Quality of Cancer Care in the North of Scotland

Pilot Review of the North Cancer Alliance

August 2019
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Introduction

Healthcare Improvement Scotland is responsible for the external quality assurance of cancer services against tumour-specific quality performance indicators (QPIs). In June 2018, we developed a methodology to evaluate all QPI data collated during 2016 to 2018. In addition to this, we considered the effectiveness of the governance structures. We wanted to understand how well tumour-specific networks were evaluating performance and implementing improvement. We also wanted to know how well actions to address these challenges were being progressed.

We began piloting our approach in October 2018 with the North Cancer Alliance. This pilot will inform the methodology used to review the performance of regional cancer networks in future. The reviews will take place annually from October 2019.

The purpose of the review was to:

- consider the effectiveness of governance arrangements within regions,
- understand the performance of tumour specific networks operating within the region
- identify areas of good practice, and
- identify areas where improvement was needed.

What are cancer quality performance indicators (QPIs)?

Cancer QPIs are small sets of outcome and process-focused, evidence-based indicators. The indicators relate to key points in the cancer patient pathway deemed by an expert group to be critical in providing good quality care. Currently, there are 18 specific tumour type sets of indicators. These QPIs were developed collaboratively by expert groups of clinicians drawn from:

- the three regional cancer networks,
- NHS National Services Scotland’s Information Services Division, and
- Healthcare Improvement Scotland.

The QPIs’ overarching aim is to make sure that activity at NHS board level is focused on the most important areas. These are improving survival and patient experience while reducing variance and ensuring safe, effective and person-centred cancer care.

Patient experience and clinical trial access QPIs, which apply to the management of all tumour types, are also in place. Measurement and reporting of the patient experience QPIs consistently are still at an early stage nationally.

The QPIs can be found on the Healthcare Improvement Scotland website:  

The North Cancer Alliance and Regional Cancer Networks

Regional Cancer Arrangements

There are three regional cancer networks operating in NHSScotland:

- The West of Scotland Cancer Network which is made up of NHS Ayrshire & Arran, NHS Greater Glasgow and Clyde, NHS Forth Valley and NHS Lanarkshire,
- The South East Scotland Cancer Network which is made up of NHS Borders, NHS Dumfries & Galloway, NHS Fife and NHS Lothian,
- The North Cancer Alliance which is made up of NHS Grampian, NHS Highland, NHS Shetland, NHS Tayside, NHS Orkney and NHS Western Isles.

Each network coordinates cancer services in the region. It acts as a forum for the NHS boards within its constituency to prioritise and deliver key tumour-specific services. The make-up of the regional networks is outlined in MEL 10 (1999) and in HDL 71 (2001). A MEL and HDL are publications addressed to NHS managers:


Regional cancer networks also have a role in improving cancer services through regional governance structures. They serve as a connection between national policy and local delivery. Healthcare Improvement Scotland’s QPI programme was designed to support improvement by developing a suite of QPIs. Networks can then monitor services against these QPIs and identify actions for improvement. This is outlined within CEL 06 (2012). A CEL is a publication addressed to NHS board chief executives. It also states that Healthcare Improvement Scotland will undertake national external quality assurance regularly.

https://www.sehd.scot.nhs.uk/mels/cel2012_06.pdf

North Cancer Alliance

The North Cancer Alliance covers three cancer centres in NHS Grampian, NHS Highland and NHS Tayside. The other two regional cancer networks each have one cancer centre. Previously, the North region’s cancer work was undertaken by the North of Scotland Cancer Advisory Network (NOSCAN). However, it was generally accepted as not having been as effective as intended. Chief executives in the region were supported to change the purely advisory network to a strategic alliance. A more defined governance structure was designed with authority to act on their behalf. This led to the creation of the North Cancer Alliance in 2018 and governance arrangements to support this are now being implemented. This review has considered data that was managed through the previous North of Scotland Cancer Network. This was taken into account by the review team and is discussed later in this report.

The North Cancer Alliance has a board which oversees a number of tumour-specific networks which it calls ‘pathway boards’. These boards are led by a clinical director who is responsible for overseeing the work and delivery of the aims and objectives of the boards. Each pathway
board has a defined terms of reference which includes responsibility for consideration of pan-regional QPI tumour-specific data and regional action planning, which spans all three cancer centres. The boards are intended to bring together clinicians from all centres and empower them to use data for change and improvement.

**Review Methodology**

**Quality of Care Approach**

Our new Quality of Care Approach is how we design our inspection and review frameworks and provide external assurance of the quality of healthcare provided in Scotland. There are three components:

- the approach itself – the methodology, and the principles that underpin it,
- the Quality Framework – this outlines the quality indicators used for self-evaluation and external quality assurance, and
- our programmes of work – the inspections and reviews that we undertake to deliver on our strategic objectives.

The approach aims to shift the focus from quality assurance of services being ‘done to’ organisations to an approach that, where possible, quality assurance and any resultant intervention is done with the provider. The emphasis is on regular, open and honest organisational self-evaluation using a common and shared Quality Framework.

Self-evaluation is a process by which organisations and services reflect on their own current practice. This process encourages them to identify areas where action could drive improvement in service delivery and ultimately, in outcomes for users of their services. Quality improvement on the basis of self-evaluation can inspire greater local ownership of issues and design of more effective solutions than that which is solely mandated by external agencies. These self-evaluations are combined with other data and intelligence available from publicly available papers and reports and nationally-held datasets. This then forms the basis of supportive improvement-focused review work with organisations to diagnose where there are issues or difficulties in initiating, sustaining and spreading improvement.

**About this Review**

Prior to this review we had undertaken two other assurance exercises related to cancer:


For this review of the North Cancer Alliance we used Healthcare Improvement Scotland’s Quality of Care approach and framework to review cancer services in the North Cancer Alliance. Our review was made up of four parts:

• A self-evaluation was submitted to us by the North Cancer Alliance in November 2018,
• An analysis took place of all available data and intelligence to create key lines of enquiry for the review team visit,
• A visit to the North Cancer Alliance offices took place on 4-5 March 2019 and focused on governance,
• A visit to the North Cancer Alliance offices took place on 14-15 March 2019 and focused on performance data related to cancer QPIs.

