West of Scotland Cancer Network
Regional Cancer Advisory Group (RCAG)

Cancer Regional Delivery Plan 2019 – 2022

Actions for 2019/20

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Regional Cancer Network Delivery Plan

There is clear expectation that cancer management is delivered to the highest standards and be provided in a way that is safe, sustainable and accessible. Services need to adapt to and efficiently manage change in demographics, epidemiology and demand in the context of new and emerging treatments/technology and predicted workforce challenges.

This workplan sets out the regional ambitions for cancer care and reflects a combination of key areas for change set out in the regional delivery plan and key work streams of the national cancer strategy Beating Cancer: Ambition and Action (2016).

- Prevention
- Improving survival
- Early detection and diagnosis
- Improving treatment
- Workforce
- Living with and beyond cancer
- Quality improvement

This high level plan is underpinned by more detailed Regional Working Group and Managed Clinical Network (MCN) workplans.

Recognising that many of the measures necessary to prevent cancer (smoking reduction, lifestyle and activity) are part of broader efforts being led nationally, regionally and by Boards to improve population health, this plan will focus on the following key objectives:

- We will improve cancer outcomes and demonstrate continuous improvement against nationally agreed cancer quality performance indicators (QPIs), utilising data to drive further improvement and identify required service change;
- We will further improve patient experience, building on feedback from the national cancer patient experience survey (repeated in 2018);
- We will create a culture of confidence in patients and professionals which facilitates self-management, develops new approaches to surveillance, minimises unnecessary reviews and supports people to regain control of their lives;
- We will work collaboratively as a system to deliver cancer access standards;
- We will develop and support the workforce to deliver their potential; and
- We will provide the highest quality of care within the resources available to us.

To meet these objectives numerous interventions are proposed over the coming years but there are a number of key interventions to be progressed at a regional level with the aims of improving outcomes, reducing variation and improving experience whilst ensuring that services remain safe, sustainable and make optimal use of the available workforce. These are summarised below.

Improving Outcomes

- Detect cancer earlier
- Increase screening uptake
- Fully implement revised cancer referral guidelines within primary care
- Deliver access standards
- Optimise diagnostic pathways and reporting
- Develop further the tiered delivery model for cancer services, setting out where further concentration of services on fewer sites, taking account of outcome and activity data and available skills/expertise as required
- Horizon scan and support, where appropriate, the introduction of new models, treatments and technologies that are evidenced based

Reducing Variation

- Review and potential reconfiguration of MDTs
- Regionally agreed clinical management guidelines fully implemented
- Standardise diagnostic reporting
- Reporting and review performance against QPIs and other national benchmarking data
- Development and implementation of regional service models and specifications (e.g. robotic surgery, acute oncology)

Improved Experience

- User feedback (cancer patient experience survey and development of PROM/PREMS)
- Redesigned models of care, incorporating systematic use of holistic needs assessment and treatment summaries
- Improved information and support (e.g. cancer treatment helpline, partnership with third sector, NHS Inform service directory)
- Personalised after care (risk stratified follow-up and cancer care reviews within primary care)
- Develop and strengthen user involvement in key workstreams

Research/Education

- Improve access to clinical trials, and promote clinical research
- Develop partnerships with educational institutions
- Develop capacity/capability within Managed Clinical Networks and maximise potential of education programmes already in place

Enablers

- Workforce: skills and competencies, role development, manpower and training
- Technology: regional/inter-regional capability (MDTs, e-prescribing, treatment summaries, holistic needs assessment, integrated diagnostic reporting, PROMS/PREMS)

The delivery of this regional cancer workplan will require contributions from the entire system, given the many complex interdependencies that exist.

The sections that follow provide further detail on the actions proposed in relation to the points previously noted.

Improving Outcomes

Detect Cancer Early (DCE) and Cancer Screening

Since the start of the programme we have seen an increase in the number of patients diagnosed with stage 1 disease for breast and lung cancer increasing from 38.2% to 40.7% and 13.7% to 18.8% respectively. For colorectal cancer we have seen a drop in stage 1 disease from 19.3% to 16%. The biggest improvement has been seen in relation to lung cancer and in those areas where screening for breast cancer were lower. Faecal immunochemical testing (FIT) was introduced nationally in late 2017. There is evidence of an increased uptake and it is hoped this will allow colorectal cancers to be diagnosed at an earlier stage and improve patient outcomes. To date however there has been a significant impact on diagnostic services with an approximate 100% increase in positive tests requiring further investigation.

All regional NHS Boards have plans in place to tackle variations in screening uptake, implementing recent evidence and working with the DCE Programme.

Plans for 2019/20

We will continue to support national campaigns and work with colleagues to develop practice profiles to help inform where future work is best targeted both at population and community levels.

We will take the learning from national DCE pilot projects in melanoma and apply, where appropriate, in other NHS Boards and work with colleagues nationally and across the UK to explore the potential to develop pilots in other cancer types, in particular head and neck cancers.

We will share learning across NHS Boards regarding local DCE campaigns, in particular those that promote and successfully increase screening uptake.

We will continue to monitor and plan for the impact of FIT testing on our diagnostic services and assess the pick-up rate of early cancers.

Referral/Access/Diagnostics

National cancer referral guidelines have recently been reviewed and published. Work is required to implement these in practice.

Nationally, performance against the cancer access standards has been challenging for some time. Performance across the region does show variance between sites and cancer types. The urological, head and neck, upper gastrointestinal and colorectal cancer 62 day pathways are particularly challenging.

Understanding our diagnostic capacity and workforce capability and requirements for the future is essential. We will work closely with regional planning colleagues to feed in specific requirements for cancer management. We have already developed detailed service maps that describe the workforce

and linked service co-location needs for specific aspects of services where there are known capacity pressures (e.g. breast radiology and interventional radiology), and will continue to seek to identify regional solutions to ensure optimal service provision and sustainability.

