

CANCER SERVICES

ANNUAL REPORT

2006/7

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INTRODUCTION

Last year saw the second major external review of cancer services at Derriford Hospital. The National Cancer Peer Review took place in September 2006 when a team of inspectors spent two days in the Trust judging local performance against the nationally accepted standards. The major cancer teams were inspected as well as the infrastructure behind cancer services such as diagnostics and imaging. Derriford hospital fared extremely well in this process and it is thanks to the many clinicians, clinical nurse specialists and many other individuals who invested a lot of time in the preparation and presentation of the data required at the inspection that this went so well. I want to particularly thank Kate Lansdell who coordinated a lot of the activity and was instrumental in the teams being so well prepared on the day. Of all the teams reviewed perhaps the most gratifying of all was the review into gynaecological cancer. So impressed were the review team that they have urged the Network to reconsider the 2004 plan, which would see a majority of gynaecological cancer surgery being moved to other hospital sites. It is hoped we can progress that during this year.

With the MDT Co-ordinators in place and the cancer office functioning very well, we now have robust data on all cancer diagnoses as well as the time taken for patients to move through the diagnostic processes to definitive treatment. This has allowed us to audit the use of the internal two-week wait mechanism. What we have shown over a 6 month period is that the percentage of patients diagnosed with cancer, who are referred through this internal mechanism, is almost 50%, which fully justifies this important pathway. As General Practitioners become aware of the ability of Consultants to internally fast track patients they consider to be at high risk of cancer, so the number of two week waits has stopped rising. This internal mechanism has come to the attention of Mike Richard's cancer action team who are considering adopting it.

Finally, a very important study run by Ed Pace in the Chemotherapy Unit, which was initiated by the cancer services team and funded by Macmillan has proven unequivocally that patients can safely receive chemotherapy in community hospitals. This was a randomised trial where all patients received 2 cycles of chemotherapy in Derriford and 2 cycles in a community hospital. Irrespective of where they received the first treatment, virtually every patient chose to have the remainder of their treatment within the community hospital setting. This is an important, novel study that will soon be published and provides the evidence to support the government policy to move patients out of the large hospitals for some aspects of this treatment.

There clearly remain problems with cancer pathways. Whilst the pathways are very robust for newly diagnosed patients, relapsed patients do not, as yet, enjoy the same fast track mechanisms. This may well be addressed in the next Cancer Plan. There remain capacity issues with radiotherapy and certainly some imaging remains a challenge. Finally, whilst we have good data collection at diagnosis, we don't have comprehensive prognostic information available on many of our patients. Ultimately of course we would like outcome data, and hopefully we will be able to build on our databases and ultimately provide this information. This is what patients need to know if they are to exercise choice in where they receive their cancer treatment.

Dr S A J Rule-Director of Cancer Services

1. PRIMARY AND SECONDARY CARE INTERFACE

Plymouth Hospitals and Primary Health Care teams have continued to meet monthly to address common issues and improve services to patients and carers.

Achievements include:

- Improving cancer pathways between independent providers and primary and secondary care
- Support to the implementation of Outreach Chemotherapy Services
- Review of follow up for breast cancer patients
- Reducing delays to 2ww referrals from primary to secondary care

2. SCREENING

2.1 Breast Screening

The Screening Programme is currently running within its target of screening every woman within three years. This is unusual in the Southwest, where almost every Unit has some delay. Though this part of the Service runs well (it is based on how many Radiographers we have and we are adequately staffed), the lack of Radiologists is seriously impacting on our ability to cope in a timely fashion with the need to read films, assess patients and perform biopsies.

Our short-term plan is to get a new Consultant Breast Radiologist. It seems that, as fast as we appoint, we lose other Colleagues (retirement etc.). In addition, in the last year, training of an Advanced Practitioner commenced. This person, who started as a Radiographer, will be taking on Radiology roles.

Currently, the ability of the Radiology side of the Unit to keep on track is in doubt, but I hope this is a short-term problem. Many members of staff have felt the strains of change within the Unit, but I hope our position will be more stable by the end of this year.

Dr J Steel – Consultant Radiologist and Associate Clinical Director

2.2 Bowel Screening

Derriford is set to be a centre for colorectal screening later this year. The endoscopy unit is undergoing a process of accreditation and subject to satisfactory peer review will start Screening in August 2007. In the first wave, all patients aged between 60-69 will be offered FOB testing. Patients with 4/6 positive samples will be offered colonoscopy at the Derriford site. Currently, response rates are 65 %. This will be the first screening programme to include men.