We met with a wide range of key staff and stakeholders during our review visits in March:

• stakeholders involved in the governance structures,
• Chair of the North Cancer Alliance and Chief Executive of NHS Tayside,
• Deputy Chief Executive of NHS Grampian,
• North Cancer Alliance Manager,
• Operational leads from North Cancer Alliance’s three constituent cancer centres,
• Director of Pharmacy, NHS Highland (in capacity as Chair of SACT Governance Group),
• Chair of the North Cancer Alliance Urology Pathway Board,
• North Cancer Alliance Urology Programme Coordinator,
• North Cancer Alliance Breast Cancer Clinical Director,
• North Cancer Alliance Lung Cancer Clinical Director,
• North Cancer Alliance Upper Gastro Intestinal Cancer Programme Coordinator,
• North Cancer Alliance Hematology Support Manager,
• North Cancer Alliance Hepatopancreaticobiliary Representative,
• North Cancer Alliance Head and Neck Cancer Clinical Director,
• North Cancer Alliance Skin Cancer Support Manager,
• North Cancer Alliance Colorectal Cancer Clinical Director,
• North Cancer Alliance Gynecological Cancer Clinical Director,
• North Cancer Ovarian Working Group Representative.

The domains from the Quality of Care framework considered as part of the review were:

• Domain 1: Key Organisational Outcomes,
• Domain 2: Impact on people experiencing care, carers and families,
• Domain 5: Delivery of safe, effective, compassionate and person-centred care,
• Domain 6: Policies, planning and governance,
• Domain 8: Partnership and resources, and
• Domain 9: Quality improvement-focused leadership.
It is important to note that this report contains a number of examples of evidence against our findings. These are only a selection and are not exhaustive.
Summary of Key Findings

The key findings of the review are summarised in this section of the report. Further detail regarding the analysis and findings of the data review process is included within this report in the section titled ‘Detailed Findings of our Review’ starting on page 10.

Key areas of Strength

- The new structure of the North Cancer Alliance has been designed with challenge in mind and is no longer advisory. We saw evidence that this is already supporting tentative change and improvement in the region. As this is still to be fully tested, we intend to undertake a further review of the network’s governance structure in 2020.
- The North Cancer Alliance is operating with an ethos of openness and transparency and this was encountered throughout the review.
- Leadership within the North Cancer Alliance structure, including at Chief Executive and Clinical Director level, would appear to be fully focused on improvement and bringing together the NHS boards within the region to develop and deliver cancer services. The strength of commitment from the Chair of the North Cancer Alliance Board was evident during our review and should be commended.
- All individuals we spoke to were enthusiastic regarding the changes in the North Cancer Alliance and expressed a willingness to work together to bring about positive change that will benefit cancer patients in the region.
- The QPI data is being used to undertake risk-based assessment and management, and where appropriate, escalation.
- The governance structure has set out clear responsibilities for its groups and committees and importantly the leadership involved within it.
- There is an awareness and willingness to see the three cancer centres work more closely together in order to improve the patient care pathway and patient experience.
- Where pathway boards are identifying QPIs which are not being met, they are investigating the reasons why and action planning for improvement. The changes within the North Cancer Alliance have meant that pathway boards are being held to account regarding the ongoing monitoring and delivery of actions.
- Areas of good practice are being identified and efforts made to share these, and where appropriate, implement them across the region.
- The change of approach to regional planning, with the boards’ Chief Executives Group directly undertaking planning decision making, is providing the North Cancer Alliance with an opportunity to more easily raise issues and work with them to identify shared priorities.
- The issue of late presentation of some cancer types in the region is being addressed through a number of actions, one of which is the inclusion of GPs and primary care representatives within the governance structure. This has facilitated direct engagement with GPs through education days. This work has the potential to support primary care colleagues to identify cancer at the earliest opportunity.
Key Areas of Improvement

Domain 1 - Key Organisational Outcomes

- The chief executives of the North Cancer Alliance constituent NHS boards should agree prioritisation of key business cases required for improvement as quickly as possible. Whilst governance arrangements are in place to allow necessary changes to be agreed, this process has not yet been tested. We felt that this remains a risk for the North Cancer Alliance and its strategy.
- NHS Grampian has developed a business case for the regional provision of services for ovarian cancer. Due to poorer survival for ovarian cancer patients in the north in comparison to other regions, we recommend that the host NHS board consider the implementation of the business case as a matter of urgency.

Domain 2 - Impact on people experiencing care, carers and families

- Patient choice and geographical constraints were cited as a reason for failure to meet some QPIs. Whilst this may be the case, the evidence to support this assertion was limited and we would wish to see the North Cancer Alliance undertake work to understand better whether this is the case and the impact that it has.

Domain 5 - Delivery of safe, effective, compassionate and person-centred care

- The pathway boards have identified a number QPIs which were not being achieved. We viewed action plans and were presented with the work being undertaken to address these. However, a number of solutions which will improve patient care in the region are dependent on the joint prioritisation by regional chief executives. We would wish to review the outcomes of this process following the first year in order to ensure its effectiveness.

Domain 6 - Policies, planning and governance

- The North Cancer Alliance is in its infancy and should be monitored through regular, formalised reporting to Scottish Government. This will support the North Cancer Alliance in making issues known at early stages, and will support the ongoing assurance that progress is continuing and allow supportive action if required.
- The North Cancer Alliance has made a great deal of progress within an 18-month period. However, this is tentative and if progress is to continue then a greater level of resource is likely to be required. Resource for the North Cancer Alliance should be considered as a matter of urgency by both Scottish Government and regional chief executives in recognition of the additional challenges of coordinating activity across three cancer centres and the geographical nature of the region.

Domain 8 - Partnership and resources

- National Managed Service Network for Children and Young People with Cancer (NMSN CYPC) should provide an update of progress to the Scottish Cancer Taskforce. This should include timelines for implementation of previously agreed objectives set out in

**Domain 9 - Quality improvement-focused leadership**

- The progress made to date is largely dependent on the leadership and management style of individuals tasked with implementing the new structure. Succession planning of leadership roles in the North Cancer Alliance should be undertaken to mitigate against the risks of movement of key leadership roles.
Detailed Findings of Our Review

Domain 1: Key Organisational Outcomes

What we were looking for

We wanted to see evidence that the North Cancer Alliance and pathway boards were considering data regularly and using this to action plan for improvement in a timely way. We also wanted assurance that the North Cancer Alliance was adhering to national and statutory duties and guidelines, in order to fulfil its regional and national functions.

