (many of these are replicated in other sections of this review)

- A programme to provide more comprehensive primary and community services for delivering cancer care 'closer to home' across the whole cancer journey. This to be a priority programme for GP commissioners that can also be a template for improvements to other clinical care services. Local incentives can be devised to augment the national Quality and Outcomes

Framework (QOF). Such schemes are often referred to as QOF plus. Budgetary devolution to GP practices for achieving transparent quality indicators can be another form of local incentives.

- Ensure high uptake of cancer screening programmes by setting year on year stretch targets and devising a multi-agency approach for delivery. There is a specific key role for GPs as the only clinicians currently with a defined population responsibility.

- Develop with education leads an on- going cancer awareness education programmes for all clinicians. Programmes also must apply to children and adolescents where diagnosis can be even more delayed. Educationalists will need to ensure an on-going programme to be varied in approach to lessen the chance of repetition fatigue amongst clinical professionals.

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- Develop a strategy for all providers to take on a defined population responsibility possibly building on GP aggregated practice lists. GP lists are already the building block for future GP commissioning consortia populations.

- Involving community pharmacy particularly in the early diagnosis programmes as they are trusted professionals with significant numbers of the public accessing their services. National data show public access is predominantly female but some examples of pharmacy recruiting male attendance by specific marketing.

- To encourage clinicians to use a cancer commissioning on line tool kit at general practice level that can be systematically utilised to assess their own practice performance.

- An audit of general practices referral rates for Chest XR and non obstetric ultrasound as indicators suggested by Professor Mike Richards. Being currently audited in Leeds as indicators of early referral for diagnosis.

- Key audit indicator-cancer patients who do not survive 1 year after diagnosis

Barrow in Furness:

- A specific project to ensure a local implementation of the cancer pathway for Barrow in Furness residents is developed with some urgency.

Children and Young People:

- For the clinical subgroup and the lead PCT Commissioner Manager to research other models of care for children and young people with complex or rare problems. Per general practice or locality such children are very small in number. A particular issue is the population locus and accountability for coordination of complex and/or rare cancer care. This is a national issue with the opportunity for Cumbria to be a leading innovator

Conclusion

The need to tackle any underperformance of cancer services locally and in the international context is urgent. A clear action plan with delivery targets set in a time frame is an essential priority with a clear public accountability to patients and the public for implementation.

National Context

According to research by the government's national clinical director of cancer services, Mike Richards, up to 10,000 people die needlessly every year of cancer because their condition is diagnosed too late. The figure is twice the previous estimate for preventable deaths. In addition, over half of all cancers could be prevented by changes to lifestyle (Cancer Reform Strategy 2007).

Office of National Statistics and the NHS Information Centre for Health and Social Care published the annual breast screening statistical bulletin on 20th January 2010. In 2008-09, just under 1.8 million women were screened, an increase of 44% from 1998-99. There were 14,166 cases of cancer diagnosed in women screened, nearly double the number compared to 1998-99. Of all cancers diagnosed, nearly 80% were invasive and over 50% were 15mm or less which could not have been detected by palpation. NHS Cancer Screening reports the outcomes for women with screen-detected cancers are better than for non-screen detected cancers.

Currently around 60% of all deaths occur in hospital although we know that 50% of people would prefer to be cared for and die at home. Only 20% of deaths occur at home with a further 20% in care homes. Nearly two thirds of all deaths occur in people over the age of 75 years.

A study published in the Cancer Research UK and National Cancer Intelligence Network identified that men are almost 40% more likely to die from cancer and 16% more likely than women to develop the disease in the first place.
There is evidence (Smith SM, Campbell NC, Macleod U, Lee AJ, Raja A, Wyke S et al. Factors contributing to the time taken to consult with symptoms of lung cancer: a cross-sectional study. *Thorax* 2009; 64 (6):523-531.) that cancer presentation is later in rural communities. A key reason for poorer outcomes in areas of lower socio economic status can be attributed to patients often having co- morbidities (multiple illnesses).

Compared to other countries, the NHS has achieved relatively poor outcomes in some areas for example, rates of mortality from some cancers (EUROCARE-4, www.eurocare.it). The National Cancer Intelligence Network (NCIN) study suggests that if England matched Norway and Sweden's survival rates for breast cancer, 957 deaths could be prevented annually within just two years of diagnosis.

By looking at the UK cancer deaths compared with countries with the lowest number of cancer deaths, we can calculate the average annual number of excess cancer deaths by age group - the figures are:

Age band	Excess deaths
• 55-64	1919
• 65-74	5512
• 75-84	10,090
• 85 plus	5723

The excess deaths are particularly high for lung cancer, followed by colorectal, breast and prostate all of which are the commonest cancers, and with a worsening trend amongst the elderly. UK survival rates for cervical, colo-rectal and breast cancer are among the worst in the Organisation for Economic Co-operation and Development (OECD) countries and below the average for premature mortality from lung cancer.

Although it must be noted the British Medical Journal published an article by Richard Peto and Valerie Beral, two Oxford academics, entitled ‘UK cancer survival statistics are misleading and make survival look worse than it is’ (BMJ. 341:c4112). There are similar doubts on the statistics by John Appleby (BMJ 2011; 342:d566), and a contrary review beyond only cancer (E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58–71).

Local Context

Cumbria sits in two cancer networks: Lancashire and South Cumbria Cancer Network (LSCCN) and North of England Cancer Network (NECN).

NHS Cumbria

Based on information from peer review and from the second annual report on the Cancer Reform Strategy, the National Cancer Director Mike Richards commented;

‘It would appear there are no major concerns in Cumbria services.

Screening coverage and two week wait performance are reasonably good; one year survival is in the top quartile for colorectal (though still poor by international standards) but in the bottom quartile for lung cancer; mortality is near average;

Improving Outcomes Guidance compliance looks reasonable, except for head and neck in Lancashire and South Cumbria; audit participation is good in North Cumbria, but could be improved at Morecambe Bay;

Elective bed day occupancy are in the worst quartile, but emergency bed day usage are average.

There was a breast screening incident at North Cumbria University Hospital now resolved and that peer review has revealed some concerns about specialist Multi-Disciplinary Teams.

In summary a more than satisfactory service but as nationally, much very good practice but not systematically embedded in the whole health system. And as ever opportunities to deliver an even better service.’

NHS Cumbria has developed a Cancer Commissioning Strategy to reduce cancer mortality and premature mortality. As part of the strategy a programme of systematic reviews of each cancer site was set up, starting with those which contribute most to cancer mortality. Reviews of lung and colorectal cancer have been completed. The review of lung cancer has resulted in a successful bid for Department of Health funding to launch a campaign to improve early detection and diagnosis of lung cancer.

NHS Cumbria's overall approach, in line with their 'Closer to Home' strategy is to retain and develop high quality locally based services while also recognising that some specialist services may need to be delivered across larger boundaries. These services will be enhanced by the creation of acute oncology teams across both Trusts and the new provider of breast screening services in North Cumbria.

NHS Cumbria has identified significant variation in rates of emergency admissions for cancer patients and wishes to reduce these rates and those of outpatient follow up. An essential component of the policy is to explore further options for developing community based cancer services to provide better support for patients undergoing cancer treatment and for cancer survivors.

Each of the six GP commissioning localities is in the process of developing a local action plan in response to the Cancer Commissioning Strategy.

NHS Cumbria's provider service, which from 1 April 2011 became part of Cumbria Partnership NHS Foundation Trust, has a community children's team which has recently started to deliver some chemotherapy at home. *All hospital aspects of children's cancer is undertaken by specialist cancer centres outside of Cumbria so outwith this review.*

Information

There is an abundance of existing information which provides a baseline on performance, including.

- NHS Cumbria wide reviews of Colorectal and Lung cancer services.
- Cancer peer review reports for North of England Cancer Network (covering North Cumbria) and Lancashire and South Cumbria Cancer Network.
- National Cancer Patient Experience Programme 2010 - National Survey covering North Cumbria University Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Trust.
- Complemented by information provided by local users of services-'the five senses report'.
- National Cancer Peer Review of both hospital trusts by National Cancer Action Team (NCAT) zonal team.
- General and detailed information about GP practices from NHS Cumbria.