Dr Chris Hayward-Consultant Gastroenterologist

3. DIAGNOSTICS

3.1 IMAGING

The major challenges in the last year have been PACS, Peer review and targets. Community wide PACS was introduced from May 2006 onwards. I think it would be fair to say that not all the “bugs” are out of the system as I write in February 2007. Although some areas of functionality have been lost in the X-ray department and some applications are rather slow, the wide dissemination of images around the medical community has undoubtedly been a major step forward for patient care.

The peer review process was undertaken in a supportive fashion and has been helpful in addressing some of our problems.

The general tightening of radiological targets and the extension of the two week waits has lead to considerable pressure in imaging particularly on cross-sectional imaging but thus far it is pleasing to report that waiting time trends are satisfactory and with the goodwill and hard work of the radiographers, clerical staff and support workers should remain so.

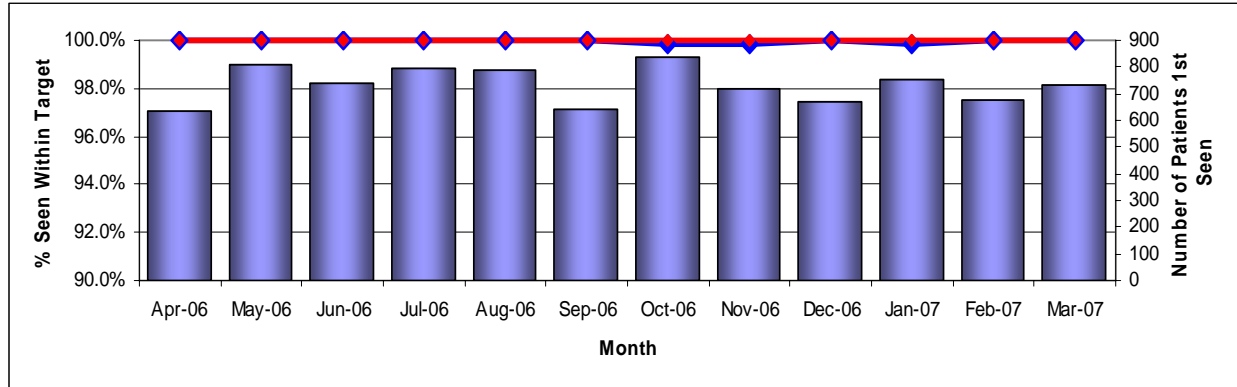
Dr M P Williams-Cancer Lead for Imaging

4. CANCER WAITING TIMES

4.1 Two Week Wait Target (Table 1 & Graph 1)

MONTH	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	2006 / 07
Number of Patients Seen	632	809	740	792	791	639	837	722	671	751	676	731	8791
Number of Breaches	0	0	0	0	0	0	1	1	0	1	0	0	3
% Seen Within Target	100 %	100 %	100 %	100 %	100 %	100 %	99.9 %	99.9 %	100 %	99.9 %	100 %	100 %	99.97%
DOH Target	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100%

Table 1



Graph 1

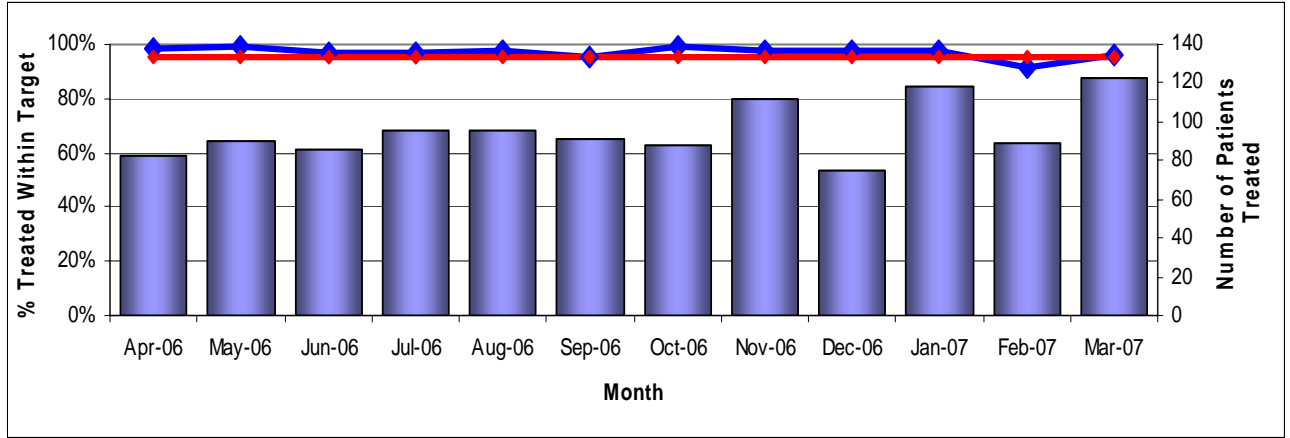
The Trust continues to achieve an average compliance rate of 100% for seeing patients within two weeks following urgent GP referral for suspected cancer. In the year April 06 to March 07 patients first seen under the Cancer 2ww increased by 1033 compared with the same period in 2005/6.