What we found

1.1 Improvement in quality, outcomes and impact

We found that there is a willingness and a desire to collaborate within the North Cancer Alliance. We saw data was being collated and considered to drive forward tangible improvements. We heard examples of this during both visits, in terms of using governance arrangements to improve services and through the use of the QPIs themselves by pathway boards.

The evidence presented to us demonstrated that the North Cancer Alliance was working across multiple tumour specific pathway boards to address common issues, using the newly formed governance arrangements to do so. Specifically we heard a number of examples including the following:

- There is work ongoing to build a business case for a brachytherapy suite in the region in order to improve outcomes for patients. QPI data for cervical, prostate and head and neck cancer is being used to support this. As a requirement to upgrade the existing provision has been identified, there is an opportunity to create a regional service and create a bespoke, purpose-built facility. This work is being considered in a wider review of surgical services, which is a ‘case for change’.

- A number of issues have been identified across multiple tumour services but we saw evidence that action is taking place to address these. Specifically the North Cancer Alliance has input into a ‘surgical case for change’ which considers the current theatre capacity and surgery rates across the region and seeks to improve patient services through wide-scale change. This work will better use theatre capacity regionally and if the recommendations are accepted, are likely to improve performance against QPI targets.

- A number of tumour-specific pathway boards had identified failing QPIs which were related to hospital stay. We heard that NHS Highland has a hotel on their Raigmore Hospital site and this was used to good effect, allowing them to meet QPI targets. This has been identified as an area of good practice and the other centres in the region were seeking to establish a similar approach. We noted that this was more efficient for
NHS boards. More importantly, it was also likely to be more pleasant for patients, improving their experience, particularly those who had to travel a distance to get to the cancer centre. The hotel allowed them to attend the day before elective procedures and, if required, stay following day surgery rather than travel.

Good practice: Hotel services within Raigmore Hospital have provided patients with the opportunity to attend hospital early or stay following discharge, without requiring a hospital bed. This is particularly helpful for patients and carers in rural areas or who are required to travel a distance to a cancer centre.

- Due to issues in recruitment and retention of pathologists, there is a lot of pressure on local pathology services and this has a knock-on effect on cancer service delivery. At the end of March 2019 a consultant pathologist in NHS Tayside will be leaving. As a result of service pressures, NHS Tayside are outsourcing their core biopsies analysis to England in order to meet demand. A number of the North Cancer Alliance clinical directors and pathway board managers informed the group that NHS Tayside and NHS Grampian both currently have a number of pathology vacancies. As the recruitment of pathologists is an emerging/re-occurring theme, the North Cancer Alliance are trying to work with NHS boards to facilitate a regional solution to ensure the demand is met instead of competing for resources.

- Challenges had been identified in interventional radiology resource. The North Cancer Alliance planned to address this through linking to the North of Scotland Radiology Group, which would sit as part of the region’s governance structure. This is intended to facilitate a joined-up approach to planning and prioritisation discussions between NHS boards and across tumour types, some of which are being adversely impacted upon due to the situation.

There were some detailed examples shared with us where QPI data, supported by other data from the region, was used to drive service improvement and deal with known issues.

- An issue identified with QPI 8: Minimising Hospital Stay for breast cancer patients is being addressed through the sharing of good practice. This QPI was being met by NHS Tayside as they have an open access assessment clinic. This has reduced the patient pathway and made better use of resources. Patients attending the clinic in preparation for surgery are assessed by a series of professionals on the same day, rather than attending several different appointments. Other centres were now considering this model and the pathway board was confident the QPI would be met in the future.

Good practice: The use of an open access assessment clinic by NHS Tayside’s breast cancer service allows patients to have all of their pre-operative assessments carried out on a single day. This has made best use of resource, whilst ensuring that patients are assessed as efficiently as possible and do not have to attend on multiple days.

- The North Cancer Alliance’s breast cancer Clinical Director informed us that he would be writing to Molecular Pathology Evaluation Panel (MPEP) and emphasising the
importance of having FISH testing for HER 2 decision making within 2 weeks of core biopsy. This specifically relates to Breast Cancer QPI 9 - HER 2 Decision Making. A benchmarking exercise was also planned in order to compare performance in this QPI against other NHS boards.

- The ovarian pathway board has escalated issues relating to survival to the North Cancer Alliance board and the Medical Directors group. We heard that QPI data had demonstrated poor survival of women with ovarian cancer and this was linked to access to surgical treatment. We were told that women may not routinely be given surgery and chemotherapy. In advanced cases, chemotherapy without surgery may lead to poorer survival. As a result of this, the North Cancer Alliance has worked with the service to implement a position of surgery for all unless there are strong contraindications, as per the ovarian cancer surgery guidelines as part of the CMG. They have standardised decision making at multi-disciplinary team (MDT) meetings and developed a regional MDT. As part of this, the North Cancer Alliance observed MDTs held by the South East Scotland Cancer Network to gain learning. This led to the service identifying the need for a regional MDT co-ordinator. Recruitment to this position is dependent on a business case being made. The service is also developing a regional database to support monitoring for improvement.

- In addition to this, NHS Grampian has recognised challenges in meeting QPIs and recognised poorer survival in the North and has developed a business case which it is hoped will address these challenges, allowing them to improve survival. We recommend that NHS Grampian, as the host NHS board, implement this business case as quickly as possible.