Lung Cancer data

Specifically for Lung cancer which is a particular priority area for Cumbria - survival data by Indices of Deprivation 2004: Income Deprivation quintiles.

- Survival is significantly lower in the least affluent.

- In England for every one person who has survived 5 years, 16 have died.

- In Cumbria for every one person who has survived 5 years, 28 have died.

- For the most deprived areas in Cumbria (quintile 5), no one will survive 5 years.

- For those in quintiles 4 and 5 (worst), nationally for every one person who survived 5 years, 17 will have died. In Cumbria 52 people will have died.

- The population need for lung cancer prevention, early diagnosis and treatment is higher in Cumbria in comparison to England, particularly in areas associated with high levels of deprivation.

- The symptoms of lung cancer may be relatively non specific, as a result of which referral routes are many and varied. National Lung Cancer Audit (LUCADA).

- LUCADA data 2007 highlights, of those diagnosed with lung cancer, almost half (47%) are referred directly from primary care to the lung cancer team with suspicion of the disease via the Two Week Wait route, and the remaining proportion (53%) are referred either after an emergency presentation or from another speciality within a hospital. The rapid referral guidelines and specialist access clinics have improved the patients journey significantly, however for many, the delay in diagnosis means that by the time they reach specialist care, many patients are found to have the disease at an advanced stage which cannot be cured.

Local concerns were raised that at the Furness hospital site half of the patients diagnosed with lung cancer were admitted as emergencies via Accident or Emergency or Medical Assessment Units. Although this fits with the LUCADA picture, comparative data analysis is required to evaluate the pattern of this further across each acute trust provider

Early Diagnosis

There are three strands to early diagnosis;

- public and professional awareness,
- screening, and
- a speedy response to relevant symptoms.

There are also two key audit measures to support early diagnosis; one year survival and the staging of the cancer.

Survival of one year or less is a good indicator of delayed diagnosis.

Staging of cancer is the most important predictor of survival, and cancer treatment is primarily determined by staging. The stage of a cancer is a description (usually numbers I to IV with IV having the most progression) of the extent the cancer has spread. The stage often takes into account the size of a tumour, how deeply it has penetrated, whether it has invaded adjacent organs, how many lymph nodes it has metastasized to (if any), and whether it has spread to distant organs.

The earlier a cancer can be diagnosed the greater the prospect of a cure. The later a cancer is diagnosed the harder it is to treat and the poorer the patient’s chances of survival. Evidence suggests that later diagnosis of cancer has been a major factor in the poorer survival rates in the UK compared with many other countries in Europe. One of the priorities of the Cancer Reform Strategy is to diagnose cancers at an earlier stage.

There is a need to prioritise programmes for the ‘underserved ’e.g. People with severe mental illness have substantially lower survival rates for stroke, heart disease, diabetes and cancer. Only 19 per cent of disabled women are screened for cervical cancer, compared to 77 per cent of the population. Research also shows that black women are likely to have more advanced cancer at the time of diagnosis than white women.

BBC News Report 2009 following publication of the second annual report of the Cancer Reform Strategy states: “New efforts led by National Clinical Director for Cancer Services Professor Mike Richards are planned to educate the public about the signs of cancer, tackle the widespread reluctance to tell their GP if they develop symptoms, and improve family doctors' ability to spot signs of the disease earlier.

Britain is poor by international standards at diagnosing cancer. Richards' findings will add urgency to the NHS's efforts to improve early diagnosis. They also raise further questions about how often family doctors fail to recognise tell-tale signs.

Experts say early diagnosis can be the difference between a patient living for a short or long time or deciding whether they need surgery, such as a mastectomy, or not because quick access to surgery, drugs or radiotherapy greatly improves chances of survival. In an article in the forthcoming British Journal of Cancer, which is published by Cancer Research UK, Richards will say: "Efforts now need to be directed at promoting early diagnosis for the very large number (over 90%) of cancer patients who are diagnosed as a result of their symptoms, rather than by screening”.

The National Awareness and Early Diagnosis Initiative [NAEDI-SEE ANNEX 1] has been established to co-ordinate and drive efforts in this area. The size of the prize is large – potentially 5,000 to 10,000 deaths that occur within five years of diagnosis could be avoided every year. "Richards reached his conclusions after analysing one-year survival rates for the three cancers in England and comparing them with those in other European countries in the late 1990s. Previously he had looked at the number of patients who were still alive five years after diagnosis. One-year survival is now thought to be a much better indicator of whether diagnosis was early or late. The study focused on Britain's three biggest cancer killers: lung, which killed 34,589 people in 2007; colon (16,087); and breast (12,082). They account for 40% of the 155,484 cancer deaths in the UK in 2007 and, Richards found, about half of all the deaths could have been avoided if diagnosis was as good as the best performing European countries. Richards found that "late diagnosis was almost certainly a major contributor to poor survival in England for all three cancers", but also identified low rates of surgical intervention being received by cancer patients as another key reason for poor survival rates.

Research by academics at Durham University led by Prof Greg Rubin has identified five types of delay in NHS cancer care: "**patient delay**", "**doctor delay**", "**delay in primary care [at GPs' surgeries]**", "**system delay**" and "**delay in secondary care [at hospitals]**".The new initiative is intended to "fix this problem", helping the UK's 53,000 GPs improve their ability to identify patients who may have cancer, said Richards. With smoking in decline "early diagnosis is our next big challenge in cancer and will be crucial in bringing our survival rates up to the best in Europe", he added.

Prof Steve Field, (then) chairman of the Royal College of GPs, said: "Mike Richards's latest findings on cancer diagnosis are really important information and reinforce the need for GPs to put a lot of effort into ensuring that patients present [their symptoms] and have access to GPs, and that we pick up the symptoms early on, and also reflect if we can do things even better in this crucial area of healthcare, which we can. It's wrong to blame GPs for all these deaths, as there are many factors involved, including patients not recognising symptoms of cancer and not talking to their GP about them, especially middle-aged men. But I'm sure that we could all at times be more alert to symptoms and investigate and refer patients quicker," he added.

Sara Hiom, director of health information at Cancer Research UK, said GPs faced a difficult task in spotting cancer: "Despite cancer being a common disease, the average GP will only see one case of each of the four biggest cancers each year. Many of the symptoms that could be cancer turn out to be something less serious, but it's best to get things like unusual lumps, changes to moles, unusual bleeding or changes to bowel motions checked by a GP. Early diagnosis usually means that treatment is more effective and milder for the patient,'' added Hiom'.

Cumbrian Focus

Further local audit within Primary care may help us understand the reasons behind late presentation and the high rate of emergency admissions in particular for lung cancer in Barrow in Furness. Such information will augment the national research on late diagnosis.

Community involvement is as relevant for working with the public on early symptom awareness as it is for prevention. A particular focus given Cumbria's poor outcome for this disease is on working with men who are the most likely to develop lung cancer.

A report from NHS Cancer Screening had flagged up some local issues;
The Cumbria breast screening programme was difficult to set up and has recently given rise to an incident (see next section for progress on North Cumbria University Hospitals services). The bowel programme performs satisfactorily. The cytology service has been transferred to be led by Manchester.

The Lancaster breast screening programme performs satisfactorily.

Screening

Screening is of particular and major importance according to NHS Cancer Screening. A high uptake of approved screening programmes is a major part of an early diagnosis strategy. The outcomes for women with screen-detected cancers are better than for non-screen detected cancers even amongst deprived or Black and Minority Ethnic (BME) communities. Breast cancer patients from deprived or black and ethnic minority communities will do just as well as white breast cancer patients if they are diagnosed by a routine mammogram.

Cervical cytology for cervical cancer is well proven, as is the breast mammogram programme, but numbers need to be higher with a focus on ‘hard to reach groups'. Screening programmes must also ensure higher numbers participate in colo-rectal cancer screening.

Community based professionals enjoy high trust amongst their patients so therefore have a particular responsibility to promote screening uptake. Promotion including programmes for breast and colo-rectal cancer which are organised and run separately from traditional community based clinical services.
As less than 10% of cancers are diagnosed by screening (14% for cervical cytology, 21% breast cancer) increased uptake of opportunities to participate in screening programmes are essential given the better outcomes produced.

