Humber and Yorkshire Coast Cancer Network

Scarborough and North East Yorkshire Healthcare NHS Trust

North Yorkshire and York

Independent Peer Review Action Plan – SUI ref 2008/6043
November 09

The content of this action plan should be considered within the context of the Scarborough clinical services review and Scarborough cancer services review which are currently ongoing. The action plan is continually under review by NHS North Yorkshire and York

(Please see Key at end of Action Plan)

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
1.	**Care Pathway and Compliance with the Improving Outcomes Guidance**				
1.1	The SNEYT MDT should be aligned to one Cancer Network both for screening and symptomatic services	• Review of existing arrangements for the Screening Programme has been undertaken with Cancer Network, the Sub-Regional Collaborative Forum (Hull). • Stakeholder meeting held 30/11/09 with all key stakeholders.	1. NHS NYY to review commissioning arrangements following option appraisal involving key stakeholders. Outcomes also to be linked to Cancer and Clinical Services Review of Scarborough Trust for breast screening provision	NHS NYY Director of Strategy David Cockayne	1.Jan 2010

1.2	Consideration should be given to the development of a fixed assessment screening unit in Scarborough providing appropriate facilities including digital and mammography or investment in digital mammography allowing for films to be read remotely, maintaining radiological skills and providing sufficient cases for audit. Attempts should be made to locate the radiological equipment close to the breast clinic. At the very least, a handheld ultrasound device could be situated in the breast clinic, with an advanced radiological practitioner to carry out ultrasound of any lesions which required investigation following mammography, or where ultrasound is required for image guided biopsy.	• Issue registered with Sub Regional Commissioning Forum (Hull) and Collaborative Screening Group (North). • Preliminary discussion taken place to put in place a facility for breast care and screening services	1. Lead commissioner working with stakeholders (inc QARC) to review commissioning arrangements for breast screening service. Following the outcome of those discussions, SNEY will be in a position to consider the development of a fixed site screening unit. 2. SNEYT reviewing the environment in which breast services are provided, which will influence whether the use of handheld devices is required in the service.	NHSNYY Director of Strategy David Cockayne SNEYT Director of Clinical Services Denise Potter	1. Jan 2010 2. Jan 2010

1.3	Video conference facilities should be provided to allow a joint MDT with Hull and/or York, allowing for any disagreement over management of patients to be resolved by consensus and would also help with resolving the problems associated with remote working between the breast screening site and the main oncology centre. Reducing the time spent travelling between meetings	• Attendance at York MDT by Breast Surgeons • Lead Breast Clinician attending Hull MDT • Installation of video conferencing facilities at SGH complete, linking SNEYT with Hull and York. • Admin support to SNEYT MDT to support the use of video link equipment established.	1. Video-conferencing Link with Leeds.	SNEYT Director of Clinical Services Denise Potter	1. April 2010

1.4	The operational policy and procedures for the unit , including diagnostic protocols and surgical management guidelines should be documented and ratified by the Trust's Clinical Governance Committee	• Network Guidelines agreed by Clinical Governance Committee and are in use • Operational Policy for MDT already in place. (Clinical Governance Committee 28/05/09). • Operational Policy and Work Programme underwent confirm and challenge internal validation process as part of Peer Review process in Oct 09. • Mentorship around breast reconstruction surgery provided by HEYNHST. • Trust cancer lead clinician has scheduled meetings with MDT cancer leads. • Monthly meetings in place between breast care lead and lead cancer	1. Audit to assess compliance with guidance.	SNEYT Medical Director Mark Andrews	1. Jan 2010

		clinician.			
1.5	Two breast surgeons with more than 50% of time dedicated to breast surgery/diagnosis should be appointed. To achieve this action, a strategic partnership is required.	• Substantive lead breast surgeon appointed March 2009.	1. Joint appointment for 2nd post 2. Agree with York and Hull Trusts management of capacity, until second substantive joint post appointed to	SNEYT Director of Clinical Services Denise Potter SNEYT Medical Director Mark Andrews	1.July 2010 2. Jan 2010

1.6	Appointees are required to demonstrate strong leadership and to demonstrate clear understanding of quality assurance guidelines (both screening and symptomatic), clinical governance and the documented policy and procedures for the unit	A range of comprehensive actions have been taken to improve the governance arrangements. These include: • All Consultants appraised on annual basis • Audit Programme now in place. • Attendance of Breast Consultant at Screening MDT continues. • Attendance of Breast Consultant at Specialist MDT in Cancer centre • Compliant with Screening Quality Assurance guidelines.	1. All evidence of actions to date to be presented to the commissioner via the Contract Management Board Meetings	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

1.7	Consideration should be given to the breast service being managed as a separate entity, with a budget and dedicated management support	• Breast speciality has developed own Business Plan as subset of Divisions plan • Work plan for MDT • Discreet cost centre for breast services implemented. • Breast speciality has own work and action plan arising from peer review process. Action Completed July 09			
1.8	The lead cancer clinician should draw up a list of non-compliant measures with regard to Improving Outcomes Guidance and identify a timescale for achieving IOG compliance in the Breast Unit.	• List of measures completed March 2009 • Reports available • Identified list of non compliant measures by internal validation peer review process reported to locality group in September 2009, further report to locality group meeting in Oct/Nov 2009. • Action plan	1. Implement Action Plan 2. Review evidence of IOG compliance following completion of all actions.	SNEYT Director of Clinical Services Denise Potter SNEYT Director of Clinical Services Denise Potter	1 Jan 2010 2. Feb 2010

		developed.			