- We were concerned about the performance of North Cancer Alliance against upper gastro-intestinal (upper GI) QPI data. However, we were assured that North Cancer Alliance have recognised the issue and are undertaking measures to address these. In addition, the latest data presented to us during the review visit had shown improvement against QPIs. Steps being taken to improve services included the surgical case for change, reconfiguration of the service and ongoing monitoring of outcomes. This will be considered as part of next year’s review. We heard that the first meeting for the upper GI pathway board was planned for May 2019. This would bring together the three cancer centres for strategic planning of regional upper GI services. There was collaboration currently ongoing between NHS Highland and NHS Grampian for surgery patients to be operated on in Aberdeen Royal Infirmary (ARI). However, the North Cancer Alliance recognised that QPI data and other data sources demonstrated that the provision of the service in the region needed to be considered, specifically closer working between centres. This was being addressed as part of the ‘surgical case for change’ work. We heard that geographical constraints in the region had meant that QPI 9: Length of Hospital Stay was not being met. However, the North Cancer Alliance had analysed available data to better understand the issue. This had demonstrated that patients stayed longer than expected due to significant travel times required to return home. The pathway board felt that it was more important to ensure that patients were ready to undertake longer journeys rather than discharge them in order to meet the QPI.
• The bladder cancer pathway board highlighted to us the failure to meet QPI 3: Mitomycin C following TURBT in NHS Highland. The North Cancer Alliance was now working with the cancer centre to address this. A number of actions were taking place or had already been implemented. Clinicians reported that they were now confident that this target would be met in the centre in the future.

• Urology, bladder and prostate cancer are being considered as part of the surgical case for change. This includes exploring theatre demand and volume/outcome relationships. The North Cancer Alliance anticipate that this will allow QPIs to be met.

• The North Cancer Alliance has identified variation in clinical practice relating to radiological staging for prostate cancer. There were plans for a prostate sub-group of the urology pathway board to review the clinical management guideline. It was expected this would lead to agreement between the three centres.

During the course of the visit to meet with clinical directors we heard that all pathway boards had examined the QPI data, specifically those which were not met. We saw evidence of the pathway boards encouraging retrospective case note review to understand this data. They then used a risk-based approach to prioritise and manage the barriers and challenges associated with these QPIs. We heard that actions for improvement were being undertaken. In most cases, these were done collegiately with other tumour type pathway boards to ensure that common issues were being addressed collectively. We felt that this demonstrated an effective and efficient approach to managing regional issues.

Domain 2: Impact on people experiencing care, carers and families

What we were looking for

Cancer is a disease which has an enormous impact on patients, their carers and their families. We wanted to understand what the North Cancer Alliance was doing to consider the quality of the experiences of patients receiving care and treatment and how this is individualised to their needs.

What we found

2.1 Patient and service user experiences

We heard that the new North Cancer Alliance structure has sought to involve patients through membership of groups and committees. However, there had been challenges regarding recruitment. As a result, local third sector organisations had been approached to become involved in the work of the North Cancer Alliance and its pathway boards.

We found, through discussions about other domains, that pathway boards were considering failing QPIs against the backdrop of their geographical context. Clinicians often reported to us that there was an acceptance of QPIs not being met if this led to a better patient experience,
such as when patients had a longer stay in hospital rather than face a lengthy journey home in pain. We questioned this and felt more information was required to fully understand the impact of geographical constraints on QPI performance. We felt that the data should be looked at in more detail where patient choice due to rurality was given as a reason for QPIs not being met.

**Recommendation:** the North Cancer Alliance should undertake an audit of cases where geographical explanations have been given as the reasons for QPIs not being met.

We also heard that the North Cancer Alliance had developed a patient-facing website ([https://www.cancersupportnorthscotland.co.uk/](https://www.cancersupportnorthscotland.co.uk/)) which held useful information for people accessing services across the region. The North Cancer Alliance told us that they had wanted to supplement what was already available through national organisations such as Marie Curie. They did this by creating a platform with information about their local services such as patient pathways. It was hoped this could help patients through their treatment.

**Good practice:** Other regions should consider the localised approach to web-based patient information, responding to the needs of the populations within the constituent boards.

The North Cancer Alliance acknowledged the impact of ancillary services such as nutrition and smoking cessation services on the care that patients received, including the need for joint working between these acute sector services and primary care. The impact of these services on patient experience was not lost on the North Cancer Alliance or the pathway boards. This was particularly clear in hepatopancreaticobiliary (HPB) cancer, head and neck cancer and oesophageal cancer all of which understand that these services are vital to patient care and experience. Work is underway in a number of pathway boards to understand the situation by collating data which will inform a detailed action plan. In addition to this, Clinical Management Guidelines (CMGs) are being considered in light of QPI performance. We accept that this work is beginning but we will be mindful of this in next year’s review and will revisit QPIs, action plans and progress reporting relating to ancillary services including nutrition, dentistry and speech and language.
Domain 5: Delivery of safe, effective, compassionate and person-centred care

What we were looking for

The QPI process was implemented in Scotland to provide a manageable way to consider data, benchmark against other centres and create an action plan for improvement. Under this domain we wanted to see how the region and its pathway boards are using QPI data and responding to what it shows. We also wanted evidence that the data was being considered as a whole by the North Cancer Alliance to identify any emerging themes or region-wide issues which could be addressed through collective action. We specifically wished to see evidence that:

- QPI data was being used to reduce harm and improve safety,
- patients were being appropriately assessed and managed (which most tumour-specific data sets have QPIs focusing on i.e. radiological staging),
- the continuity of care is assured and pathway journeys are seamless,
- care is delivered to a level of excellence, using standardised best practice through the use of clinical management guidelines (CMGs), and
- Processes and systems are in place to support improvement activity.

What we found

During our review we consider QPIs which were not being met. Where there QPI which were narrowly failing, some of which were cause by small numbers of patients, we understood that this had been investigate. We were content that the results of these QPIs did not necessarily suggest wider service issues. As a result we focused on QPIs which were not being met repeatedly or were falling significantly short of the nationally agreed target. By doing this we were able to focus on the actions undertaken to address service delivery and quality issues.

We will reconsider progress against these QPIs during our 2020 review of the North Cancer Alliance.

5.1 Safe delivery of care

The North Cancer Alliance provided examples of QPI data being used to improve patient safety. For example, the escalation of concerns around ovarian cancer survival data had led to changes in practice. The use of QPI data to support the North Cancer Alliance surgical case for change was a second example. A further example was the work which was underway to address the failure to meet bladder cancer QPI 3: Mitomycin C following TURBT in NHS Highland. These examples are discussed in more depth above under Domain 1.