The benign to malignant ratio for all cancers referred by GPs under the 2ww is 15.23% for 2006/07 an improvement compared with 14.29% for the same period last year.

4.2 62 Day Cancer Waiting Time Targets (Table 2 & Graph 2)

MONTH	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	2006 / 07
Number of Patients Treated	82	90	85.5	95.5	96	91.5	87.5	112	74.5	118.5	89	122.5	1114.5
Number of Breaches	1	0.5	2.5	3	2.5	4.5	1	2.5	1.5	2.5	7.5	4.5	33.5
% Seen Within Target	99%	99%	97%	97%	97%	95%	99%	98%	98%	98%	92%	96%	97.07%
DOH Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Table 2



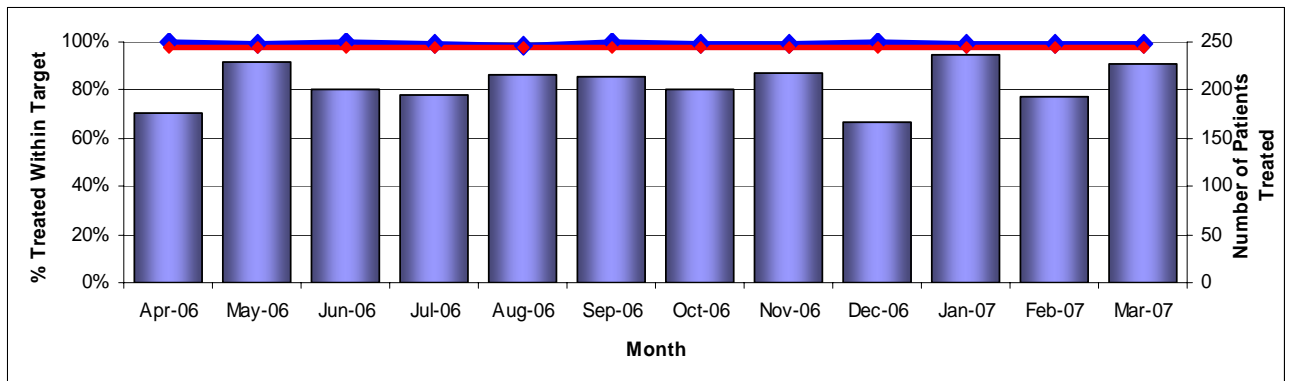
Graph 2

At the end of March 07, the Trust continued to achieve over 95% from 2ww referral to treatment for cancer patients referred under the 2ww (62 Day Target) with a performance of 97% for 2006 07. This is a credit to multidisciplinary teams, admin, managerial and clerical staff who have worked hard to ensure patients are treated quickly as possible.

4.3 31 Day Cancer Waiting Time Targets (Table 3 & Graph 3)

MONTH	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	2006 / 07
Number of Patients 1st Treated	177	230	201	195	215	214	201	218	166	237	194	227	2475
Number of Breaches	0	2	0	2	3	0	2	1	0	2	1	1	14
% Seen Within Target	100%	99%	100%	99%	99%	100%	99%	100%	100%	99%	99%	99%	99.43%
DOH Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Table 3



Graph 3

At the end of March 07, the Trust continued to achieve over 98% for all diagnosed patients from decision to treat to treatment (31 Day Target) with a performance of 99% for 2006 / 07.

4.4. Internal Consultant Referrals

Following the success of the Cancer Waiting Times Targets, the Trust agreed to ensure that all patients with a suspicion of cancer should be fast tracked through diagnostics to enable faster treatment times. In June 2006 a process was implemented to enable Clinicians within the MDT to upgrade suspected cancer patients not referred through the 2ww system.

The results below illustrate the number of patients upgraded, the benign to malignancy ratio. Accurate information of time taken to treatment cannot be presented due to difficulty in recording suspensions however this will form part of next year's objectives.