Referral

Just as important to achieve better outcomes, patients who potentially have cancer symptoms need to be referred earlier even if that entails more investigations that turn out to be negative. Less than 50% of cancers are diagnosed by the two week suspected cancer target. And National Institute for Health and Clinical Excellence (NICE) lung cancer guidance recommends chest X-ray for designated symptoms persistent for more than three weeks in order to promote earlier detection of lung cancer.

GP continued direct access to all mainstream diagnostic facilities is an essential component of good cancer services.

Recommendations:

- Promote early cancer awareness programmes tailored to local community needs as an integral part of a public health strategy.

- Ensure high uptake of cancer screening programmes by setting year on year stretch targets and devising a multi-agency approach for delivery. There is a specific key role for GPs as the only clinicians currently with a defined population responsibility.

- There is a need to target programmes on the ‘underserved’ as they disproportionally have worse cancer outcomes.

- The above three recommendations to be key priorities for the nascent local Health and Well Being Board (annex 3).

- Develop with education leads an ongoing cancer awareness education programmes for all clinicians. Programmes also must apply to cancers in children and adolescents where diagnosis can be even more delayed due to their rarity. Educationalists will need to ensure an on-going programme is varied in approach to lessen the chance of repetition fatigue amongst clinical professionals.

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- Develop a strategy for all providers to take on a defined population responsibility possibly building on GP single or aggregated practice lists. GP lists are already the building block for future GP commissioning consortia populations

Prevention

To reiterate, over half of all cancers could be prevented by changes to lifestyle-Cancer Reform Strategy (2007). The Office of National Statistics reports that one in three people in the UK will develop cancer in their lifetime, with breast, lung, colorectal and prostate cancers being the four most common types.

Someone who starts smoking aged 15 is three times more likely to die of cancer due to smoking than someone who starts in their late twenties.

Alcohol use disorders are also associated with a wide range of physical problems including various cancers.

Cancer can significantly be reduced through simple measures. The challenge is to ensure sustainability of any approaches, which could include:

- Stop tobacco use and avoid exposure to second-hand smoke
- Limit alcohol consumption
- Maintain a healthy weight through healthy eating
- Protect against cancer causing infections (for instance cervical cancer).

There is a need to build on work currently in existence.

From April 2010 to April 2011 the Cumbria Stop Smoking Service (CSSS) supported 3312 people to stop smoking. The conversion rate from setting a quit date to a successful 4 week quit is an average of 56% (well above the national average). The Stop Smoking Service offer clinics at over 50 venues across Cumbria, offering a variety of one to one, group or telephone support. Support can also be obtained from GP practices and trained Community Pharmacists.

Colo-Rectal cancer is of particular concern locally because of its higher incidence in Cumbria and is largely related to dietary or lifestyle factors (NHS Cumbria review).

Identified factors related to increased risk of colorectal cancer include:
- High intake of red and processed meat
- Being overweight or obese
- Being inactive
- Drinking more than 30g/day of alcohol (around 4 units)
- Having diabetes, ulcerative colitis or Crohn's disease
- Having a direct relative who developed bowel cancer

There is a high incidence of lung cancer and of poor clinical outcomes particularly in Allerdale, Carlisle, Copeland and Furness and a high incidence generally in Cumbria of colo-rectal cancer. A specific local more intense approach will be necessary to augment the general programme of health promotion.

An opportunity beckons in the new government proposals on public health and in particular the proposal for a County Council led Health and Well Being Board. The proposed Board, working through the leadership of the Director of Public Health, offers a major opportunity to formulate and implement plans for specific health promotion and education programmes. Such an approach necessitates wider public involvement and offers an opportunity for the public and their elected representatives to hold these programmes to account. To ensure sustainability of such programmes, local approaches are an imperative and require NHS involvement. NHS Cumbria is a national leader in implementing the policy on GP commissioners who will be an integral part of the Health and Well Being Board.

Local public health outcome measures within the national outcomes framework will enable the system to be held to account. The national outcomes domains currently out to consultation are;

- Protect the population's health from major emergencies and remain resilient to harm

- Tackling the wider determinants of health

- Health improvement

- Prevention of ill health

- Healthy life expectancy and preventable mortality

The basic underpinning of a prevention strategy must involve local community engagement and involvement but needs to go much further by adopting clear community organising principles.

There are existing Cumbria programmes of engagement - ‘Cumbria voice’ and the one hundred members of the public involved in each of the six PCT localities in Carlisle, Barrow, Eden, Allerdale, Copeland and South Lakeland . The localities were designed to be coterminous with the six district council boundaries to aid partnership working.

More needs to be undertaken with new approaches to engage the more ‘hard to reach’. (Reference; Ganz, Marshall. "Leading Change: Leadership, Organization, and Social Movements." Handbook of Leadership Theory and Practice. Ed. Nitin Nohria and Rakesh Khurana. Harvard Business School Press, 2010, 509-550).

A project the author of this review is involved in ‘Engaging Communities Staffordshire’ is an innovative approach that can provide a model for Cumbria’s future Healthwatch to commission (see annex 3). It enables all organisations, including the voluntary sector and members of the public, to work better together on how to engage and involve people across the County in health and social care matters from consultation to complaints and consumer advice. By coordinating things centrally and becoming a social enterprise, the organisation will become a hub of information, to enable the ‘bigger picture’ in a way that has not been possible before. The transcripts from the public inquiry into Mid Staffordshire NHS Foundation Trust are beginning to provide evidence that there are areas of overlap and disconnection and that the idea for this new organisation was well founded. Work has been on-going on this project since May 2010 and following a development and testing of concept phase sponsored by Staffordshire County Council in partnership with South Staffs PCT, Mid Staffs NHS Trust and the Department of Health. The Council has been funding the next phase of its development from September 2010. The work in progress is available for information on www.staffordshire.gov.uk/health/engagingcommunities.

Given the intensity and commitment required, such approaches will need to be targeted initially on areas with poor cancer outcomes and socio economic issues. These are two related factors as the incidence of cancer, with the exception of breast cancer, exhibits a marked gradient towards areas of more social deprivation. Based on public health data, the four areas in Cumbria to initially focus upon in alphabetical order are Allerdale, Carlisle, Copeland and Furness.

Significant behaviour change needs to entail a multiagency approach. Examples of which are the Karelia Project on heart disease in Finland and the SunSmart skin cancer programme in Australia with its catchy slogan Slip! Slop! Slap!. England in recent years has developed the health promoting multi agency ‘Change for Life’ programme that encourages small died and lifestyle changes to improve health.

The 25-year results and experiences of the North Karelia Project show that a determined and well-conceived intervention can have a major impact on health related lifestyles and on population risk factor levels. It also demonstrates that such a development leads to reduced disease rates and improved health of the population. By 1995 the annual mortality rate of coronary heart disease (the disease it was designed to focus on) in North Karelia in the working age population had fallen approximately 75%, compared with the rate before the Project.

In discussion with local Director of Public Health, John Ashton, there presents a good opportunity to focus on more imaginative but evidence based approaches to local community development. There are two complementary programmes both of which are highly relevant to the proposed future policy for the NHS and the wider concepts of public health - ‘Community-oriented primary care’ (COPC) which particularly fits well with the renewed focus on list based general practice, and ‘Asset Based Community Development’ (ABCD).

Community-oriented primary care (COPC)

Community-oriented primary care (COPC) is a systematic approach to health care based upon principles derived from epidemiology, primary care, preventive medicine, and health promotion. In the 1950s, Sydney Kark showed dramatic positive changes in the health status of the population of Pholela, South Africa, using this approach. Similar approaches showed positive change in the health status of poor and underserved populations in the United States.

Asset based community development (ABCD)

Asset based community development (ABCD) is a methodology that seeks to uncover and utilise the strengths within communities as a means for sustainable development. The first step in the process of community development is to assess the resources of a community through a capacity inventory. This is achieved by involving the residents to determine what types of skills and experience are available. The next step is to support communities to discover what they care enough about to act on. The final step is to determine how citizens can act together to achieve those goals.

Recommendations:

- To implement the Asset Based Community Development (ABCD) programme in Barrow in Furness and Carlisle. These two areas have the most significant socio economic deprivation together with poor cancer outcomes in Cumbria. A future focus on Copeland and Allerdale given poor cancer survival outcomes- overall in Copeland and for lung cancer in Allerdale.