5.2 Patient or service user assessment and management

We found that the North Cancer Alliance, through its pathway boards, was seeking to address failing QPIs which pertained to patient assessment and management. We heard the following examples:
The hepatopancreaticobiliary (HPB) pathway board had considered its own service structure within the North region and was working towards a regional service, which would better support volume and outcome for surgical teams. The HPB pathway board is now working to have a regional service. In addition, it is working to identify how it will support the national Scottish HPB network.

The importance of MDTs in assessment and decision making was recognised by the North Cancer Alliance and their pathway boards. A number of pathway boards were considering the need for regional MDTs and were scrutinising effective MDTs and their approach.

The importance of regular mortality and morbidity data meetings as a method of learning and improving was noted by the North Cancer Alliance and its pathway boards. A number of pathway boards were implementing or considering implementing regional mortality and morbidity meetings, which can act as peer review. We felt that this was an important step in developing a regional approach to learning for improvement and should be commended.

5.3 Continuity of care

The north of Scotland is the only region with three cancer centres. North Cancer Alliance staff described their ‘once for the north’ vision of these three centres working together as a virtual cancer centre. This ambition to have seamless care includes a single regional systemic anti-cancer therapy (SACT) prescribing system to support the care of patients who were treated by more than one NHS board within the region. The surgical case for change, regional tumour-specific pathway boards and creation of CMGs are further elements of this vision. While more work was needed, we felt that the North Cancer Alliance recognised the challenges they faced in this area and had begun to put actions in place to address them.

Regional integrated pathways are also discussed under Domain 8.

5.4 Clinical excellence

We found that the one of the key drivers for the North Cancer Alliance was to ensure clinical excellence across all of the pathways in the region, ultimately ensuring standardisation of high quality clinical practice. We saw evidence of this from multiple pathway board presentations. For example, we saw the following.

The North Cancer Alliance recognised that there is a relationship between the number of surgical procedures carried out by each surgeon and the outcomes for those patients. Pathway boards had identified that several QPIs relating to this volume/outcome relationship were not being met. This was the case in HPB cancer, prostate cancer, bladder cancer and head and neck cancer. Some actions were already being taken to address this.
• We heard that pathway boards were working to further standardise treatment through the review of the current CMGs highlighting evidence-based best practice. We noted that this would support the delivery of better care by eliminating unwarranted variation in practice and standardising care. While there had been issues in the past regarding escalation when agreement of CMGs could not be met, a high number of CMGs have now been signed off by pathway boards and more are expected to be signed off at the next pathway board meetings. An escalation process for the development of CMGs had also been developed and agreed. The North Cancer Alliance had also developed a simplified template for CMGs which would make future development easier.

• We saw evidence of significant improvements made using QPI data. The Colorectal pathway board was able to present the most recent QPI data which showed that all QPIs were being met following action planning for improvement. This was commendable and we wish to highlight the efforts made by the pathway board and the clinicians working in the service to achieve this.

Domain 6: Policies, Planning and Governance

What we were looking for

We wanted to understand governance arrangements, processes and policies within the region and how these support ongoing use of QPI data for improvement. We also wanted to consider how the network deals with concerns and issues across its constituent boards, engaging clinicians and bringing together the three cancer centres. We considered this important in ensuring openness to talk about issues of safety.

Due to the importance of this part of the review we conducted a separate governance visit and met with individuals involved in the governance and functioning of the North Cancer Alliance.

What we found

Governance Arrangements

The North Cancer Alliance is a regional network which has moved from a being an advisory group to a full strategic governance structure (See Appendix 3). Historically the North of Scotland Cancer Network (NoSCAN) was structured around a small network office which supported the North of Scotland Regional Cancer Advisory Forum. This was an advisory group which provided advice and recommendations to the region’s NHS boards and regional planning group. During the review, the panel heard that the region had recognised the limitations of the structure, which was considered ineffective. It also lacked the ability to lever change due to its advisory nature. This had led to situations where escalation had taken place because the network was not sufficiently set up or resourced to deal with pressing issues or concerns within services.
We found that this had led to chief executives within the region agreeing that change was required. A new regional cancer manager was sought to revise the structure and its processes. It was also recognised at that time that a different approach to regional planning was required. The cancer network needed regional planning to understand cancer priorities in the region and to discharge its functions on behalf of NHS boards. Previously, this did not happen, as recommendations by the NoSCAN Forum were only advisory. This led to situations where these recommendations were not prioritised by regional planners or the constituent NHS boards.

The review panel found that a new structure had been designed collegiately with stakeholders and is now being implemented, although the North Cancer Alliance Board had not yet held its first meeting. The review found that whilst there had been significant change for the North Cancer Alliance over an 18-month period there was the presence of ‘green shoots’ in terms of progress. Tumour-specific pathway boards were meeting to consider issues and areas of improvement, and issues were being identified and escalated.

We heard that there was a great deal of innovation taking place within the North Cancer Alliance and a very clear vision in terms of governance. This has great potential. However, we were told that there was concern that further resource would most likely be required by the North Cancer Alliance in order to fully realise the benefits of the new structure and its ways of working.

6.1 Policies and Procedures

The changes within the North Cancer Alliance have meant that they have an opportunity to completely revise policies and protocols. Previously these had been lacking due to NoSCAN’s advisory structure but we heard that a number of policies and protocols were now agreed and more were being developed. For example, an escalation process and protocol was now developed which allowed two possible escalation routes within the structure: to the medical directors group and the North Cancer Alliance board.

Regional cancer networks use policies and protocols to provide a sound foundation for governance and best practice. We note that continuing development of these will be vital for the North Cancer Alliance. However, we found that a significant level of work was still needed to fully establish a suite of clinical management guidelines, SACT processes and protocols and governance protocols. We were concerned that key policies and guidelines will not be delivered as quickly as they should be unless the North Cancer Alliance is better resourced.

6.2 Risk management and audit

The North Cancer Alliance uses a risk-based approach to consideration of QPI data. While the process of risk-based exception reporting was clear it is not yet fully embedded, thus the review is limited in its ability to provide assurance of it. During the review, the North Cancer Alliance consistently flagged issues which had been raised through consideration of QPI data by clinicians, and their pathway boards, and managed through a risk-based assessment and
reporting approach. This level of transparency was commended by the review who felt that the North Cancer Alliance desired to be as open as possible in order to support constructive conversations across the region and arrive at improvements.