Cancer Site	ICR Referrals Received										Total
	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	
Brain						1					1
Breast		1		1				1	1	2	6
Colorectal	1	5	3	7	5	8	11	15	5	4	64
Gynaecology	1	2	1		1	4	2	1	1	2	15
Haematology						2		5	2		9
Head and Neck	2		4	2	3	5	1	2	4	6	29
Lung	1	4	3	2	1	2	5	15	7	6	46
Other		1	1			3			3	3	11
Paediatric										1	1
Sarcoma		1			1		2				4
Skin	1						2	1			4
Upper GI	6	2	5	7	4	1	7	5	2	4	43
Urology	4	17	22	26	37	47	25	30	30	16	254
Total	16	33	39	45	52	73	55	75	55	44	487

Data Produced by Katie Caley – Performance Information Manager

5. NATIONAL CANCER PEER REVIEW

In September 2006, thirteen cancer teams were peer reviewed as part of the National Cancer Measures. Over 60 reviewers attended the Trust to interview staff and patients and view the services. Overall the results were extremely positive and highlighted the hard work and commitment of the teams to this process. The immediate concerns regarding intrathecal administrative errors and space on haematology ward were addressed immediately. Those remaining outstanding concerns in particular are the lack of Cancer Nurse Specialists (CNS) to meet the workload and this requires action.

The Trust Board formally congratulated the teams and specifically the CNS who played a major role in coordinating the process.

In 2008 Head and Neck, Intrathecal, Liver Resection and Thyroid is expected to be reviewed

6. IMPROVING TREATMENT AND OUTCOMES

6.1 COLORECTAL CANCER MDT

The Colorectal unit is a progressive team of 7 consultant surgeons and a specialist nursing team of 7 clinical nurse specialists comprising a cancer nurse, laparoscopy nurse assistant, Colonoscopy nurse and 4 stoma nurses. In 2006, 365 colon and rectal cancers were treated. The colorectal MDT had a satisfactory Peer review in 2006. We are pleased with the achievements of the unit.

Laparoscopic Colectomy

3 colorectal surgeons regularly offer laparoscopic colorectal resections. 3 others are undergoing preceptorship. One Colorectal surgeon is a College preceptor. Derriford Hospital will be inspected shortly with the view to becoming a centre for training in Laparoscopic surgery.

Transanal Endoscopic Microsurgery (TEMS)

Derriford Hospital is unique in the Peninsula in offering this endoscopic surgery for early rectal cancer. The unit will shortly be equipped with a 3D ultrasound facility for assessing early rectal cancer.

Flexible Sigmoidoscopy Clinic

Derriford now offers a one-stop clinic for investigation of rectal bleeding. Patients are offered limited colonoscopy, barium enema and if necessary banding of piles on the same day.

Anal Cancer

The Colorectal unit in conjunction with the Plastic Surgery Unit specialises in perineal reconstruction with a rectus abdominis flap following Abdomino-perineal resection for low rectal cancer and anal cancer. These patients would have had pre-operative radical radiotherapy, which impairs wound healing. A rectus flap avoids a chronically discharging perineal wound.

Complex (Multidisciplinary) Pelvic Surgery

A multidisciplinary team of gynaecologists, colorectal surgeons and plastic surgeons operate on complex pelvic tumours.

Colonoscopy Waiting List

This has been reduced drastically to the extent that 2-week patients are offered the next available list.

Future Developments

1. Appointment of a second cancer clinical nurse specialist
2. Development of colorectal cancer database
3. One Stop Imaging for Rectal cancer with CT colography and MRI scan.

Chris Oppong - Consultant Colorectal Surgeon and Colorectal MDT Lead

6.2. SKIN CANCER MDT

The Skin Cancer MDT has become recognised and well-attended weekly meeting reviewing all skin Squamous Cell Carcinomas and Malignant melanomas, which come through the Path department. The MDT is recognised by the Network as the most NICE Guidance compliant MDT in the Peninsula. Our major deficit is still a Skin Cancer Clinical Nurse Specialist, for which we have persistently failed to attract funding from the Trust/PCT. However, we now have a job description proposal, which has been submitted to the Trust and is waiting to go before the Executive Board for approval of funding under the Trusts scheme for increasing Clinical Nurse Specialists.

The MDT has done well in achieving the 31/62-day targets. We have also started to attract GP's into the MDT on occasions.

The see and treat clinic has been very successful since its reintroduction following agreement for funding with the PCT. This is added to by the development and approval of our Clinical Nurse Biopsyist who is fully trained and signed off and is part way through a 3 month pilot period. Early results indicate a significant and very effective throughput of extra patients leading to an estimated extra income for the 3 months of £53600.

I have been intimately involved with the implementation of the NICE Guidance via the Network, in particular the development of accreditation for GPs with a special interest in Skin Malignancy across the Peninsula. I am hoping to arrange meetings with interested GPs across the Network soon to discuss the accreditation process.