- Develop direct or indirect incentives for general practices to adopt the Community Oriented Primary Care (COPC) approach. To initially focus on the four geographic areas described above.

- For the forming Health and Well-Being Board (see annex 3), to prioritise a programme for cancer prevention. It will be necessary to develop a local outcomes framework to assess progress of a multi-agency strategy. Attention should be given to evaluating the empowerment of communities and the changes in the quality of community life that result. Some specific outcomes could include indicators such as four week and twelve month quit rates for smoking and assessment of '5 a day' fruit and vegetable intake.

- For future population health, to maintain support for evidence based programmes for the positive health and well-being of children –The Healthy Child, Sure Start and Family Nurse Partnership programmes. The latter being currently piloted in Barrow in Furness.

Survivorship

1.6 million people in England have had a diagnosis of cancer. An ageing population, the resulting increase in cancer incidence and improved survival mean that cancer prevalence will continue to grow at over 3% a year. Some 50% of cancer patients have a five year survival and need to be part of generic long term conditions programmes.

End of Life Care

Currently around 60% of all deaths occur in hospital although we know that 50% of people would prefer to be cared for and die at home. Only 20% of deaths occur at home with a further 20% in care homes. Nearly two thirds of all deaths occur in people over the age of 75 years.

Recommendations

- General practice populations should be the focus for long term conditions and end of life programmes.
- A clear commitment to provide regularly audited services that enable patients to have the end of life care they request

Hospital based care

North Cumbria University Hospital Overview

North Cumbria University Hospital NHS Trust (NCUHT) is unusual in having had a standalone radiotherapy service for a number of years. This is unusual for radiotherapy in that in most places in England this type of unit would be run as a satellite of a main tertiary centre.

NCUHT has an establishment of 4 consultant clinical oncologists (combined radiotherapy and chemotherapy specialists) and a nurse consultant serving a population of around 320,000.

Due to its distance from a specialist centre, NCUHT also has agreement to provide surgical services for less common cancers, including head and neck cancer and upper GI cancer as a satellite from Newcastle. The recent round of Peer review visits have revealed concerns at specialist cancer multi-disciplinary team (MDT) level about the small numbers of patients for certain services in North Cumbria.

A concern in the provision of hospital based cancer services centre on the fragility of the oncology service. There has been a period during which the Trust had inadequate oncologist cover and no established network arrangements to cover such a gap. The NCUHT will need additional oncologist posts to implement the acute oncology recommendations of the National Chemotherapy and Radiotherapy Advisory Group reports. The funding of such posts should be identified from delivery of more efficient and effective current provider services including cancer services. It is of note *nationally well over 50% of cancer monies are spent on patients being in hospital beds rather than specific cancer therapies*.

There needs to be detailed plans in regard to specific tumour sites with a clear and audited delivery strategy. For instance for urological cancers, until two years ago patients had to travel to Newcastle for Trans Rectal Ultrasound. Two new surgeons have now been appointed.

Breast cancer had also been of concern due to there being one substantive breast surgeon; however there is now a second surgeon in post. The breast screening incident did highlight some concerns about the effectiveness of the multi-disciplinary team and for example whether latest best practice was being systematically implemented.

More care needs to be delivered ‘closer to home’ or indeed in the patients home as happens currently in many non cancer NHS services.

The following information is publically available on the National Cancer Peer Review website, www.CQUINS.nhs.uk. This is a report of their local zonal team.

“North Cumbria Hospital Trust has been subject to a number of Chief Executive appointments and changes in the senior management team and cancer management team over the past 5 years, which has influenced the development of fully constituted and functioning Multi Disciplinary Teams (MDT). When we visited in November 2010 a number of new appointments had been made that should lead to a period of stability.

It is a very independent Unit that strives to keep hold of services to enable care closer to home in what is a very complex geographical area. North of England Cancer Network (NECN) supports some complex care being delivered locally, either as stand alone or in partnership with Newcastle i.e. radiotherapy services; specialist Oesophago-Gastric, Head and Neck and first line treatment for testicular cancer. These arrangements are often fragile due to small numbers of patients, lack of cover and/or problems with staffing for specialist on-call rotas.

The Zonal Team was aware that their breast screening service was suspended in July 2010, but restarted in January under monitored governance from elsewhere.

Looking back over previous reports, there is a general weakness of clinical/pathway governance and in the clinical infrastructure. Many services are dependent on locums, which sometimes compromises secondary to tertiary relationships. During the locality update in November 2010 reviewers and the Zonal Team were advised that ‘management require staff to deliver a safe, patient focused service across all tumour sites’, but there are challenges to achieving this aim. (See section 4 below)

2. Specific Issues

A number of specific issues are highlighted below. Where appropriate the Trust’s/Network’s response and actions to the issues is given in summary following each issue (in bold italic font).
Given the number of technical terms used please refer to annex 3 glossary.

2.1 Radiotherapy

Peer Review compliance 2010 = 90% and above for all four areas. The Radiotherapy Unit is free standing rather than a satellite of Newcastle and as such there are staff shortages in therapeutic radiography and in the physics department, and also small numbers of consultant oncologists. This situation means the service is vulnerable, as appropriate cover is not always available during periods of leave and staff are not able to develop the service in line with new technologies/techniques. In addition, more complex treatments will require staff to sub-specialise in order to develop the necessary expertise.

Brachytherapy numbers are low overall and a serious concern was raised during peer review. Reviewers also urged the Trust to implement plans for Intensity Modulated Radiotherapy (IMRT).

The Trust’s response to the Zonal Team indicated that brachytherapy referrals will reach the required levels by 2013; the Zonal Team has indicated they are satisfied with the explanation provided.

2.2. Head and Neck Specialist Cancer Service

This service should be a satellite of Newcastle, but there are worrying signs, picked up during External Validation (EV), that it is functioning as a separate multi disciplinary team (MDT). Both the Internal Validation (IV) and EV reports were damning and we are visiting to ensure action has been taken. It is likely that 60 surgical procedures were undertaken in 200/10 without discussion with the Specialist Team in Newcastle. The Team is scheduled for a visit in 2011.

The position regarding the status of the MDT remains as planned i.e. as a satellite of the Newcastle MDT. Documentation will be amended to reflect this and the opportunity of the visit later in 2011 will be taken to reassure the Zonal Team that arrangements are suitable.

2.3 Oesophago-gastric Specialist Cancer Service

The service currently functions well and has a very good lead clinician who works in partnership with colleagues in Newcastle. However, he is due to retire soon and it will probably be difficult to replace him given the small number of patients treated. Given the advances in medical technology leading to a reduction in oesophageal resections, the Zonal Team has suggested an external review is needed to determine future configuration of this service in NECN.
The Network will continue to work with both Trusts to ensure an appropriate scale of population is maintained.

2.4 Local Skin MDT

The death of the Lead Clinician in 2009 led this team to underperform but information received in November was reassuring.

- Consultant lead appointed for MDT
- Consultant Nurse Specialist (CNS) in post
- MDT functioning much better – attendance improved
- Stronger links with Network Site Specific Groups (NSSG)
- Stronger links with Northern (Newcastle) Centre for cancer care (NCCC) – shared care
- Good attendance at Advanced Communications Skills Training (ACST) course
- General Practitioners with Special Interests (GPwSIs)– under PCT governance arrangements (model 1)

The Team is scheduled for a visit in 2011.

2.5 Local Urology MDT

Continues to be a low performing team and nephron sparing surgery is being undertaken locally. We are visiting again in November 2011 when, hopefully, this practice will have stopped.