The review heard that two significant issues with tumour-specific QPIs had been escalated using the risk-based approach. These were ovarian and melanoma QPIs. Escalation had led to work being undertaken to address the issues at regional level. The Alliance had identified that patients in the north appeared to be waiting longer for wide local excision than those elsewhere in Scotland. The Alliance described the actions which were being taken by the skin cancer pathway board. Work was underway to understand how patients were prioritised on theatre lists in order to address delays.

We felt that whilst limited comment could be made about risk-based reporting and management in the North Cancer Alliance, the building blocks for a robust risk-based approach were evident in:

- the escalation reporting prepared for pertinent governance groups,
- the use of risk-based escalation processes to commission key pieces of work such as service business cases, and
- work undertaken within the 18-month period to inform constituent NHS boards of key risks through the use of the regional chief executives group.

### 6.3 Assurance framework and governance committees

We found that the structure, and the committees within it (as outlined in Appendix 3) was evidence of a functioning cancer alliance which is seeking to take responsibility for monitoring, assuring and improving cancer services for its constituent boards.

The North Cancer Alliance does not use QPI data in isolation. Instead, it accepts that it is part of a larger suite of information which can provide an account of the quality of services and patient pathways within the region. This was evident in its approach to assessing unit performance through the pathway boards and the action taken thereafter. For example, the breast cancer pathway board has identified issues in meeting the immediate reconstruction rate QPI, which seeks to ensure that women are given the opportunity to have breast reconstruction following surgical treatment. This QPI is not met in the region. The pathway board and North Cancer Alliance office have undertaken investigative work to consider why this is. In order to do this, the cases not being met were considered, and the reasons behind these were discussed, with all NHS boards. We felt that this wider approach to the remit of the QPI programme is more robust and will strengthen and inform improvement actions going forward.

The committees within the structure have defined roles and terms of reference, most notably responsibilities and accountability. This was identified as a requirement when the North Cancer Alliance was established, following learning from an issue regarding non-consensus around a clinical management guideline (CMG) for breast cancer. In addition to this the potential consequences of the functions of the groups needed to be clear in order for boards
and committees to have power to instigate change. We heard that committees were being equipped to function fully on behalf of the region, and steps had been taken to ensure this was the case. For example, the review heard that board meetings do not go ahead unless all three cancer centres are represented during the meeting.

We found that the structure had been designed with challenge in mind, with clear accountability at all levels, ultimately reporting to the North Chief Executives Group. The North Cancer Alliance appeared to be mindful of the need for openness and transparency at all levels. The region had clear expectations of what it wanted pathway boards and governance groups to achieve, with action planning focused on solutions for clearly-defined problems. However, we understand that the structure is yet to be fully tested.

6.4 Planning

The North of Scotland has changed its regional approach to planning. In the past, a director of planning led a regional planning group which oversaw coordination of cancer services. Planning is now undertaken by the regional chief executives group instead. This is used as the forum to discuss resources and make regional planning decisions. Each constituent NHS board’s director of planning then has responsibility for implementing the group’s actions and decisions. This is different to other regional approaches.

We heard that this has allowed frank discussions to take place and that the chair of the North Cancer Alliance Board, who is a chief executive, is able to fully articulate the needs of the North Cancer Alliance. A number of examples were shared with the review including a business case which was commissioned by the group addressing known issues within surgical services. This case is being considered by the group and a decision regarding resources was imminent. We felt that this would test the structure as collective understanding and agreed prioritisation will be required if the business case, which provides a regional solution, is to be successful.

We also found that the North Cancer Alliance was using regional planning routes to ensure a joined-up approach to planning and the most effective use of patient pathways, spanning benign and malignant disease. We heard that community hospitals would be used to ensure timeous treatment of benign urological disease. This has meant that a two-tier service is avoided for those experiencing benign disease. Members of the review team felt that this demonstrated a bottom-up approach to planning, based upon ‘on the ground’ knowledge. This approach is commendable, but its effectiveness will only be known with time.
Domain 8: Partnerships and Resources

What we were looking for

We wanted to understand how effective the North Cancer Alliance processes are in encouraging improvement through collaboration with stakeholders. We also wanted to consider how the region identifies and overcomes challenges to cost effectiveness and efficiency, and how the North Cancer Alliance shares learning and intelligence.

What we found

8.1 Collaborating and Influencing

We found that there was high level of evidence to suggest that the North Cancer Alliance is actively seeking to develop robust and positive relationships across the region. The North Cancer Alliance demonstrated that it has sought patients and members of the public to join governance groups. Engagement with local third sector organisations is through input into these groups. GPs are also represented within governance groups. This has facilitated direct engagement with GPs.

However, there was evidence that there were issues relating to engagement from centres in some pathway boards, although assurances were given that this was being addressed. The North Cancer Alliance recognises that NHS Tayside is not yet fully working as collegiately as it could with other parties within the upper GI pathway board and is making efforts to address this. It is the responsibility of NHS boards to facilitate engagement with the pathway boards and every effort should be made to support clinicians to engage at a regional and cross centre level.

Demonstrable efforts had been made to begin to collate and understand survival data in order to understand the quality and effectiveness of services in the region. We heard that work on this was being led by the North Cancer Alliance who had been engaging with NHS National Services Scotland’s Information Services Division (ISD) and the other Regional Cancer Networks. There was an intention to feed this into a wider piece of work considering socio-economic data of patients in the area. The North Cancer Alliance hope that this work will be replicated across the other regions.

8.2 Cost Effectiveness and Efficiency

While the review did not ask for cost-effectiveness data, this was presented during the visit. During presentations by stakeholders, it was clear that there was a significant driver to establish a ‘once for the north’ approach and maximise the efficient use of resources.