The major problem with the Skin service follows the retirement of Di and Peter Kersey last year leaving no Surgical Dermatologist. All of the work has had to be covered by the Plastic Surgery department, which together with the move to F2 SHOs has impacted greatly on our capacity problems.

A new Surgical Dermatologist has been appointed and is due to start on 1st August 2007.

Mr. S M Wharton - Adult and Paediatric Plastic Surgeon, Skin Cancer and Paediatric Plastic Surgery Clinical Lead

6.3. UROLOGY CANCER MDT

The Urology department, in co-operation with the department of Oncology and Medical Physics, has successfully established a Prostate Brachytherapy service at Derriford. The training and mentoring process is still taking place, but it is anticipated this will have been completed within the current financial year. The establishment of this service means that patient's can now be treated locally with Brachytherapy for localised prostate cancer without the need to be referred to Leeds or Guildford for the treatment. It is anticipated that, once the mentoring process is complete, we should be able to treat approximately 40 patients a year for the Peninsula.

Peer Review represented a challenge for the Urology unit and in the year appraised for the review (2005). The number of radical pelvic cancer operations was slightly below the required standard of 50 cases. A review has therefore been undertaken for 2006 and this confirms that the number of cases exceeds the required standard of 50 and it is believed this is due to an increased referral rate from Cornwall and it appears that this trend is going to continue.

Finally, the Urology dept has been selected as one of six national sites to pilot a Decision Aid for patients having to make difficult choices about treatment options for local prostate cancer.

P D McInerney MD FRCS (Urol) - Consultant Urologist and MDT Lead

6.4 BREAST CANCER MDT

6,500 patients (New and Follow up attendances) were seen in the Breast Unit, with an average delay of 80 days for non-urgent cases. 210 symptomatically diagnosed breast cancers were seen. All new patients were seen in a 'One-Stop Clinic', except that same-day results are not currently provided by the Trust. In this year, Sentinel Node Biopsy training has commenced and been completed for the majority of Surgeons, with a plan for all to be trained so that Sentinel Node Biopsy can be offered by all Surgeons within one year.

The Primrose Ward, which was previously within the Primrose Unit itself, has moved from the unit to Marlborough ward. We are still struggling with teething problems connected with this. The freed-up space will allow reconfiguration of the Unit.

Breast diagnosis and timeliness has been impaired by a lack of radiological staff, a chronic issue connected, in part with difficulties in recruitment and, in part,

with under resourcing. These issues are being addressed and I am optimistic that next year should see, for the first time, an adequate number of Radiologists within the Department.

The Surgeons have been opting to perform Day Case, rather than In-patient procedures, where possible, and this has resulted in a much greater proportion of Day Case surgery towards the end of last year than previously.

Dr J Steel - Consultant Radiologist and Associate Clinical Director

6.5. HEAD AND NECK CANCER MDT

Discussions are currently underway to finalise centralisation of Head and Neck Oncology services to Derriford Hospital and Exeter. This will provide a Network wide hub and spoke referral service for the service. Derriford will receive referrals from Truro/Cornwall via a videoconference link at the weekly MDT.

Mr. Tass Malik our newly appointed ENT consultant with a Head and Neck interest will be starting in May to help take the service forward. He has a specialist interest in Thyroid disease and laser surgery.

We are currently applying for funding for the purchase of a laser system to allow minimally invasive trans-oral laser resection of upper aero digestive tract cancers, which will reduce the length of stay and quality of care of our cancer patients.

Discussions are currently ongoing with Macmillan and the Trust regarding the funding of 1 w.t.e Speech and Language therapist for the Head and Neck Service. Currently the service is on demand only, which impacts on our ability to provide a fully centralised service for the West of the Peninsula.

We continue to provide data for DAHNO and the SWAHN Head and Neck outcome audit. A quality of life study to compare outcomes with one or more treatment modalities is currently underway.

The Head and Neck Lumps clinic continues to run successfully with a 95% diagnostic accuracy rate. The results are communicated to the patient at the same visit. We would welcome neck lump referrals from within Plymouth Health Community via the lead clinician secretary.

Mr. D Courtney - Consultant Maxillofacial Consultant and Head and Neck MDT Lead

6.6 GYNAECOLOGICAL ONCOLOGY MDT

The previous year witnessed significant progress for the Gynaecological MDT. The numbers of new patients continues to be between 150-200. Members of the group have continued to provide excellence in all aspects of care. This was indicated by the recent external review, where this MDT was uniquely identified as a being an exemplar of high quality care. The objective scores achieved for both the specialised and non-specialised components of the MDT work and functions were the highest in the Peninsula.

Members of the group have continued to present new scientific evidence both through publications and through academic meetings. Co-operation with SWCIS has facilitated this work.