3. Progress Reported During Peer Review November 2010

- MDT attendance – much improved
- Nursing input for all MDT's, although not all are CNSs
- Good compliance with 31/62 day targets
- MDT Co-ordinators for each tumour site
- Increased clinical trials portfolio and recruitment – actively recruiting into 29 trials
- Improved video link facilities for MDT's & NSSG meetings
- Delivered Advanced Communication Skills Training courses in North Cumbria – 30 professionals attended in 2010, 2 MDT's fully compliant
- Good Patient & Carer involvement in peer review processes

4. Challenges Reported During Peer Review November 2010

- Limited histopathology input into MDT's
- Limited palliative care input into MDT's
- Access to video link facilities - improving
- Limited input into the NSSG meetings – improving, but Network meetings held in the North East so reliant on effective video conferencing (VC)
- Retention and recruitment of staff - Lung CNS, Head and Neck CNS, Gynaecology CNS
- Hospital sites trying to provide equitable services
- Appointing Lead Cancer Nurse (acting post)
- Cost Improvement Program & Bed reconfiguration

On meeting the senior management and clinical leaders of the trust in very open discussion, I was informed that MDT attendance and the work load of the clinical nurse specialists now presented no problem, recruitment problems are improving and the recruitment of two new urologists, one of whom has a special interest in cancer, has greatly improved the service. There is good research undertaken at the trust, the acute oncology model has decreased admissions but that local chemotherapy services need to be developed further. Skin cancer services are improving and in general peer review of services demonstrates good care. One haematologist is to retire which will put great pressure on the service if not replaced quickly and for haematology there is a very good working relationship with the Newcastle centre as there is with the Newcastle cardio thoracic surgeons.

Most notably their Lung MDT has been ranked as joint top in the country, scoring 94%. A separate set of results from the National Lung Cancer Audit have also shown a dramatic and sustained increase in numbers referred for potentially curative surgery as well as patients being offered chemotherapy and radiotherapy over the past 3 years across North Cumbria.

There is a great need for a clinician to clinician forum with Newcastle to help to allay perceived fears and relationships at the Cumberland Infirmary. There is excellent collaborative working between the local GPs and West Cumberland hospital producing good models of care and delivery. The relationship with the cancer network NSSG is good for updating knowledge.

A view was expressed that the PCT should facilitate service transformation and there is an enthusiasm for a trust population responsibility.

Network feedback expressed no quality concerns other than those identified in Peer Review, but expressed concern of poor smoking quit rates and the inadequate patient information as revealed by surveys could be much improved.

University Hospitals of Morecambe Bay NHS Foundation Trust

The local GP view of the overall cancer service provided by the Trust is positive:

- South Lakes reports no hospital quality concerns and good GP/consultant relations
- Barrow in Furness reports no concerns on hospital quality

This is generally supported by the Cancer Network.
UHMBFT has its own and more usual oncology service, with two medical oncologists plus a visiting service from Lancashire Teaching Hospitals covering a catchment population of over 300,000 (South Cumbria and North Lancashire).
UHMBFT have commendably set up a cancer quality peer review system which now includes NHS Cumbria.

The Trust reports it has been pro-active in pushing forward the cancer agenda and service delivery locally including:

1. The Trust is looking to develop a satellite radiotherapy unit at Westmorland General Hospital, in response to the National Radiotherapy Action Group (NRAG) report, in partnership with Lancashire Teaching Hospitals NHS Foundation Trust, the tertiary provider. The Trust will provide support services on the site but the clinical oncologists and the service will be managed by the tertiary provider. An outline business case for a one linear accelerator unit has been produced and shared with commissioners.

2. The Trust directly employs medical oncologists and proposes to expand this with the development of an acute oncology team. One of the Trust's medical oncologists was on the NCAG Team that developed the proposals. The Trust has pushed hard with commissioners to ensure this service can be developed and an agreement is close to being signed.
3. The Trust has secured charitable funding in addition to its own funds to open a day case chemotherapy unit at Westmorland General Hospital, Kendal from summer 2011.
4. The Trust also provides a range of screening services including bowel screening across Cumbria and Lancaster plus breast screening services across Morecambe Bay and Lancashire.

The following information is publically available on the National Cancer Peer Review website –www.CQUINS.nhs.uk. This is their local Zonal Report.
A number of specific issues are highlighted below. Where appropriate the Trust's/Network's response and actions to the issues is given in summary following each issue (in bold italic font).
Given the number of technical terms used please refer to annex 3 glossary.

South/West Cumbria Overview

Many of the issues in Morecambe Bay are similar to North Cumbria; the South Cumbria element (at Barrow) is very isolated and Kendal is finding its role following planning decisions made in the 1980s about an independent General Hospital service there. The major problem is that the whole Trust, covering three hospitals, has a catchment of just over 300,000 and each of the hospitals is small.
The infrastructure to support cancer services is weak; although the Cancer Management Team is enthusiastic, they need be more pro-active in identifying and resolving problems.

Although unified Multi Disciplinary Team arrangements for cancer topics are becoming established, the delivery of care in each hospital is largely dependent on one or two people and many locums are used to keep services local. Whilst many of these are retired consultants from the locality, this is obviously a time-limited resource and it is likely that many of the services are not going to be sustainable locally.

The development of a local Medical Oncology service in the 1990s followed by the opening of the radiotherapy unit at Preston has helped to improve the management of solid tumour cancers enormously. Overall performance though, in terms of access to treatments, survival and team compliance is below average. An example is the extremely poor lung cancer record.

There has been some concern about the creation of an inpatient oncology service at Barrow, but this may be closer to current thinking than it was at the time. There are, however, concerns about governance, which also emerged with regard to haemato-oncology with the wish to make Barrow a site for ITC.
It is recognized that this is a difficult geographical setting in which to deliver modern health care, but the local commissioners and providers need to ensure that the

balance is right between quality care/treatment and local provision. There are no Specialist MDTs in the locality.

Internal validation (IV) processes were robust and issues identified, but the Zonal Team is not convinced that the Cancer Management Team has enough influence to effect change.

6. Specific Issues

The following teams are all low performing compared to the national average, mainly due to weak governance around multi disciplinary team (MDT) functioning.

Although concerns were raised, some of the MDTs have a 75% + compliance rate, so to say they were all low performing against national average does not give a true reflection.

6.1 Local Skin MDT

This team does not meet on a regular basis; treatment decisions are made without full MDT discussion; job plans do not include time to prepare for/attend meetings and there is no CNS. The issues were picked up as IRs/SCs during internal validation, but the team is due to be visited in May 2011 to confirm that appropriate action has been taken.

An action plan is now in place to address these issues.

6.2 Local Urology MDT

The CNSs work as nurse practitioners, therefore, they are unable to fulfill the role of CNS in supporting patients through the pathways. The Team does not have an MDT coordinator, which leads us to question governance arrangements. The Zonal Team is keeping a watching brief on developments.

An action plan is now in place to address these issues.

6.3 Breast MDT

There was no clear leadership of this team when visited in May 2010 and IRs were identified regarding some cases not being discussed by the MDT prior to surgery and also a vascular surgeon was operating on patients with breast cancer, but was not a core member of the MDT. Correspondence subsequently received confirmed the issues had been addressed.

All the above concerns have been addressed.

6.4 Lung MDT

The CNS workload is excessive resulting in not all patients receiving the level of support needed and also not being able to fulfill other aspects of the CNS role e.g. research, audit activity, service improvement.

The Lancaster CNS workload was excessive but this has now been addressed.

6.5 Paediatric Oncology Shared Care Unit (POSCU)

A debate is ongoing regarding the feasibility of a shared care unit that does not deliver chemotherapy. The measures are written to include chemotherapy with the result that Morecambe Bay POSCU could not demonstrate compliance. LSCCN has advised us that if the measures are not amended or deemed not applicable for units where chemotherapy is not delivered, the service will be discontinued and children transferred to Manchester.

A debate is ongoing regarding the feasibility of a shared care service which is compliant with the Improved Outcomes Guidance for cancer (IOG) and Peer Review measures and meets the need of the local population. The Trust has had an informal shared care arrangement with the Principal Treatment Centre at Royal Manchester Children's Hospital. This arrangement does not comply with the NICE Guidance and does not meet the peer review requirements. The Trust, both PCTs, CNB, CCNCG (Children's Cancer Network Co-ordinating Group) have been pro-active in discussing our concerns with the national team and feedback is awaited on an alternative approach if this is possible.

7. Progress Reported During Peer Review May 2010

- Family history breast service
- Installation of new video conferencing equipment
- Implementation of ePrescribing
- Focus on early awareness and early detection
- Strong GP cancer leadership and Public Health engagement
- GP / Primary Care Cancer Newsletter
- Strong engagement with local cancer partnership group in service delivery
- End of Life (EOL) service – supporting patients to die at home /support to Nursing Homes.