We heard that the north faces a number of challenges regarding resource. While funding might be available, the area has found it hard to recruit to key clinical director posts within urology and haematology. Retention of highly-skilled staff could also be a challenge in certain disciplines. As a result, the North Cancer Alliance has had to consider how best to deliver services efficiently. We heard that this has led to a culture of resource sharing occurring and is
something which the network sought to further capitalise on. For example, in pathology, this was being addressed by workforce mapping of the staff available to support reporting on lymph node yields, which had been recognised as a challenge across Scotland for some tumour types. At the time of the review, some pathology work was being outsourced to NHS England to help meet demand. The review heard about additional challenges regarding access to endoscopy for patients with suspected upper GI cancer. The North Cancer Alliance advised us that work being carried out as part of their surgery case for change included a review of diagnostic endoscopic services. The upper GI pathway board was also due to review relevant CMGs as part of its work plan. However, this had been overtaken by national CMGs being developed. We also heard of other solutions being taken forward to address identified challenges, such as pooling of surgical resources and upskilling of members of the multidisciplinary team.

We were struck by a consistent attitude from all of the individuals we talked to during our governance visit to the North Cancer Alliance. Everyone referenced their ambition to see all patients receive consistently high quality care regardless of which unit or service they access. During discussions, and from the evidence submitted, there is a clear patient focus in the work undertaken by the North Cancer Alliance. This was reiterated during a presentation by the Chair of the North Cancer Alliance Board who told the review that “It’s our families” using these services. This tone of patient-focused leadership was present through all those we talked with.

We are assured that the North Cancer Alliance, and the Chair of the North Cancer Alliance Board, are focused on maximising the efficiency of services across the region but are also mindful of quality of service and patient experience. This desire for efficiency also has the benefits of allowing creative solutions for long standing problems, such as the staffing issues discussed above.

### 8.3 Sharing Intelligence

We heard that there is a real desire in the North Cancer Alliance to share data for improvement, quality monitoring and to improve patient experience. This was evident through a number of pieces of work currently being undertaken through the North Cancer Alliance. The North Cancer Alliance has articulated an ambition to see SACT prescribing systems replaced with one regional system. This could support care of patients moving across territorial borders within the region.

Pathway boards were also seeking to share data, particularly regarding good practice, in order to further develop services. However, the North Cancer Alliance noted that they have significant challenges in terms of sharing data across three territorial NHS boards. This includes the levels of permission required for clinicians to work across territorial borders, which may have the potential to be disruptive to service delivery. They are navigating this through data governance leads within boards and hope to address some of the barriers they have encountered.
One of the significant issues raised by the North Cancer Alliance during the review was the progress of actions by the National Managed Service Network for Children and Young People with Cancer (NMSN CYPC) in accordance with the Scottish Government’s Cancer Plan for Children and Young People in Scotland 2016-2019. The NMSN has been funded to develop a single national paediatric chemotherapy electronic prescribing and administration system (CEPAS), a governance framework and national protocols to support children’s SACT services. The North Cancer Alliance has indicated that the work of the NMSN will be vital in facilitating safe delivery of SACT to children closer to home, which would have a positive impact on the patient journey. We felt that the work of the NMSN CYPC is vital to a patient population which is spread over a vast geographical area, which is also remote, and recommend that the NMSN CYPC work to resolve the issues articulated.

**Recommendation:** NMSN CYPC should provide an update to the Scottish Cancer Taskforce. This should include timelines for implementation of previously agreed objectives set out in The Cancer Plan for Children and Young People in Scotland 2016-2019 and referred to in the June 2017 SACT national external review.

### Domain 9: Quality Improvement Focused Leadership

**What we were looking for**

We wanted to find out about the North Cancer Alliance strategy, vision, values and aims and how widely these are understood. We also wanted to consider how well leadership within the organisation inspires, empowers and motivates staff, giving them opportunities and the skills to innovate and contribute to quality improvement.

**What we found**

**9.1 Vision and Strategic direction**

There is strong evidence that the North Cancer Alliance has a clear vision and aims which are being progressed in collaboration with stakeholders to support delivery. However, we currently can only have limited assurance as the governance structure is still to be fully tested. Due to this, we intend to undertake a further review of the network in 2020.

The Chair of the North Cancer Alliance Board acknowledged that there needs to be a high standard of leadership set for the north in order to achieve anticipated outcomes. In order to realise its aims and ambitions the North Cancer Alliance will require transformational leadership to bring its constituent NHS boards and cancer centres together. This will be particularly important if the North Cancer Alliance is to support the implementation of seamless pathways which transcend any territorial borders.

We heard a very clear vision and intent set out by the North Cancer Alliance, but it also described and acknowledged a number of challenges which will have to be addressed if services and pathways are to improve for the regional population. This improvement focus
was demonstrated in the attempts made thus far to address a number of identified service issues, some of which had been escalated to the NHS board chief executives group.

The long-term strategic direction of the North Cancer Alliance has also been clearly articulated. It further supports the efforts made by NHS board leadership to integrate the function of regional planning into the chief executive group. This will likely enable the strategic direction of planning and the North Cancer Alliance to be aligned. We felt it also demonstrated an understanding of the symbiotic nature of the alliance and the North Chief Executives Group.

9.2 Motivating and Inspiring Leadership

The Chair of the North Cancer Alliance Board previously held the position of Chief Operating Officer at the Beatson Cancer Centre in Scotland. This experience will be important to the position of Chair of the North Cancer Alliance Board, as they will likely be equipped with the experience and knowledge to support North Cancer Alliance and its structures to achieve its aims. During conversations with the Chair there was a sense that there was a focus and aspiration for patient-centred planning of care and a desire for the North Cancer Alliance to become the best it can be, facilitating seamless care which transcends any territorial boundaries.

The North Cancer Alliance Regional Cancer Manager has been identified as a potential leader by senior staff and is undertaking the Leading for the Future programme. We found that the progress made by the North Cancer Alliance the past 18 months has been in part due to the regional manager’s determination and drive and this was articulated by many of the staff and clinicians we spoke to. When presenting to us, this individual was very mindful of robust governance and its role in effective change and improvement. This has led to the creation of a structure which seeks to ensure that responsibility and consequence is fully understood.

We heard that the North Cancer Alliance is currently recruiting a new regional Clinical Director and it was anticipated that a new appointment would be announced imminently. The review recognises the importance of the role within the governance structure and for the Clinical Directors of the pathway boards.