We will continue to pursue integrated diagnostic reporting solutions, particularly in relation to the reporting of haematological malignancies in conjunction with laboratory colleagues. Molecular diagnostics is an area of rapid advancement with significant implications for cancer management. We will continue to keep abreast of developments and work with colleagues regionally and nationally to ensure that we horizon scan and plan appropriately for future service requirements.

Plans for 2019/20

We will work with GP cancer Leads in partner Boards to implement and embed revised Cancer Referral Guidelines into practice. Working with Cancer Research UK we will facilitate and run multiprofessional educational events across the region bringing primary and secondary care colleagues together to discuss the guidelines and review referral processes.

We will seek to standardise downgrading policies and implement more systematic processes of regular feedback to GPs from secondary care regarding referrals that may not meet referral criteria.

We will review diagnostic pathways and identify those areas where triage straight to test, potentially by different healthcare professionals, may shorten pathways. Work will initially focus on the lung cancer pathway.

We will hold an educational meeting to consider the future of genomics in clinical practice and consider how our current processes can be improved.

We will assess the companion pathology testing implications of new cancer medicines prospectively to aid service planning to support introduction of new medicines into practice.

Regional and Tiered Service Delivery Treatment Models

There is overwhelming evidence demonstrating improved oncologic and functional outcomes in high volume units and that the relationship between volume of activity and patient outcome may be greater than has been previously appreciated. This fact, and the necessity to make optimal use of workforce, equipment and financial resources, points the way to further decreasing the number of units offering inpatient cancer management, especially for highly specialised and complex care.

The majority of cancer care will however continue to be delivered by local Boards. Emerging treatment and follow-up options also offer the real prospect of cancer care being increasingly delivered in the community and self directed care becoming a realistic option for increasing numbers of patients**.** Every effort needs to be made to provide and improve access to appropriate diagnostic, outpatient, and day-case care as locally as possible.

There are a number of established national cancer services - ophthalmic oncology, and bone marrow transplantation. There are a number of very low volume services currently provided on a

regional basis which might also be better provided on a national basis (e.g. salivary gland tumours, paediatric radiotherapy and penile cancer management).

Other services have been planned and delivered regionally, for example specialist oncology – systemic anti cancer therapy (SACT), radiotherapy, microvascular surgery for head & neck cancer and ovarian cancer surgery. Extensive work has been undertaken regionally in relation to SACT modelling future demand and capacity requirements, and defining a future tiered service delivery model that optimises the use of workforce through the substantial development of non medical prescribing and optimising the use of our medical workforce. Similar work has been undertaken in relation to radiotherapy within the Cancer Centre and satellite unit with role development for radiographers and the development and introduction of newer techniques.

In the coming period greater focus is required on surgical oncology with the need to revisit some established models to ensure they remain 'fit' for future requirements. In particular changing patterns of demand and complexity, predicted changes in locally available skill sets, and challenges in delivering the volume/outcome benefit may identify certain services which will be increasingly difficult to sustain going forwards. There is therefore a need to consider further developing and formalising networks of care, and inter Board/inter regional strategic alliances, across a growing number of services as current service delivery models are challenged both in terms of capacity (workforce and physical), but also in what levels of intervention are required to both diagnose and treat the cancer. This requires review of current service models and provides a potentially useful opportunity to redesign aspects of the service models for the specialties in question.

An agreed tiered regional strategy for cancer surgical services requires to be developed that takes cognisance of the West of Scotland's role in the provision of many national services. Established regional services such as complex gynaecological cancer surgery and microvascular surgery, and proposed regional services such as hepatic and upper gastrointestinal cancer surgery, should be prioritised to best manage current service issues. Completion of work in relation to possible regional urological service reconfiguration will also have an impact on future cancer service provision.

Plans for 2019/20

We will take forward the consistent implementation of the regional SACT strategic review in conjunction with partner Boards. Regionally work will focus, for example, on maintaining the upward trajectory of non medical prescribing (NMP), implementation of the NMP competency framework, developing a minimum service specification for outreach service models and service modelling.

We will continue to provide Boards with horizon scanning information for new cancer medicines to aid financial planning. In this coming year we will further develop service impact forward look.

We will work with regional planning colleagues to deliver the cancer workstream of the urology services review.

We will continue to monitor activity and outcomes of the regional robotic prostatectomy service and further explore why activity in the WoS appears lower than that of other regions.

We will seek to determine the future use cases for the use of robotic cancer surgery in the West of Scotland.

We will work with regional planning colleagues to deliver the cancer workstream of the upper gastrointestinal surgery services review workstream.

We will work with regional planning colleagues to deliver the cancer workstream of the ear, nose and throat services review workstream.

Reducing Variation

Multidisciplinary Working

Cancer multidisciplinary team (MDT) meetings are well established at local, regional and national levels with high levels of compliance against the nationally agreed quality performance indicator which stipulates all patients should be discussed at an MDT. There is however a need to explore the potential for more innovative MDT models in some cancer pathways to manage the growing demand and variable case complexity. A more streamlined approach to MDT working would free up time for greater consideration of complex cases and the possibility of more reactive services, with MDTs more responsive to patient need.

Plans for 2019/20

We will establish and evaluate a regional MDT for renal cancers.

We will hold a regional workshop for MDT chairs, coordinators, and cancer managers to explore how we can further develop and optimise MDTs, including consideration of protocolised case management.

We will explore the potential for innovative MDT models in some cancer pathways in conjunction with our Clinical Leaders and MCNs.

We will work with eHealth colleagues to evaluate potential technical solutions to support local, regional and national MDTs, reaching a conclusion on the way forward.