It is hoped that the continued work of this group will be strengthened through the appointment of a new Sub-specialised gynaecological oncologist. The group currently works under a cloud of uncertainty. The group has made representation to the network group for sensible long term planning for the patients of Plymouth and its surrounding areas. This pressure and anxiety needs to be removed once and for all, so that the group can continue to develop the service for the population we serve.

New Cases	2003	2004	2005	2006
Ovary	54	64	69	65
Uterus	47	63	52	60
Cervix	31	35	51	31
Vulva	11	16	19	18
Other	7	4	4	4
Total	150	182	195	178

Mr. T Falconer – Consultant Gynaecologist and MDT Lead

6.7 UPPER GASTRO INTESTINAL CANCER MDT

Pancreatic cancer surgery for the Peninsula was finally centralised to Plymouth in April 2006, and there are now 3 surgeons providing this service in Derriford (Prof Kingsnorth, Prof Midwinter, and Mr. Stell). Cases are referred in from the MDT meetings at Truro, Torbay, Exeter, and Barnstaple, and all pancreatic cancer resections are now being performed at Derriford. The 3 surgeons have worked hard at establishing a good clinical network for referrals within the Peninsula, and are currently attending MDT meetings in person at Torbay and Exeter. In time, as video conferencing becomes more established, it is hoped that Upper GI MDT meetings across the Peninsula can be co-coordinated to make use of existing video links.

Coincident with the expansion of pancreatic surgical services, Derriford has developed liver surgery, which may be indicated for patients with colorectal liver

metastases, as well as some other metastatic cancers, and other liver lesions. The number of cases referred to this service is increasing rapidly, and avoids the need to send patients from the Peninsula to London, Basingstoke, or Birmingham, as was the case previously.

A decision as to where oesophago-gastric cancer surgical services will be located within the Peninsula is still awaited, and continues to delay development of a fully functional Peninsula-wide network. Surgeons at Derriford have formed strong links with the oesophageal surgeon in Truro, who now has an honorary contract to work in Derriford, and is using an operating list here on alternate weeks to operate on oesophago-gastric cancer patients from Truro. This link has facilitated development of minimally invasive surgery for oesophageal tumours, which is now offered to selected patients at Derriford. Seven minimally invasive procedures have been performed over the last 10 months, and the patients have all done well with no complications relating to the minimally invasive approach.

The Upper GI MDT was reviewed in 2006 as part of the National Cancer Peer Review process, and had an excellent report from the reviewers, who were clearly impressed by very strong team working. The review recognised the hard work of the single-handed Upper GI Cancer CNS, and strongly advised that another CNS be appointed to support her role, and this will be a priority for the MDT this financial year.

Tim Wheatley - Lead Clinician Upper GI MDT

6.8 HAEMATOLOGY MDT

The Peer Review process was extremely complementary about the organisation and cohesion of haematological services at Derriford Hospital. The major problem however was in the facility within which some of our patients were being treated as part of the day unit. It was felt that this was unsafe and we had to close that shortly after the inspection. This has led to some very major issues on Birch Ward where currently we are running a mixed sex bay for the management of the complex haematological patients who can't be managed on other wards. It is hoped this will be resolved shortly. The department is running 21 clinical trials at the moment and such has been the success of the unit that the hours of the Clinical Trial Nurses have had to be doubled to accommodate this. Finally, a national cancer research network (NCRN) lymphoma trial has just opened that is being run from the trials unit in Plymouth. This is the first time an NCRN trial has been run out of a trial office in the South West and it won't be the last as there are already plans in place for a subsequent study.

Dr S Rule - Consultant Haematologist and Director of Cancer Services

6.9 LUNG CANCER MDT

The lung cancer MDT has continued to develop services for patients with intra-thoracic malignancy, including lung cancer and mesothelioma. We now have two clinics each week for fast-track referrals and accept inpatient referrals. Diagnosis has been aided by the arrival of new bronchoscopes and an improvement in time to CT-guided lung biopsy. The appointment of more lung function staff has also allowed us to more accurately assess patients prior to definitive treatment.

Having been discussed at MDT (over 360 patients last year), treatment options are discussed, including thoracic surgery (also provided to Cornwall and Torbay), chemo- and/or radiotherapy and good symptom control. The peer review highlighted under-resourcing of the cancer nurse specialists; this is an issue that we will address in the next year. The collection of data and uploading to the Lung Cancer Database (LUCADA) is also an issue that will need to be solved soon.

We are still happy to be asked to see any patient suspected of having intra-thoracic malignancy (lung cancer / mesothelioma / other) and will endeavour to see and treat them as quickly as possible.