8. Challenges Reported During Peer Review May 2010

- Affordability e.g. breast screening age expansion and access to local psychological and rehabilitation services
- Tariff development
- Establishing a breast assessment clinical in Barrow
- Need for targeted Interventions to ensure equity of care/treatment
- Developing acute oncology service for presentations via A&E and emergency re-admissions.
- Meeting new Going Further on Cancer Waits (GFOCW) targets
- Addressing outstanding IOG Issues e.g. Head and Neck and Supportive and Palliative Care.

On meeting the senior management and clinical leadership of UHMBFT, several key points emerged from their personal comments, a brief summary of which is below. There is lower manning and funding for local oncology services compared with regional centres (which is the service norm). For instance there is a fast track complete diagnostic service for lung cancer in Barrow and Kendal (Westmorland) with progress to bronchoscopy in one week. Complications of paediatric cancers were treated locally but the latest network guidance (see annex 4) clarifies the optimal pathway. There is a bid for another full time oncologist for Furness General.

If successful, this could aid unnecessary admissions to hospital. Clinicians are also of the view that brachytherapy is not the palliative approach they prefer.

Clinicians have an acceptance that care closer to home is an inevitability and improvements need to be made in MDT attendance, some IOG groups could perform better and a review is necessary. Quality of care is good but the governance of the process could be improved. The Cancer Quality Group involves clinicians and managers. Their preferred approach is their current model of medical oncology and separate radiotherapy service.

In the Liverpool regional centre area there is a lead clinician and chief executive for each cancer IOG sub group. There was executive interest in a Cumbria wide hospital identity, primarily as federations could be more cost effective, with a population healthcare focus and in being a health promoting hospital.

The LSCN reported video conferencing facilities in all hospices and electronic communications are saving specialist palliative time. Cancer peer review tests good technical skills but not support systems. There is some resource for GPwSI to support hospices and larger care homes with a plan to extend this. I recommend promotion of the cancer awareness online toolkit for staff.

Dr Hunt, the local GP cancer lead for South Lakes, has written a most useful dissertation on ‘cancer care pathways in primary care’ and reports the on-going ‘cough,cough’ NAEDI GP project-involving a few practices-has a lung cancer early stage pick up of 11-19%.

GPs need to be supported with more information for their patients about what will happen and has happened to them in the hospital cancer pathway - preferably online and including two week wait information. Video conferencing would help Dr Hunts role considerably, which is as a patient and primary care advocate and in raising cancer awareness in primary care. The patient survey should be more geared to socially deprived populations.

In Barrow in Furness the GP cancer lead, Dr Thimmiah, reports there is an action plan for early diagnosis of lung cancer involving GP training but not as yet community pharmacy. The local problem is a high degree of diagnosis on emergency admission and low resection rates, maybe as a consequence of advanced disease. Generally there is a need for acute oncology advice and a physical presence of cancer specialists.

Radiotherapy

National Radiotherapy Action Group (NRAG) report of 2007 states that cancer affects one in three of the population.

Radiotherapy (the use of high energy x-rays to treat disease) is a key component of both radical (with the aim of curing a patient) and palliative (for symptom relief in incurable cancer) treatment for cancer. Detailed modelling by Delaney et al indicates that 52% of cancer patients should receive radiotherapy as part of their treatment. Of those cured of their cancer (i.e. go on to survive at least 5 years), it is estimated that radiotherapy contributes to that cure in 40% of cases either alone or in combination with other treatments such as surgery.

NRAG believes that some increase in capacity could be achieved by using existing equipment to its full potential. It recommends that all radiotherapy departments should ensure their linear accelerators (linacs) deliver at least 8,000 fractions per annum averaged across all linacs in the department with immediate effect. (NCUHT do deliver at least this level of fractions and over many years).

There is a general consensus among experts that the projected need for radiotherapy was significantly underestimated 15-20 years ago. There is a large gap (63%) between current activity levels and optimal treatment levels, if radiotherapy were to be given to all who might benefit. The position is set to worsen as cancer incidence increases with the ageing population. This means that PCTs will need to commission more fractions (i.e. attendances for radiotherapy treatment) for their population.

Generic hospital issues

There are significant challenges to existing models of care and of culture if we are to build a sustainable hospital service. To reiterate based on information from peer review and from the second annual report on the Cancer Reform Strategy, the National Cancer Director Mike Richards commented;
‘It would appear there are no major concerns in Cumbria services.

Screening coverage and two week wait performance are reasonably good; one year survival is in the top quartile for colorectal (though still poor by international standards) but in the bottom quartile for lung cancer; mortality is near average;

Improving Outcomes Guidance compliance looks reasonable, except for head and neck in Lancashire and South Cumbria; audit participation is good in N Cumbria, but could be improved at Morecambe Bay;

Elective bed day occupancy are in the worst quartile, but emergency bed day usage are average.

There was a breast screening incident at North Cumbria University Hospital now resolved and that peer review has revealed some concerns about specialist Multi-Disciplinary Teams.

In summary a more than satisfactory service but as nationally, much very good practice but not systematically embedded in the whole health system. And as ever opportunities to deliver an even better service.’

The Cumbria wide issue of the fragility of existing services remains due to the rurality of the county. As was discussed in my hospital visits, we need to develop a federated model of partnership to obviate the recourse to structural solutions. Takeovers or mergers rarely alone bring benefits to patients.

Recommendations:

- A key priority for the proposed cancer clinical director supported by the proposed cancer clinical board would be to ensure implementation of these particular recommendations.

- Patient surveys and the innovative PCT led ‘five senses’ survey need to be publicly available with clear action plans in response

- To have a clear goal of delivering accountable services across organisational boundaries.

- To enhance relationships with the specialist centres in Newcastle, Preston and the children’s services in Manchester for south Cumbria.

- The whole local NHS system needs together to improve one and five year cancer survival and the cancer staging at diagnosis. Each provider held to account for their individual performance.

- Both hospital trusts to have a clear public action plan to implement on-going cancer review proposals with regular updates for the public on achievements and progress. Any new services to be ‘self funded’ by releasing resources from the current local programme budget for cancer. There is much evidence nationally of duplication between hospital and community based services in all disease areas not only cancer services. Locally clinicians need to explore if duplication or avoidable hospitalisation is occurring in their localities. Devolved budgetary responsibility would ensure a focus on inappropriate and ineffective care delivery.

- There is strong evidence that more complex treatment and treatment of some rarer cancers should be concentrated on fewer sites as clinicians build up and maintain a high level of expertise. Unless there is agreed transparent clarity of which aspects of cancer care can safely be delivered locally, the safe option is to centralise both the running of the service and where care is delivered. The latter in particular could create an unnecessary burden on the people of Cumbria.

- There needs to be several and accountable service federations or partnerships formed to provide comprehensive clinical provision and sustainability of service.;- local hospitals with specialist centres, hospital and primary and community services, the PCT and providers together with the cancer networks.

- One suggestion I promulgated was a Cumbria wide hospital federation as the travel distance between the trusts will often be less than with the specialist centres. I received support from University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) to consider the feasibility of the proposal. Given this proposal for many is new territory or induces a feeling of *déjà vu*, my recommendation is to actively explore possibilities. The suggestion emanates from recognition that any Cumbrian cancer services can quickly become non functional when unexpected events such as illness to staff occurs.

Furthermore numbers treated per individual trust e.g. gastro intestinal cases can be too small to ensure high quality continuity.

- There must be a fresh focus on how to prioritise more local cancer services for isolated communities which concomitantly have socio-economic problems. In particular for the residents of Barrow and the surrounding Furness peninsula.

- The two week cancer wait patients must have their services reviewed as I have received several complaints that even if patients are seen within that time frame, there are then longer waits in particular for ensuing investigation. There are of course three cancer related indicators; 2 week target /31/62 day standards (annex 3 for details). These targets are being met but the whole healthcare system of which hospitals are a key component have to improve earlier cancer diagnosis.

- All the major NHS organisations need to develop a community focus such as recruiting a membership, organising deliberative events for the local public and by defining a population of patients for which they are responsible. A clear community focus will enable all providers to view themselves as a resource for their communities for instance identifying themselves as a ‘health promoting hospital’.

- For the individual hospital clinicians to be a population defined specialist resource for the public and specifically primary care professionals. The tariff system does not as frequently claimed preclude such approaches.

- A population proactive responsibility must not prevent patients or their GPs outwith that population having access to services.