Guidelines and Protocols

The regional cancer MCNs have well developed system-wide clinical management guidelines and protocols and are increasingly taking a lead on the development of national guidance in conjunction with the other regional cancer MCNs. Robust regional governance mechanisms are in place and clearly evidenced through the management of cancer medicines into practice via the Regional Prescribing Advisory Group. All guidance, to date, issued by this group has been endorsed and implemented by Board Area Drugs and Therapeutics Committees ensuring consistent and equitable access to cancer medicines across the region. We will continue to support and further develop this process going forward.

Plans for 2019/20

We will review and update 37 Clinical Management Guidelines and Clinical Guidance Documents to ensure that they continue to reflect current and evidence based best practice.

We will develop new Clinical Management Guidelines and Clinical Guidance documents, where required, to drive consistency and optimise care.

We will undertake sample audits of compliance against guidelines through the MCNs, focussing initially on haematology.

We will continue to support the Cancer Medicines Outcome Programme through timely data submission and clinical input to the work programme.

Quality Improvement

There are a number of sets of national QPIs that services report against on an annual basis. While overall accountability for performance sits with NHS Boards, responsibility for analysing and reporting QPI and other benchmarking data sits regionally. Overall performance against QPIs has been good and regional review allows benchmarking and quality assurance of services to a degree which was not feasible before these data were gathered. Critical analysis of these data have led to changes in practice, for example, patient selection for certain treatment modalities, changes in clinical management guidelines, diagnostic reporting and improving access to some treatments

where uptake was lower than expected. Emerging data point to the need to consider further service reconfiguration due to low volume of cases for certain procedures, supporting the need for the work previously outlined.

A further round of SACT CEL compliance reviews are due to commence in 2019. The audit tool previously used has been further developed and multiple auditors have been trained to undertake this work. Regionally there was a high level of compliance with the standards when previously assessed.

The Innovative Healthcare Delivery Programme and Scottish Cancer Registry and Intelligence Service (SCRIS) are taking forward the development of cancer dashboards that will enable us to draw more readily on the large amounts of data already collected and turn this into intelligence that can be used to drive change and support improvement. This will enable our clinical leaders and MCNs to better direct service improvements.

Plans for 2019/20

We will review the regional assessment report of performance against national cancer QPIs produced by Healthcare Improvement Scotland, when issued, and identify any areas where specific action is required.

We will deliver a programme of annual audit reports in line with our agreed reporting schedule, initiate regional actions where required and monitor delivery of local actions.

We will work with information colleagues to build fuller service profiles of clinical services to inform discussion within MCNs around potential pathway improvements/service redesign.

We will continue to lead delivery of the National Cancer Quality Programme on behalf of the Scottish Government, working in partnership with other Networks, ISD, and HIS.

We will initiate the regional review programme and undertake a series of Board and Unit reviews in line with the requirements of CEL 30 (2012). We will also participate in inter regional audit in the north and south east of Scotland Cancer Networks.

We will work with SCRIS to develop the national Cancer Dashboard to ensure that it meets the requirements of clinicians and managers within the region and promote utilisation of the Dashboard by clinicians and managers.

We will work with clinical colleagues to optimise audit activity within the region by clarifying and streamlining processes for obtaining data sharing permissions.

We will respond to national survival analysis results undertaken in relation to OG, gynaecological cancers and head and neck cancers.

Regional Service Models

A number of regional cancer service models have developed with well defined regional pathways and clinical management guidelines in place. Regional MDTs have also been established to support these (e.g. gynae-oncology, head and neck). More recently the regional robotic prostatectomy service has been established, with very positive early outcome data evidenced. Different medical staffing models are in place for each service (e.g. in-reach surgery, or fully centralised surgical team) and consideration will require to be given as to how we sustain delivery models going forward. To date, these regional services are all provided in NHS Greater Glasgow and Clyde, but the potential for two centres for complex bladder surgery will require wider consideration as to where regional services are located. Given the interdependencies with other specialties, careful consideration will require to be given to co-location requirements.

As non surgical cancer care and treatment delivery models evolve, consideration also requires to be given to managing the toxicities of such treatment. During 2018 we will build on the progress made so far in establishing acute oncology services in our hospitals and seek to develop a more integrated and sustainable model.

Going forward consideration also requires to be given to other services that have become de facto regional services, such as, trans arterial chemo embolisation and newer ablation techniques. Work is required to better understand the range and number of services involved the level of associated activity and for these services to be appropriately planned.

Plans for 2019/20

We will further refine the proposed service model for acute oncology and develop a resource plan to support this for consideration.

Improved Experience

User Experience

NHS Boards review data and MCNs review pathway specific data from the National Cancer Patient Experience Survey. Findings from the last survey highlighted care planning, information and shared decision making as key areas for improvement. Since then a number of improvements have been taken forward and the work of the Transforming Care after Treatment Programme (TCAT), noted below, also seeks to address these. The survey was repeated in 2018 with results available in Spring 2019.

Some MCNs have sought to gain a better picture of their patient experience and have run bespoke surveys (e.g. sarcoma) where numbers completing the national survey did not allow any conclusions to be drawn. Patient experience feedback has also been actively sought as part of regional work streams such as SACT and used to inform service development.

Despite its many challenges interest in collecting PROMS and PREMS data is growing with two companies recently having developed tools in partnership with the service through the Cancer

Innovation Challenge. The challenge has now ended with companies seeking to further develop tools with other interested pilot sites.

Plans for 2019/20
We will review the outcomes of the national patient experience survey (available Spring 2019) and identify areas where further improvement work should be targeted.

We will as a Network seek to develop patient involvement in our workstreams as they develop, building on successful participation in work relating to SACT.