Dr P J Pearson - Consultant Respiratory Physician

7. RADIOTHERAPY SERVICES

1000 new courses of Radiotherapy treatments were registered on the Varis System and a total of 1270 courses treated in 2006-2007. All palliative and urgent patients were treated within the Cancer Standards guideline of 14 days, but the Cancer guideline of 28 days for Radical patients was unable to be achieved for all patients, the average wait for Radical treatment being 35 days. During the last year there has been an introduction of dose checking for all patients during their first treatment and protocols for the imaging of treatment sites.

A wide bore C.T Scanner will be installed in the department on June 11th, this should have been delivered in March, it will be a dedicated scanner for radiotherapy and will allow for the progression from 2D planning to 3D planning and will enable the Cancer Standards to be achieved as required by the Peer Review. The introduction of the dedicated scanner will allow greater flexibility in the planning process for patients and will enable the targets for Radical patients to be achieved.

The last year has seen the Stereotactic service progress from Stereotactic Radiosurgery to also include Stereotactic fractionated Radiotherapy, 38 patients were treated with the surgical frame and 8 patients using a mask for immobilisation.

Sue Lamb - Radiotherapy Manager

8. SUPPORTIVE AND PALLIATIVE CARE

8.1 Educations and Development

In September 2006, Liz Ridgway was appointed in a two year Macmillan cancer education and development lead. Having established some training priorities in light of Macmillan/ governmental/regional initiatives, and post discussion with management the following has been successfully implemented:

Learning to live with cancer: An education programme for patients and carers has been established, with three successful sessions covering nutrition, self-esteem and relationship issues. Two hundred questionnaires have been distributed to patients and carers in the outpatient/chemotherapy/radiotherapy setting in order to establish what further educational events may be useful utilising a patient/carer centered approach. The former are currently being evaluated. A rolling educational programme will be planned based on the outcome of the questionnaires.

Oncology/palliative care education for staff at all levels. Liz established a hospital cancer/palliative care education steering group, and as a result, a rolling programme for a diversity of health care professionals has been implemented utilising aspects of the Key Skills Framework. The Oncology Foundation Study Days incorporate the patient pathway from diagnosis throughout treatment. In collaboration with the clinical nurse specialists, various cancer specific study days/palliative care study days have been included, as have a variety of cancer related issues, i.e. ethics and oncology. Liz, and another member of the steering group Sue Hackworth, have worked closely with the specialist palliative care team and other providers of cancer/palliative care education to map local provision via a catalogue which hopefully will enable staff to access relevant study days, avoid duplication, and utilise resources appropriately.

Breaking bad news and communication skills. Breaking bad news and communication skills workshops for senior healthcare professionals have been re-established, and successfully facilitated. Liz and Annie Charles a member of the hospital palliative care team have also undertaken four pilot workshops for staff other than senior professionals, which have been well evaluated. A full day workshop for staff other than trained is planned as part of the oncology/palliative care rolling programme.

Volunteers - Various teaching sessions have been organised for new volunteers in collaboration with the specialist palliative care team. The volunteers are also able to access some of the study days in the rolling programme.

Liz has also taught on various departmental study days on a variety of cancer/palliative care related subjects. Within these sessions Liz has been able to enhance understanding of the role of Macmillan cancer support, and the role of the cancer support centre.

Liz Ridgway -Macmillan Cancer and Palliative Care Education Lead

8.2 THE MUSTARD TREE MACMILLAN CENTRE

The Mustard Tree Macmillan Centre has developed several new services during the last year funded by Macmillan. These include: -

- Benefits Advisor

Denise Martin joined the Macmillan Centre full time on the 6th February 2006. This service provides arranged appointments at the Centre, visits to patients/carers on the Wards and Outpatient clinics as well as telephone advice, presence at the three satellite centres one day a month and domiciliary visits when necessary. IN addition, she provides advice and works closely with the Community Macmillan Teams and St. Luke's Palliative Care Team, including attending their weekly MDT.

The service has been met with much enthusiasm and appreciation by both patients and other service users. There has been a degree of external publicity but the referrals have in the main come direct from CNS's, Wards and Clinics or direct from patients themselves.

To illustrate the success of this service the following are details of **known** benefits raised within the first 9 months of her being post.

Period: w/c 6/2/06 – w/c 29/1/07 (44 actual working weeks)

Number of clients seen: 660

Known weekly benefit take up (to period ending 6/11/06) – 36 actual working weeks **£18,671.64 per week**

These known benefit awards, together with those still to be calculated **and** those unobtainable awards, equate to an increase in annual income in excess of **£1 million**

Known one-off payments to period ending 7/11/06 - **£82,373.36**

Sue Smith-Macmillan Cancer Support Centre Manager

8.3 St Luke's Hospital Specialist Palliative Care Team

St Luke's Hospital Specialist Palliative Care Team comprises of Dr Mary Nugent, Consultant in Palliative medicine, three Clinical Nurse specialists: Barbara Carroll, Pippa Knight, Anne Munton and a part time staff grade doctor Dr Karen Gilmore.