- Nationally there is a focus on avoiding ‘never events’ which are aspects of care that should never occur. One of the suggested national topics is wrong route administration of chemotherapy. It is also well evidenced that chemotherapy delivered by well trained staff and with rigorous process measures can be delivered locally even in the patients home.

- Diagnostic facilities in many technologies can also be delivered locally-a clear developing role for local hospitals. Furness Hospital for instance currently provides access to Magnetic Resonance Imaging, Computerised Tomography, Endoscopy, Bronchoscopy, breast screening.

- To ensure implementation of the recommendations of the National Radiotherapy Action Group (NRAG) report. In particular by working with the cancer networks and with the nationally led work for a future cost effective expansion of radiotherapy services.

- To provide a satellite radiotherapy service at the Westmorland hospital in Kendal to help the local population with access particularly the Barrow-in-Furness area

Role of community based services

The providers of first contact primary care are general medical practitioners, who nationally provide some 90% of all NHS clinical contacts with patients, general dental practitioners, community pharmacists and community optometrists. Care is also provided by community health services, social services, voluntary organisations and on occasions privately funded services.

All community based services need to contribute to the whole cancer pathway from prevention, screening, early diagnosis through to co-ordination of care. Dentists for instance can be a source of health promotion and raising awareness of oral cancers. Community pharmacists who are amongst the most popular of local professionals and whose services have a large 'footfall' of the public are very well placed to contribute. There are excellent national examples of the extended role of community pharmacy.

Community health services in conjunction with social services and GP practices can provide personalised support for both long term survivors and also for end of life care.

The 'Gold Standard Framework' or the 'Liverpool Care Pathway for the dying patient pathway' provides excellent audit tools for end of life care. Long term care should be audited against the national generic long term conditions framework and any locally agreed standards.

The national QIPP (Quality, Innovation, Productivity and Prevention) programme majors on delivery of the long term conditions policy. This programme can be utilised locally to focus and deliver on the long term care aspect of cancer services.
But general medical practice provision with its local and popular focus, its major clinical activity and its list based population responsibility will have the key provider role in system care. The successful delivery of the national pay for performance Quality and Outcomes Framework (QOF), the allocation of generic practice based budgets and the future GP leadership role in NHS Commissioning all depend on or are a consequence of a population responsibility. It is to be hoped that other community based professionals and their various organisations will embrace a population focus.

The role of the GP and the role of the practice, despite being inextricably linked, are essentially separate. A good GP 'has a liking for people and a flair for diagnosis' to quote Kenneth Robinson the Minister of Health who introduced the ground breaking 1966 GP contract. Two attributes that must stand the test of time as community credibility enhances the potential to lead. An individual GP optimally has a continuing relationship with their patients and extended family often over many years. But it is the practice with its extended team and population responsibility that has the potential to be the major local resource for their registered patients.

The key attributes of a GP service are;

- First point of contact care for many
- Continuous person and family focussed care
- Care for all common health needs
- Management of long term conditions

- Referral and coordination of specialist care
- Care of the health of the population as well as the individual (Chambers and Colin-Thomé. Doctors Managing in Primary Care – International Focus 2008).

Apart from specialised care, all aspects of the cancer pathway can be delivered through the practice working with fellow community based health and social care services and supported by hospital staff with a community role.

By adopting the community oriented primary care approach practices can significantly contribute to and potentially lead the necessary multi agency approach to prevention and community cancer awareness. The practice can play a major role in promoting all aspects of screening and could be incentivised and equally held to account in ensuring uptake.

Early diagnosis is the key skill of the clinician "*the ability to organise; the chaos of the first presentation...*'' as Paul Freeling late emeritus Professor of General Practice described.

Early diagnosis awareness can be much aided by computer system support, for instance flagging smokers, heavy alcohol drinkers and those with a relevant family history to be a constant reminder to clinicians to respond promptly to relevant symptoms. There are incidentally systems well on the way to development that can identify for clinicians a likely differential diagnoses from patients previous input of their symptoms. Primary care clinicians must have easy access to diagnostics with no stigma attached to negative investigations but regularly audited to identify unwarranted variation and investigations that are part of locally agreed pathways. Map of Medicine (annex 3) software can underpin the development of these pathways and lead to a future increase in direct access to more advanced diagnostics.

Those patients who are currently on treatment, are survivors or require end of life care should have access to practice based 'community matron' nurses to ensure co-ordination and responsive care. In my former practice (Castlefields, Runcorn) a cancer community nurse employed by the practice resulted in better audited care that produced significant reduction in hospital bed days and more importantly an increasing number of patients dying in the place they wished.

There is an opportunity to look at the role of the cancer clinical nurse specialist working across primary and secondary care and whether that is an option for future funding. Their role is to enhance better co-ordination and partnership working across organisations that could be self funded from improved productivity and by lessening duplication and unwarranted hospitalisation.

The individual practice may lack the capacity, capability and willingness to provide such an extended service but if they are part of a federation or locality of provider practices, that organisation can provide the strategic and operational management skills and staff needed.

Recommendations: (some are replicated in other sections of this review)

- A programme to provide more comprehensive primary and community services for delivering cancer care 'closer to home' across the whole cancer journey. This to be a priority programme for GP commissioners that can also be a template for improvements to other clinical care services. Local incentives can be devised to augment the national Quality and Outcomes Framework (QOF). Such schemes are often referred to as QOF plus. Budgetary devolution to GP practices for achieving transparent quality indicators can be another form of local incentives.

- Develop direct or indirect incentives for general practices to adopt the Community-oriented primary care (COPC) approach.

- Ensure high uptake of cancer screening programmes by setting year on year stretch targets and devising a multi-agency approach for delivery. There is a specific key role for GPs as the only clinicians currently with a defined population responsibility.

- Develop with education leads an on- going cancer awareness education programmes for all clinicians. Programmes also must apply to children and adolescents where diagnosis can be even more delayed. Educationalists will need to ensure an on-going programme to be varied in approach to lessen the chance of repetition fatigue amongst clinical professionals.

- GP direct access to all mainstream diagnostic facilities to be maintained. It will be necessary to regularly review the opportunity to increase the scope and extent of future GP direct access to diagnostics.

- All clinical organisations which have a cancer treatment or population responsibility to audit all survival rates for cancer.

- To perform a significant event audit for all patients with one year or less survival and to develop a future programme to audit cancer staging. The numbers of such patients may be small per primary care organisation but should not preclude an audit process. It is essential there is a recognised connection between high level clinical strategies and locally based clinicians.

- Develop a strategy for all providers to take on a defined population responsibility possibly building on GP aggregated practice lists. GP lists are already the building block for future GP commissioning consortia populations.

- Involving community pharmacy particularly in the early diagnosis programmes as they are trusted professionals with significant numbers of the public accessing their services. National data show public access is predominantly female but some examples of pharmacy recruiting male attendance by specific marketing.

- To encourage clinicians to use a cancer commissioning on line tool kit at general practice level that can be systematically utilised to assess their own practice performance.

- An audit of general practices referral rates for Chest XR and non obstetric ultrasound as indicators suggested by Professor Mike Richards. Being currently audited in Leeds as indicators of early referral for diagnosis.

- Key audit indicator-cancer patients who do not survive 1 year after diagnosis.

Barrow in Furness

Of the areas of social deprivation with poor cancer outcomes, Barrow has specific issues that need to be addressed as a priority. Its problems are further magnified by its geographical isolation from many hospital services.

Barrow has high smoking incidence, a high number of lung cancer patients diagnosed at emergency admission and having poor cancer outcomes. For patients with suspected breast cancer diagnosis requires travel.

Recommendation:

- A specific project to ensure a local implementation of the cancer pathway for Barrow in Furness residents is developed with some urgency.

Children and Young Adult's Services

Earlier diagnosis of cancer is a major issue.
Virtually all specialist care for cancer in children and young adults is delivered outside of Cumbria and will require cancer network overseeing of quality and efficiency.

Paediatric Oncology Shared Care Unit (POSCU)

A debate is ongoing regarding the feasibility of a shared care unit in south Cumbria that does not deliver chemotherapy. The measures are written to include chemotherapy with the result that Morecambe Bay POSCU could not demonstrate compliance. LSCCN has advised us that if the measures are not amended or deemed not applicable for units where chemotherapy is not delivered, the service will be discontinued and children transferred to Manchester (see UHMBFT response in the section on hospital services).