Redesigned Models of Care

The 5 year national TCAT Programme officially ended in December 2018. Learning to date clearly demonstrates the added value of a number of interventions which when delivered together can greatly improve experience and coordination of cancer care: for example, holistic needs assessments (HNA), treatment summaries, cognitive rehabilitation and practice nurse-led cancer care reviews in primary care.

Through the cancer MCNs a review of follow-up practice was previously undertaken and risk stratified approaches to follow-up were developed and implemented across the region. The shift in focus led to the development of a more holistic approach, improved quality and experience for patients post treatment, and a significant reduction in the number of out-patient appointments.

Recognising the adverse physical and psychological effects of cancer, work has also been undertaken regionally to develop a psychological therapies and support framework in conjunction with our many partners.

Plans for 2019/20

We will explore digital systems which can support cancer follow-up by providing scheduling tools and/or supporting self-management (achieved by providing PROMs/PREMs/HNA and access to information (personalised and generic)).

We will further develop risk stratified follow-up guidance which is underpinned by clinical evidence and ensures a person is seen in the right place at the right time by the right professional. This will be carried out in head and neck and lung cancer.

We will, where risk stratified pathways already exist (i.e. gynaecological cancers, prostate, acute leukaemia and upper GI), incorporate the HNA and Treatment Summary in to follow-up guidance to enable supported self-management and rapid re-entry in to secondary care if/when required.

We will continue to work with partners to embed cognitive rehabilitation services across the West of Scotland ensuring self-management advice is readily available and services which meet the needs of those with more complex needs are available locally.

We will explore opportunities to enhance the prehabilitation offer to those going for endometrial and oesophagogastric surgery in the first instance. We will look to utilise available assets to support each of the three main elements of prehabilitation (psychological care and support, diet and nutrition, and physical activity and exercise) and build upon ERAS principles.

We will continue to drive forward and support implementation of the psychological therapies and support framework across organisations by:

- ***Increasing access to training tools to partner organisations***
- ***Promoting awareness of the Psychological Therapies and Support Framework via a variety of media channels***

Workforce

The increasing incidence and prevalence of cancer, and growing number and complexity of cancer treatment options available, pose real challenges in service delivery. Finite workforce resources struggle to keep pace with demand. The development of extended roles such as non-medical prescribers, advanced nurse practitioners, clinical nurse specialists consultant and reporting radiographers, has been key to managing this demand but the full potential of these key team members is yet to be realised (as evidenced in the regional SACT review). Every effort needs to be made to recruit, train and retain these key personnel to deal with the predicted further increase in workload. In addition a new approach to medical and non-medical staff appointments may be required, where staff are recruited to work within a network rather than be restricted to one or two hospital sites.

Plans for 2019/20

We will identify emerging 'new roles' with each cancer specialty and their potential to expedite patient pathways (e.g. Breast Advanced Nurse Practitioners, Consultant Breast Radiographers and Reporting Radiographers) and share learning across the region by holding a Learn and Share Event.

We will benchmark oncologist staffing levels with other regions.

We will monitor the uptake of non medical prescribing quarterly and provide feedback to Boards and support a further 8 training places for NMP.

We will optimise the Network education programme and target this to help drive forward the overall objectives of the Cancer Plan.

Technology

Safe and efficient management of patients across traditional Board based boundaries is predicated on efficient, secure and robust systems of communication and data transfer. Appropriate information technology solutions, which have regional/inter-regional capability, need to be delivered as discussed elsewhere in the plan. To date, some regional capability has been exploited to support cancer management (e.g. chemotherapy electronic prescribing and radiotherapy delivery) but requires to be developed further, and with a degree of urgency, to better support natural patient flows (e.g. regional MDT meetings, integrated diagnostic reporting, electronic treatment summaries and holistic needs assessments).

Plans for 2019/20

We will work with eHealth colleagues to prioritise work to be taken forward to ensure maximum benefit:

- ***Determine future roadmap for chemotherapy electronic administration and prescribing: upgrade/replacement and plan for this.***
- ***Determine roadmap for progressing regional MDT solution and plan for this.***
- ***Determine options and scope for progressing PROMS/PREMS.***
- ***Determine the feasibility of utilising My Medical Record to support prostate follow up in the first instance within one NHS Board.***
- ***Finalise national eCASE Service Level Agreement for 2019/20 and review delivery model.***
- ***Continue to pursue potential solutions that will support the introduction of treatment summaries into practice.***

Research

In the further development and delivery of the work plan as a Network we will aspire to:

- reflect at every level the importance and value of research;
- apply the full range of research based activity from day to day practice based learning through to funded research projects;
- promote equity of access to research through clinical trials; and
- learn from others beyond the field of cancer.

Our work plan reflects many of the national research based priorities, such as, earlier diagnosis, screening, diagnostics, high value pathways and living with and beyond cancer.

We are not starting from scratch, rather building on the extensive research activity that is already ongoing in relation to cancer in the West of Scotland: work, such as, Precision Panc and the Cancer Medicines Outcome Programme.

Measuring Success Across the Cancer System and Across the Pathway

By implementing the key recommendations of the national Cancer plan throughout the West of Scotland and our Regional Work Plan we would expect to see a number of measurable improvements in the care provided and patient outcomes.

Improving Outcomes

Short term
Earlier diagnosis: increased uptake of bowel screening and number of cancers diagnosed at an earlier stage. April 17 – Mar 18 35% (91) of screen referred cancers diagnosed as Dukes A; 19.6% as Dukes B; and 23.5% as Dukes C.

Medium term
Earlier treatment: consistent delivery of cancer access standards. As at 18th Dec 18 the 62 day standard is 81.4% and the 31 day standard is 96.3%.

Longer term
Earlier diagnosis: increased number of cancers diagnosed at stage 1 across those cancers included in the DCE programme. Jan 16-Dec 17 West of Scotland 25.5% (2,957) Stage 1 cancer diagnosed for lung, breast and colorectal cancers combined.