Throughout the course of the visit we heard that people want to work together collegiately to overcome service barriers. However, there was acknowledgment of tensions between local and regional responsibilities and commitments. We believe that strong leadership will allow the benefits of collegiate working to be articulated and understood and there was a sense that the North Cancer Alliance understands this. As a result, all of the individuals spoken with during the visit made clear their intention to work together to solve problems and overcome barriers.
9.3 Developing People

We heard that there are a number of threads relating to this domain in the North Cancer Alliance.

The services within the region are finding it difficult to recruit to certain specialities and posts, which has resulted in some service issues. To address this, the North Cancer Alliance is thinking regionally about how best to develop the current staff. For example, we heard that the use of nurse consultants is being considered at regional level and sharing key resources between centres is being planned. Although this was presented as an efficient way to deal with issues, the patient perspective was being actively considered by those in the North Cancer Alliance. Whilst innovative use of roles helps to fill service gaps, it also means that locality of service can be preserved, preventing patients who are unwell from travelling unnecessarily. This is particularly important for patients receiving SACT. The region is building on non-specialist expertise in SACT with thirty healthcare professionals enrolled for SACT training to ensure that patients can receive treatment as close to home as possible.

The progress made by the Alliance can, in part, be attributed to high quality leadership within the North Cancer Alliance and its programme boards. However, there is no evidence of a contingency plan or resources allocated to build resilience into the current structure. We queried whether future workforce planning was sufficiently robust to allow continued delivery of the vision and the aims of the North Cancer Alliance. If the North Cancer Alliance is to continue to make such progress then the resource and succession planning requirements of the office need to be considered as part of regional planning discussions.

**Recommendation:** The review team recommends that steps are taken to succession plan for the role of Alliance Manager, in order to ensure sustainability.

**Capacity for Improvement**

We found that the North Cancer Alliance has a significant capacity to support improvement. Tumour-specific pathway boards have ownership of QPI data. This is now used to support risk-based assessment, management and action planning. There are clear routes of escalation when this is needed. The North Cancer Alliance will need to make effective use of these governance mechanisms to sustain its initial progress. However, as noted above, this remains a risk until it is fully tested.

Effective collaboration between centres will be needed to jointly prioritise actions which will improve patient care. Continued strong leadership from the North Cancer Alliance will be crucial to support the development of collegiate working. The North Cancer Alliance should consider succession planning for leadership roles. It may also be helpful to review the level of resource required to maintain continued improvement. This may help prevent the level of resource from limiting progress.
We felt that the North Cancer Alliance’s capacity for improvement could be supported through regular, formalised reporting to the Scottish Government. This would allow issues to be highlighted at an early stage. It would also allow supportive action to be taken if necessary.

APPENDIX 1: Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>FISH</td>
<td>Fluorescence in situ hybridisation – a type of genetic test.</td>
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<tr>
<td>HER2</td>
<td>Human epidermal growth factor receptor 2 - a protein which promotes the growth of cancer cells. Tumours which test positive for this protein are less likely to respond to hormone treatments and more likely to respond to treatments which specifically target HER2.</td>
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<tr>
<td>MPEP</td>
<td>Molecular Pathology Evaluation Panel</td>
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<tr>
<td>TURBT</td>
<td>Transurethral resection of bladder tumour</td>
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### APPENDIX 2: Review team

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Dr Nadeem Siddiqui</td>
<td>Review Chair – Consultant Gynaecological Oncologist, NHS Greater Glasgow and Clyde</td>
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<tr>
<td>Dr Peter Sandiford</td>
<td>Review Deputy Chair, Consultant in Public Health Medicine</td>
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<tr>
<td>Professor Sean Duffy</td>
<td>External Clinical Advisor – Programme Clinical Director and Alliance Lead, West Yorkshire &amp; Harrogate Cancer Alliance, and Strategic Clinical Lead / Programme Director for Leeds Cancer Programme</td>
</tr>
<tr>
<td>Belinda Henshaw</td>
<td>Senior Inspector/Reviewer</td>
</tr>
<tr>
<td>Uzma Aslam</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>Kat Wilkinson</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Susan Seigal</td>
<td>Public Partner</td>
</tr>
<tr>
<td>John Woods</td>
<td>Public Partner</td>
</tr>
<tr>
<td>Alastair Delaney (observer)</td>
<td>Director of Quality Assurance</td>
</tr>
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APPENDIX 3: Governance Structure

NORTH CANCER ALLIANCE
GOVERNANCE STRUCTURE

North of Scotland Chief Executive’s Group

North Cancer Alliance Board (NCAB)
Chair: Grant Archibald, Chief Executive, NHS Tayside

North Cancer Clinical Leadership Group (NCCLG)
Chair: NCA Clinical Director

North Medical Directors Group
Chair: Nick Fluck

Expert Groups
- SACT Governance Group
  - Delivery Group
  - Pharmacy Leads
  - Children & Young Adults Group
  - Electronic Prescribing
- Primary Care Group
- North Radiotherapy Group (*)
  - Brachytherapy Group
- Surgery Sub Group (*)
- Diagnostics (*)
- Acute Oncology (*)

Tumour Specific Boards
- Breast Pathway Board
- Colorectal Pathway Board
- Gynaecology Pathway Board
- Haematology Pathway Board
- Head & Neck Pathway Board
- Lung Pathway Board
- Upper GI Pathway Board
- Skin Pathway Board
- Urology Pathway Board
- HPB Pathway Board
- Cancer Unknown Primary (*)

Sub Groups
- Patient/Public Interface Group (*)
- Nurse Consultants Group
- Acute Management Interface Group (*)
- SACT Pathway Board

Formal National Links
- Cancer Intelligence (HDP)
- Sarcoma National Network
- HPB National Network
- SCONes
- Children & Young People’s MSH
- Scottish Cancer Taskforce
- National Cancer Clinical Services Group
- National Cancer Quality Operational Group
- National Cancer Quality Steering Group
- Radiotherapy Sub Group
- SACT National Groups (Various)
- TOAT Groups (Various)
- DCE Programme Board
- National Robotics Review
- NCAIE Executive Group

* Group under discussion to establish
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