The team have endeavoured to be proactive across the hospital, to maintain a high profile on all the wards and to be available to provide specialist symptom control, advice and support. The team received 809 referrals last year providing 3,162 face-to-face contacts between staff and patients during this period.

Between 3 and 4 Outpatient clinics are held each week at both St Luke's at Pearn and St Luke's hospice. The team are resourced to provide an 8.30 to 4.30 service 5 days per week. Undoubtedly people suffer symptoms at all hours of the day and night and we hope to address this problem in the future. St Luke's Hospice provides out of hours advice.

The integration of specialist palliative care services (hospice, community and hospital) has enabled us to provide better continuity of care and we now have access to St Luke's Bereavement service for the families of patients known to the hospital team.

Liverpool Care Pathway for the dying patient

Approximately, 1770 patients die in Derriford each year. Many of these are expected deaths and fall within the remit of the Liverpool Care pathway (LCP). Annie Charles was appointed as Clinical Nurse Specialist (.6 WT.E.), educator and facilitator, for implementing the Liverpool care pathway of the dying in January 2006, the post was originally funded for 12 months with 'end of life' monies. Annie has now been given a permanent contract with St Luke's services.

The LCP has been implemented on 8 wards and the intention is to roll the pathway out to all adult wards / units at Derriford. An LCP Lead nurse programme is being developed to ensure project sustainability. Ward based educational sessions are being offered to all staff to support implementation of the LCP and over 300 multi-professional colleagues have attended. To date 159 patients have had been put on the LCP and their progress, care and treatment recorded using the new documentation.

A retrospective audit of 30 patients pathways demonstrated significant improvements in the documentation of care following implementation. Data from a further 30 LCP patients has recently been submitted to the LCP central team for the first ever National Care of the Dying Audit (124 hospitals).

Palliative Care Education

All healthcare professionals hold an ongoing responsibility to provide palliative care for their patients; it is therefore essential that St Luke's Specialist Palliative Care Team provide support and education in order for this to be achieved. The multidisciplinary team are committed to improving the quality of care and raising awareness about palliative care and are involved in teaching doctors, nurses and allied health care professionals. The team provides clinical teaching for 4 to 5 medical students on the palliative care module every week. There are also additional teaching sessions/lectures provided by the team at the Peninsula Medical School.

Dr Mary Nugent - Consultant in Palliative Medicine and Medical Director of St Luke's services

Barbara Carroll- Team Leader and Clinical Nurse Specialist

9. RESEARCH

A Crossover Study of a Nurse Led Chemotherapy Outreach Service Project (NCOP)(Dennison et al 2007)¹

This 22month research study was based at the Chemotherapy Unit, Derriford Hospital and was supported by a grant from Macmillan Cancer Relief. The aims of the project were to compare the outcomes of chemotherapy given at Derriford with the outcomes of chemotherapy given at outreach centres.

This was a randomised crossover study. Patients were randomised to receive their first two chemotherapy treatments in the outreach clinic and then crossed over to receive the next two treatments in the hospital; or to receive their first two chemotherapy treatments in the hospital and then crossed over to the outreach clinic. Following these four treatments, patients were asked to specify the setting in which they would prefer to receive the remainder of their treatments and reasons for their choice. They received the remainder of their chemotherapy at the hospital of their choice. 42 patients were randomised, 35 female and 7 male receiving a broad range of day case chemotherapies. Thirty-one patients reached the end of the crossover period, 30 chose the outreach location for the remainder of their chemotherapy treatments.

There were no differences between the groups regarding chemotherapy side effects or levels of anxiety and depression. There were no adverse reactions during chemotherapy at any location. No outreach patients had to be referred back to the Cancer Centre immediately following treatment. There was no

¹ Dennison et al (2007) A randomised crossover study of a nurse-led chemotherapy outreach project (NCOP). Final report to Macmillan Cancer Relief. Plymouth: PHNT.

incidence of extravasation chemotherapy. There was strong evidence that patients were more satisfied with outreach location for ease of access. Patients were more satisfied with outreach location in terms of the environment.

Following the success of this outreach project, we are now commencing a permanent outreach service initially starting at Tavistock Community Hospital. The service will then be rolled out to Liskeard, Kingsbridge and a Plymouth community unit.