Improved survival: at 1 and 5 year overall survival. Overall 1 year survival for males currently 66.8% and for females 71.2%. % year overall survival for males 49.9% and for females 56.9%.

Reducing Variation

Short term
Assurance of CMG compliance and demonstration of equity of access to treatment across region.

Continuous improvement in performance against nationally agreed Quality Performance Indicators. Demonstrable upward trajectory year on year.

Medium term
Optimal clinical decision making: MDT improvement and protocolisation of cases *where appropriate.* Increased efficiency of MDTs and effectiveness of clinical decision making. Increased number of regional MDTs.

Longer term
Implementation of regionally agreed service models with agreed standards of care being met. Greater service resilience.

Improved Experience

Short term
PROM/PREMs piloted in different patient groups/locations
Increased user input to inform key regional workstreams.

Medium term
Improved feedback from national patient experience survey in units across the region when compared to previous survey.

Longer term
PROMS/PREMS in use in all NHS Boards and being used to drive local improvements.

Each patient will have access to a Holistic needs assessment (HNA) with evidence of referral to services best placed to meet their individual needs.

Each patient will have a treatment summary at key points in their pathway, improving communication between healthcare professionals and patients and across care organisations.

Research/Education

Short term
CPD points secured for educational meetings/events, maintaining the quality of regional/national events.

Medium term
Improve uptake of clinical trials across the region by tumour group.
Learning from funded research projects such as CMOP.

Longer term
Evidence of influence over future educational programmes at undergraduate and postgraduate levels.

Enablers

Medium/Longer term
Workforce plans in place for key specialties e.g. non medical prescribing with trajectories for service delivery being met.
Integration of IT solutions with wider health record.

Priority Actions Summary 2019/20

Regular updates on progress against actions contained within the workplan will be presented to RCAG.

Plans for 2019/20	Timescale	Lead	Progress
Improving Outcomes			
We will continue to support national campaigns and work with colleagues to develop practice profiles to help inform where future work is best targeted both at population and community levels.			
• Maintain regional input to Detect Cancer Early Programme Board, with regular feedback to RCAG.	4 monthly	RMC/Clinical Director BWoSCC	
○ Provide clinical input to development of new social marketing Lung Cancer campaign.	May-Aug 19	Lung Cancer MCN Clinical Lead	
• Work with national primary care group to inform the development of practice profiles.	Ongoing	Primary Care Clinical Lead	
We will take the learning from national DCE pilot projects in melanoma and apply, where appropriate, in other NHS Boards and work with colleagues nationally and across the UK to explore the potential to develop pilots in other cancer types, in particular head and neck cancers.			
• Assess outcomes of skin cancer pilots and assess for wider applicability across the region.	Dec 19	Skin Cancer MCN	
• Identify opportunity for targeted work to be undertaken in relation to head and neck cancer, ensuring alignment with other work ongoing within the region and nationally.	tbc	Head and Neck Cancer MCN	Awaiting final national approval.
We will share learning across NHS Boards regarding local DCE campaigns, in particular those that promote and successfully increase screening uptake.			

Plans for 2019/20	Timescale	Lead	Progress
• Assess screening uptake variability and methodologies being applied to improve uptake across Boards, with a view to sharing best practice.	Dec 19	Colorectal/Breast/ Gynaecological Cancers MCN Clinical Leads/ Mans/Board Leads	
We will continue to monitor and plan for the impact of FiT testing on our diagnostic services and assess the pick-up rate of early cancers. • Assess impact of FiT testing in the screening population on service and pick up rate, reporting findings to RCAG. • Assess impact of FiT testing in the symptomatic population on service and pick up rate, reporting findings to RCAG.	6 monthly	Colorectal Cancer MCN Clinical Lead/Man	
We will work with GP cancer Leads in partner Boards to implement and embed revised Cancer Referral Guidelines into practice. Working with Cancer Research UK we will facilitate and run multiprofessional educational events across the region bringing primary and secondary care colleagues together to discuss the guidelines and review referral processes. • Disseminate referral guidelines across the region. • Facilitate educational meetings across the region. • Review referral processes. • Assess impact of new referral guidelines in practice.	Mar 19 Ongoing throughout 19/20	Primary Care Cancer Network/ Board Leads	
We will seek to standardise downgrading policies and implement more systematic processes of regular feedback to GPs from secondary care regarding referrals that may not meet referral criteria. • National agreement of downgrading policy. • Regional implementation. • Assessment of impact of introduction of new policy on reducing number of USOC referrals/cancer yield.	In line with national work	Cancer Service Managers/ Information Services Scotland	

Plans for 2019/20	Timescale	Lead	Progress
We will review diagnostic pathways and identify those areas where triage straight to test, potentially by different healthcare professionals, may shorten pathways. Work will initially focus on the lung cancer pathway. • Review practice across Scotland and UK. • Optimise sequencing of diagnostic tests. • Identify optimal regional model for EBUS. • Work with GGC to appraise potential for a single centre for diagnosis of lung cancer within the city.	Sept 19 Dec 19 Ongoing	Lung Cancer MCN Clinical Lead/Man	
We will hold an educational meeting to consider the future of genomics in clinical practice and consider how our current processes can be improved. • Host multiprofessional educational meeting.	Oct 19	QSIM	
We will assess the companion pathology testing implications of new cancer medicines prospectively to aid service planning to support introduction of new medicines into practice. • Production of forward look horizon scan report to aid service planning.	Dec 19	RMC	
We will take forward the consistent implementation of the regional SACT strategic review in conjunction with partner Boards. Regionally work will focus, for example, on maintaining the upward trajectory of non medical prescribing (NMP), implementation of the NMP competency framework, developing a minimum service specification for outreach service models and service modelling. • Produce quarterly NMP activity report for Boards to monitor trajectory across tumour types. • Oversee implementation of the regionally agreed service model, ensuring consistency of approach via SACT Service Delivery Group. • Develop a minimum service specification for outreach service models.	Quarterly 6 monthly Dec 19	QSIM SACT Service Delivery Group QSIM	