Children with long term conditions, including survivors, need their complex care better co-ordinated. As numbers of these patients per practice or even locality are small, different approaches than traditional community led care may be appropriate.

Recommendation:

- For the clinical subgroup and the lead PCT Commissioner Manager to research other models of care for children and young people with complex or rare problems. Per general practice or locality, such children are very small in number. A particular issue is the population locus and accountability for coordination of complex and/or rare cancer care. This is a national issue with the opportunity for Cumbria to be a leading innovator.

Annex 1

The National Awareness and Early Diagnosis Initiative aims to ensure that this work is taken forward. There are seven workstreams, one of which focuses on interventions in primary care and is led by Professor Greg Rubin on behalf of the Royal College of General Practitioners. There are four parts to the programme of work. The focus in the NHS North West is on lung cancer.

1. A baseline assessment of interval from first presentation to diagnosis

There is limited available data on the interval from symptom onset to diagnosis for most cancers. The time covered by this period can be attributed to patient, doctor or system factors. The national audit will examine factors affecting the patient journey from the time of first presentation to the point that the diagnosis is made, i.e. it will focus on doctor and system delay.

2. An analysis of Significant Event Audits for cancer diagnoses

Significant Event Audit is a quality improvement tool that is in routine use in general practice. SEA provides a structured narrative analysis of the circumstances surrounding the event of interest. Qualitative analysis of the content of a large number of SEAs for the same event allows recurring themes to be identified. These can then form the focus for service improvement.

3. Development of an audit template

Audits of cancer diagnosis have already been undertaken in some parts of the UK, notably in Scotland. Their focus has been largely on the use of the rapid referral process. National audits are in place for some cancer sites (bowel, head and neck, upper GI) but these largely concentrate on the post-diagnosis experience.

4. Programme development

This programme has an oversight group drawn from academic and service general practice, the DH NAEDI team and the cancer charities. This group will take an overview of the development of the National Audit, ensuring that it integrates with service delivery in general practice, the objectives of the Cancer Reform Strategy, and the shared research agenda of NAEDI, CR-UK and the NCRI. It will meet 2-3 times a year, and also communicate by email and teleconference as necessary.

Annex 2

People interviewed with a huge thank you for their time:

Personal contact in order of meeting
Dr Mike Bewick Medical Director –NHS Cumbria
Johanna Reilly Commissioning Director-NHS Cumbria
Jenny Weaver Network Commissioner – NHS Cumbria
Ros Berry Senior Commissioner – NHS Cumbria
Mr Irving Cobden Medical Director – NHS Cumbria
Prof John Ashton Director of Public Health– NHS Cumbria
Carole Heatly Chief Executive – North Cumbria University Hospitals Trust (NCUHT)
Dr Mike Walker Medical Director – NCUHT
Dr Jonathan Nicholl Clinical Lead – NCUHT
Dr Peter Weaving Lead GP – NHS Cumbria (North)
Roy McLachlan Network Lead, North of England Cancer Network
Dr David Fyfe Clinical Lead, MBHT
Dr Hugh Reeve Lead GP – NHS Cumbria (south)
Dr Arun Thimmiah GP Cancer Lead – NHS Cumbria

Dr Peter Dyer Medical Director – MBHT
Tony Halsall Chief Executive – MBHT
Kath Nuttall Network Lead, LSCCN
Dr Chrissie Hunt GP Cancer Lead – NHS Cumbria
Peter Clark- patient and public involvement NHS Cumbria

Phone and/or email
Professor Michael Richards National Clinical Director for Cancer, Department of Health England
Ruth Bridgeman Acting National Coordinator National Cancer Peer Review National Cancer Action Team.
Julietta.Patnick@cancerscreening.nhs.uk
Su Sear lead for the Stop Smoking Services – NHS Cumbria

Annex 3

Glossary

Asset Based Community Development (ABCD)

Advanced Communications Skills Training (ACST)

Brachytherapy also known as internal radiotherapy, sealed source radiotherapy, curietherapy or endocurietherapy, is a form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment

Cancer Targets and Standards
Two-Week Wait. Currently all patients referred by their GP should have their first appointment within a maximum of 14 calendar days.
31 Day Standard. Currently once the decision to treat a (cancer) patient has been made, that first definitive treatment (i.e. treatment with a curative or therapeutic intent) must be delivered within 31 calendar days
62 Day Standard. Currently this only applies to those patients initially referred via the GP as a suspected cancer (i.e. via the Two-Week Wait route). First definitive treatment must be delivered within 62 calendar days from the date of initial GP referral.

Community-oriented primary care (COPC)

Clinical nurse specialist (CNS)

End of Life (EOL)

General Practitioners with Special Interests (GPwSI). GPs who remain GPs but have a recognised special interest in a specific care area e.g. Cancer.

Going Further On Cancer Waits Targets (GFOCW) - January 2009 changes

- All surgical & drug treatments within 31 days.

- 62 day pathway for screen detected patients (breast; cervix; bowel).

Healthwatch. The new system of Local Healthwatch organisations will harness local involvement so that everyone can benefit from health and social care services that are fit for the purposes of the local community. They will continue to be funded by local authorities but will be more accountable for operating effectively and providing value for money. They will also have a fundamental new role in designing and developing health and social care services through new Health and Wellbeing Boards.

Health and Well Being Boards. Health and Well Being Boards in Local Authorities will join up commissioning across the NHS, social care, public health and other services directly related to health and wellbeing, to secure better health and wellbeing outcomes for their whole population, better quality of care for all patients and care users, and better value for the taxpayer

Improving outcomes guidance (IOGs)

Immediate Risks and Serious Concerns (in Peer Review) (IRs/SCs)

Intensity Modulated Radiotherapy (IMRT)

Lancashire & South Cumbria Cancer Network (LSCCN)

Multi Disciplinary Team (MDT)

Map of Medicine. Care maps for healthcare, incorporating evidence-based information, national policy and expert knowledge. The topics that the maps address are prioritised based on cost, healthcare burden and unjustified variations in care. The Map was used as the template by NHS Cumbria to develop a heart failure service, as referenced by Price CP, Martin L. Novel markers, a payer's perspective: Commissioning a new service. Scand J Clin Lab Invest 2010; 70: 103-08. doi 10.3109/00365513.2010.493420.Local clinical groups agree how their particular challenges will be met and adapt the map to reflect their service design decisions.

National Awareness and Early Diagnosis Initiative [NAEDI]

National Chemotherapy Action Group (NCAG)

National Lung Cancer Audit (LUCADA)

National Radiotherapy Action Group (NRAG)

National Institute for Health and Clinical Excellence (NICE)

Northern (Newcastle) Centre for cancer care (NCCC)

North Cumbria University Hospitals NHS Trust (NCUHT)

North of England Cancer Network (NECN)

Primary Care Trust (PCT)

Network Site Specific Groups - NSSG. Each cancer network to have clinical sub groups to address specific cancer services.

Paediatric Oncology Shared Care Unit (POSCU)

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT)

Annex 4

Information on Cumbria cancer services (Available on request)

NHS Cumbria - Cancer comparisons

Five Senses Observation Report Cumberland (Carlisle) Infirmary –NECN
UHMBFTT North Zone Cancer Peer Review

Lancashire and South Cumbria Cancer Network Board Peer Review Self Assessment/Internal Validation Process 2010

National Cancer Action Team review response

Cancer Peer Review Report North of England Cancer Network July 2010

NHS Cumbria Lung Cancer Service Model 2010

NHS Cumbria Lund Cancer Pathway Review Interim Document and Summary Document

Subsequent Oncological Treatments for Testicular Cancer Patients: The Newsacctle Upon Tyne Hospitals

National Cancer Peer Review External Verification Report: Colorectal

National Cancer Peer Review External Verification Report: Head and Neck

National Cancer Peer Review External Verification Report: Urology

NHS Cumbria Colorectal Cancer Review Report for Cancer Carestream Board

National Cancer Patient Experience 2010 National Survey North Cumbria University Hospitals Trust

National Cancer Patient Experience 2010 National Survey Morecambe Bay University Hospitals Trust

Cancer Services in Cumbria – Position Statement

Children's Cancer Network: Guidelines for the referral of patients with complications related to chemotherapy