Plans for 2019/20	Timescale	Lead	Progress
We will continue to provide Boards with horizon scanning information for new cancer medicines to aid financial planning. In this coming year we will further develop service impact forward look.			
• Produce and circulate horizon scanning report to WoS Boards to aid service planning.	Dec 19	RCCP	
• Develop, test and validate methodology for assessing service impact modelling of new cancer medicines.	Nov 19	RCCP	
• Produce horizon scanning report for WoS NHS Boards to aid service planning.	Prov Feb 20 *(dependant on above)*	RCCP	
We will work with regional planning colleagues to deliver the cancer workstream of the urology services review.			
• Submit business case for partial nephrectomy robotic surgery for consideration by DOFs and the Regional Health and Social Care Delivery Group.	June 19	RMC	
• Take forward implementation planning in conjunction with Regional Planning colleagues.	tbc *(dependant on approval of above)*	RMC	
We will continue to monitor activity and outcomes of the regional robotic prostatectomy service and further explore why activity in the WoS appears lower than that of other regions.			
• Maintain record of monthly activity data and referral patterns.	Monthly	Urological Cancers MCN Man	
• Submit data for national review annually, ensuring continence data is included.	Annual	IM	
• Review casemix, referral criteria and patient pathway with a view to optimising uptake and timeliness of treatment.	Sept 19	MCN Clinical Lead/Man	
We will seek to determine the future use cases for the use of robotic cancer surgery in the West of Scotland.			
• Submit business cases for TORS and partial nephrectomy	June 19	RMC	

Plans for 2019/20	Timescale	Lead	Progress
to DOFs and Regional Health and Social Care Delivery Group for consideration. • Ensure regional input to national working group looking at the future provision of robotic surgery in Scotland.	May 19	RMC/RLCC	
We will work with regional planning colleagues to deliver the cancer workstream of the upper gastrointestinal surgery services review workstream. • Provide management leadership for workstream. • Deliver project plan. • Ensure appropriate representation from MCN and cancer managers across the region, leading on cancer specific pieces of work around data, pathways, redesign etc.	May 19 May 20 Ongoing in line with project plan	RMC/QSIM	
We will work with regional planning colleagues to deliver the cancer workstream of the ear, nose and throat services review workstream. • Provide management support for workstream. • Ensure appropriate representation from MCN and cancer managers across the region, leading on cancer specific pieces of work around data, pathways, redesign etc.	April 19 Ongoing in line with project plan	QSIM RMC	
Reducing Variation			
We will establish and evaluate a regional MDT for renal cancers. • Establish regional MDT. • Undertake initial review at 3 months and then at 1 year to ensure all cases are being discuss, that meeting is functioning effectively and efficiently and agree any areas for further improvement.	April 19 June 19/March 20	Urological Cancers MCN/ MDT Chair	
We will hold a regional workshop for MDT chairs, coordinators, and cancer managers to explore how we can further develop and optimise MDTs, including consideration of protocolised case management.			

Plans for 2019/20	Timescale	Lead	Progress
• Hold a regional workshop, involving speakers from across the UK to inform development of a regional work plan. • Scope and develop regional work plan based on output from above. • Initiate programme of work.	June 19 Aug 19 Oct 19	RMC/RLCC RMC RMC	
We will review and update 37 existing Clinical Management Guidelines and Clinical Guidance Documents to ensure that they continue to reflect current and evidence based best practice. • 16 CMGs and CGDs • 10 CMGs and CGDs • 5 CMGs and CGDs • 6 CMGs and CGDs	 Q1 Q2 Q3 Q4	 MCN Mans MCN Mans MCN Mans MCN Mans	
We will develop new Clinical Management Guidelines and Clinical Guidance documents, where required, to drive consistency and optimise care. • As set out in individual MCN work plans (links at end of this document).	Ongoing	MCN Mans	
We will undertake sample audits of compliance against guidelines through the MCNs, focussing initially on haematology. • Identify CMGs and specific section of pathway to be audited. • Identify data requirements and undertake audits, having obtained appropriate data sharing permissions. • Report outcomes of audits, identifying any areas where change to practice may be required. • Initiate any required change to practice or any further audit required.	 May 19 June 19 Dec 19 *Dependant on above*	 MCN Clinical Lead/Mans	
We will continue to support the Cancer Medicines Outcome Programme.			

Plans for 2019/20	Timescale	Lead	Progress
• Collaborate with programme to determine the outcomes of new myeloma medicines (pomalidomide, carfilzomib and panobinosat) in WoS patients. • Collaborate with programme to share learning on the use of PROM/PREMS in routine clinical practice.	Ongoing Ongoing	Haemato-Oncology MCN RMC	
We will review the regional assessment report of performance against national cancer QPIs produced by Healthcare Improvement Scotland, when issued, and identify any areas where specific action is required. • Submit regional response to HIS on questions raised following original submission. • Host 2 day external review visit. • Provide response to HIS report. • Devise any action plan required as a result of external review.	 May 19 June 19 July 19 Aug 19	 RMC RMC/RLCC RMC/RLCC RMC/Board Leads	
We will deliver a programme of annual audit reports in line with our agreed reporting schedule, initiate regional actions where required and monitor delivery of local actions. • Prostate, Endometrial • Brain, Ovarian, Upper GI • Lung, HPB, Sarcoma, Colorectal, Head & Neck, Melanoma, Breast • Renal, Bladder/Testicular, Acute Leukaemia.	 Q2 19 Q3 19 Q4 19 Q1 20	 IM/MCN Clinical Leads IM/MCN Clinical Leads IM/MCN Clinical Leads IM/MCN Clinical Leads	
We will continue to lead delivery of the National Cancer Quality Programme on behalf of the Scottish Government, working in partnership with other Networks, ISD, and HIS. • Undertake formal review of breast QPIs. • Undertake formal review of renal QPIs. • Undertake formal review of prostate QPIs.	 Jul 19 Jul 19 Nov 19	 NCQPC NCQPC NCQPC	

Plans for 2019/20	Timescale	Lead	Progress
• Undertake a formal review of upper GI QPIs. • Undertake a formal review of lung QPIs.	Feb 20 Mar 20	NCQPC NCQPC	
We will initiate the regional review programme and undertake a series of Board and Unit reviews in line with the requirements of CEL 30 (2012). We will also participate in inter regional audit in the north and south east of Scotland Cancer Networks. • Undertake Board audits: o Ayrshire and Arran o Forth Valley o GGC o Lanarkshire • Undertake Unit audits over a 30 month period: o Ayr o Crosshouse o Forth Valley Royal Hospital o Monklands o Wishaw o Hairmyres o Royal Alexandra Hospital o Vale of Leven o Inverclyde o New Victoria o Queen Elizabeth o BWoSCC o Glasgow Royal Infirmary	 May 19 June 19 June 19 June 19 tbc tbc tbc tbc tbc tbc tbc tbc tbc tbc tbc tbc tbc	 SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive SACT Executive	
We will work with SCRIS to develop the national Cancer Dashboard to ensure that it meets the requirements of clinicians and managers within the region and promote utilisation of the Dashboard by clinicians and managers. • Participate in workshops to contribute to dashboard design. • Beta test dashboard and provide user feedback.	 Ongoing June 19	 Clinical Leads/ Information Team Clinical Leads/	

Plans for 2019/20	Timescale	Lead	Progress
• Manage user access to dashboard once operational.	tbc	Information Team RMC/IM	
We will work with clinical colleagues to optimise audit activity within the region by clarifying and streamlining processes for obtaining data sharing permissions. • Develop business as usual processes to include wider audit function of Network/regional working and seek national approvals for same through Information Governance Leads/PBPP. • Assuming approval of above run awareness sessions with key staff groups to raise awareness of 'new' process that will facilitate regional audit via MCNs.	 Oct 19 tbc *(dependant on above)*	 IM IM	

We will respond to national survival analysis results undertaken in relation to OG, gynaecological cancers and head and neck cancers.
 	
• OG: submit data to enable further analysis of more recent cohort of patients to be undertaken.
• Gyn: undertake further data analysis, once further approvals obtained, to further investigate underlying factors that may contribute to survival variances seen within the region in relation to ovarian cancer surgery.
• Head and Neck: review analysis provided by ISD to determine any areas where further work is required or any change in practice may be indicated.
• Submit data to enable survival analysis to be undertaken for other cancer types in line with national reporting schedule:
  o Cervical
  o Endometrial
  o Lung
• Develop action plans in response to any findings from above.
	
	Feb 20
	
	tbc *(dependant on approvals)*
	
	Sept 19
	
	May 19
	May 19
	tbc
	tbc *(dependant on above)*
		
		IM
		
		IM/ MCN Lead
		
		IM/MCN Lead
		
		IM
		IM
		IM
		MCN Clinical Leads/Mans	

Plans for 2019/20	Timescale	Lead	Progress
We will further refine the proposed service model for acute oncology and develop a resource plan to support this for consideration. • Review proposed model with Boards. • Develop resource plan and submit to RCAG	 May 19 Sept 19	 RMC QSIM	
Improved Experience			
We will review the outcomes of the national patient experience survey (available Spring 2019) and identify areas where further improvement work should be targeted. • Analyse key themes emerging from national survey. • Agree with constituent Boards actions to be progressed at a regional level.	 Jul 19 Sept 19	 RLLWBC RLLWBC	
We will as a Network seek to develop patient involvement in our workstreams as they develop, building on successful participation in work relating to SACT. • Review and develop methodology.	 Dec 19	 RLLWBC	
We will explore digital systems which can support cancer follow-up by providing scheduling tools and/or supporting self-management (achieved by providing PROMs/PREMs/HNA and access to information (personalised and generic)). • Submit cancer innovation challenge bids for PROMS PREMS. o If successful, support implementation into clinical practice within pilot site. • Take forward work to develop app to support PROMS reporting in patients with prostate cancer. • Work with MCN members to continue to establish the use of HNAs in routine clinical practice.	 May 19 Dec 19 Mar 20 Ongoing	 RLLWBC/ MCN Clinical Leads RLLWBC /MCN Mans/ Clinical Leads RLLWBC MCN Mans/Clin Leads	

Plans for 2019/20	Timescale	Lead	Progress
We will further develop risk stratified follow-up guidance which is underpinned by clinical evidence and ensures a person is seen in the right place at the right time by the right professional. This will be carried out in head and neck and lung cancer. • Undertake review of follow up guidance, considering scope for risk stratified follow up and introduction of HNA into practice. • Facilitate implementation of the revised regional guidance.	Dec 19 Mar 20	MCN Mans/ Clinical Leads – Head & Neck and Lung Cancer MCNs	
We will, where risk stratified pathways already exist (i.e. gynaecological cancers, prostate, acute leukaemia and upper GI), incorporate the HNA and Treatment Summary in to follow-up guidance to enable supported self-management and rapid re-entry in to secondary care if/when required. • Modify follow up guidance to incorporate the use of HNAs and Treatment Summaries in practice.	Mar 20	MCN Mans/ Clinical Leads – Gynaecological, Prostate, Haem Onc, Upper GI Cancers	
We will continue to work with partners to embed cognitive rehabilitation services across the West of Scotland ensuring self-management advice is readily available and services which meet the needs of those with more complex needs are available locally. • Liaise with those trained in Cognitive Rehabilitation to support implementation of group sessions within each Board area. • Provide opportunities to share learning across providers and maximise impact of cognitive rehabilitation. • Work with Macmillan Cancer Support and NES to ensure resources for first line support and group sessions are available to patients and providers • Highlight availability of resources and group sessions to clinical teams thereby supporting the development of referral routes	Dec 19 Dec 19 Oct 19 Aug 19	RLLWBC	

Plans for 2019/20	Timescale	Lead	Progress
We will explore opportunities to enhance the prehabilitation offer to those going for endometrial and oesophagogastric surgery in the first instance. We will look to utilise available assets to support each of the three main elements of prehabilitation (psychological care and support, diet and nutrition, and physical activity and exercise) and build upon ERAS principles. • Raise awareness of the role and benefits of prehabilitation through RCCL and MCNs, highlighting core components and definition. • Disseminate FACT Prehabilitation Framework and Consensus Statements. • Review opportunities to implement FACT Framework through utilisation of local assets and consider pathways of care in partnership with MCN Advisory Boards. • Review outcomes of prehabilitation in endometrial and oesophagogastric cancers and consider rationale for replication in other hospital sites.	Mar 20 Dec 19 Sept 19 Mar 20 Mar 20	RLLWBC / Upper GI and Gynaecological Cancers Clinical Leads RLLWBC RLLWBC RLLWBC/ MCN Clinical Leads RLLWBC / Upper GI and Gynaecological Cancers Clinical Leads	
We will continue to drive forward and support implementation of the psychological therapies and support framework across organisations by: • Increasing access to training tools to partner organisations • Promoting awareness of the Psychological Therapies and Support Framework via a variety of media channels	June 19 Sept 19	RLLWBC RLLWBC	
Workforce			
We will identify emerging 'new roles' with each cancer specialty and their potential to expedite patient pathways (e.g. Breast Advanced Nurse Practitioners, Consultant Breast Radiographers and Reporting Radiographers) and share learning across the region by holding a Learn and Share Event. • Host regional event to consider new and emerging roles.	Dec 19	QSIM	

Plans for 2019/20	Timescale	Lead	Progress
We will benchmark oncologist staffing levels with other regions. • Source and analyse data from other regions. • Undertake benchmarking exercise.	Dec 19	RMC/General Manager BWoSCC	
We will monitor the uptake of non medical prescribing quarterly and provide feedback to Boards and support a further 8 training places for NMP. • Issue reports to Boards setting out activity by tumour type. • 4 training places to be filled in Sept and 4 places to be filled in Feb (2 from each WoS Board).	Quarterly Sept 19 Feb 20	QSIM RMC	
We will optimise the Network education programme and target this to help drive forward the overall objectives of the Cancer Plan. • Host a series of educational meetings throughout the year, ensuring programmes are targeted appropriately and secure CPD accreditation. • Host Upper GI national education/audit meeting.	Ongoing Nov 19	MCN Man/Clin Leads MCN Man/Clin Lead	
Technology			
We will work with eHealth colleagues to prioritise work to be taken forward to ensure maximum benefit: • Determine future roadmap for chemotherapy electronic administration and prescribing: upgrade/replacement and plan for this. o Develop business case to support V6 upgrade. o Submit business case for regional approval. o Assuming approved, develop and progress project plan/implementation.	June 19 Aug 19 Sept 19 tbc *(dependant on above)*	CEPAS Executive	
• Determine roadmap for progressing regional MDT solution and plan for this.		Multi-Disciplinary Team Meetings Short Life	

Plans for 2019/20	Timescale	Lead	Progress
○ Complete options appraisal. ○ Develop and test prototype with preferred supplier. ○ Assess outcomes. ○ Develop business case for wider development (assuming +ve evaluation)	Oct 19 Dec 19 Mar 19 tbc *(dependant on above)*	Working Group	
• Determine options and scope for integrating PROMS/PREMS with EPR. ○ Work with eHealth to determine feasibility as part of pilot with women with gynaecological malignancies.	Dec 19	RLLWBC	
• Determine the feasibility of utilising My Medical Record to support prostate follow up in the first instance within one NHS Board. ○ Determine feasibility of piloting within 1 NHS Board and develop business case.	Sept 19	RCCL/RLLWBC	
• Review national delivery model for eCASE service support.	Sept 19	RMC	
• Continue to pursue potential solutions that will support the introduction of treatment summaries into practice. ○ Contribute to ongoing national discussions. ○ Continue to embed system in use within NHS Forth Valley. ○ Consider other potential options avaialbe within core clinical systems.	Ongoing Ongoing Mar 20	RMC/RLCC/ RLLWBC RLCC RMC/RLCC/ RLLWBC	

Lead Abbreviations

IM	Information Manager	RCCP	Regional Cancer Care Pharmacist
MCN Man/s	MCN and Improvement Manager/s	RLCC	Regional Lead Cancer Clinician
NCQPC	National Cancer Quality Programme Coordinator	RLLWBC	Regional Lead for Living With and Beyond Cancer
QSIM	Quality and Service Improvement Manager	RMC	Regional Manager (Cancer)

MCN Workplans Website Links

Breast Cancer
Colorectal Cancer
Gynaecological Cancer
Haemato-Oncology
Head and Neck Cancer
Lung Cancer
Primary Care Cancer Network
Skin Cancer
Urological Cancer
Upper Gastro-Intestinal Cancer
Scottish HepatoPancreatoBiliary Cancer
Scottish Neuro-Oncology
Scottish Sarcoma