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
2.	**Clinics**				
2.1	The service needs to be reorganised to have two symptomatic clinics per week.	• Two symptomatic clinics per week established • Benign disease clinic is up and running, consultant lead clinic with nurse specialist present every Wednesday at Bridlington. Nurse led follow up at Scarborough every Tuesday. Completed Oct 2009			

2.2	Trust management must provide funding for at least three further sessions of breast imaging	• Trust has identified funding for three further sessions	1. Mapping capacity requirements for new patient clinics pre and post commissioning decision regarding screening programme.	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

2.3	Any new appointment must have more breast radiology time allocated (a minimum of five sessions) and should be linked into a screening unit, be it Hull or York.	• Trust has identified funding for a joint appointment with Hull which will provide for a minimum of five sessions.	1. Mapping capacity requirements for new patient clinics pre and post commissioning decision regarding screening programme.	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

2.4	New radiological (mammography, ultrasound and image guided core biopsy) equipment needs to be purchased by the Trust. In preference, new mammographic equipment would be digital to allow clinicians at other sites (eg the screening centre) to read mammograms	• Ultrasound probe replaced • Capital funding for new equipment has been obtained from Trust Executive Group. • Preferred equipment identified, meeting held 29th Sept. with key stakeholders. Implementation plan to be drawn up from that meeting re. dates for installation. • Capital alterations to the radiology room have been identified by the Director of Estates and Facilities • SNEYT are assured the existing equipment is fit for purpose prior to the procurement of new equipment	1. Currently undergoing process to procure appropriate equipment.	SNEYT Director of Clinical Services Denise Potter	1. April 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
3.	**Diagnostic Services**				
3.1	Radiographers should be trained to be advanced practitioners to assist in film reading, mammography and ultrasound guided biopsy. Regular on-going training and checking of competence in practice is required.	• Reviewed current position	1. Facilitate training for existing post holder 2. Potential for additional capacity to be reviewed in partnership with HEYNHST at the appointment of Radiology posts	SNEYT Director of Clinical Services Denise Potter SNEYT Director of Clinical Services Denise Potter	1. Jan 2010 2.July 2010
3.2	SNEY to ensure that there is adequate Breast Consultant Radiologist capacity, in line with IOG (minimum 5 sessions) and linked to a screening unit	• Trust has identified funding for a joint appointment with Hull which will allow development of capacity	1. Mapping capacity requirements for new patient clinics pre and post commissioning decision regarding screening programme.	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

3.3	A specialisation in breast pathology needs to be achieved by at least one individual (preferably with a deputy) to achieve national IOG compliance and ensure continued pathology provision for breast services in SNEYT.	• SNEYT is reviewing joint appointments to achieve IOG compliance	1. Confirm appointment of additional capacity in breast pathology	SNEYT Director of Clinical Services Denise Potter	1. March 2010

3.4	Trust management to ensure compliance with NHS Breast Screening Programme reporting guidelines within pathology and appropriate performance of the receptor assays	• Compliance with NEQAS for oestrogen receptors, have documented evidence of this. • Three audits completed indicating satisfactory results. Completed June 2009			

3.5	Standard Operating Procedures are required to ensure appropriate sampling of specimens.	• Royal College guidance procedures followed. • Audit complete regarding sampling of specimens with satisfactory results.	1. All evidence of actions to date to be presented to the commissioner via the Contract Management Board Meetings 2. Standard operating procedures to be developed	SNEYT Director of Clinical Services Denise Potter SNEYT Director of Clinical Services Denise Potter	1. Jan 2010 2. Feb 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
4.	**Multi Disciplinary Team (MDT)**				
4.1	A pluralistic or distributed decision-making model should be encouraged within the MDT with lead individuals identified for each discipline.	Internal peer review completed in preparation for external peer review 2010. Action plan developed from peer review Lead Individual Clinicians indentified	1. Peer Review action plan implemented 2. Implementation assessed in peer review 2010	SNEYT Director of Clinical Services Denise Potter SNEYT Director of Clinical Services Denise Potter	1. Jan 2010 2. March 2010

4.2	The SNEY MDT should hold management meetings on at least a monthly basis, reviewing communication with the NYBSS MDT	• SNEY MDT has identified a dedicated management session once per month commencing in March 2009 • Meetings developed and scheduled to follow on from SNEY MDT • The MDT holds a business meeting once a month at the beginning of the MDT.	1. Review of effectiveness at Peer Review in March 2010.	SNEYT Director of Clinical Services Denise Potter	1. March 2010

4.3	SNEYT must ensure that the new Radiologist appointee has time to attend the breast screening MDT in York and adequate time for diagnostic breast imaging and image guided biopsies outside of the breast clinic.	Video conferencing links with York and Scarborough completed Completed June 2009 Radiologist uses videoconferencing to link with York Screening MDT, and has capacity to achieve this.			

4.4	Facilities for the new lead radiologist to report screening mammograms should be provided. A joint appointment with a screening unit would be optimal.		1. Strategic Clinical Review of Scarborough services to be completed 2. Option appraisal of Breast Screening provision to be completed	NHSNYY Director of Strategy David Cockayne NHSNYY Director of Strategy David Cockayne	1. Dec 2009 2. Jan 2010

4.5	The lead breast clinician needs to ensure that all pathology and surgical management data from screened patients is recorded and forwarded to the NYBSS – review at monthly SNEY MDT meetings	• Pathology inputting surgical management data since April 2009 • Clinical audit as part of annual quality assessment programme since April 2009			

4.6	The management and ways of working of the MDT should be in line with IOG, with lead individuals identified for each discipline.	• MDT operational policy now in place • Lead breast surgeon identified. Full representation at joint MDT York • Lead radiologist and lead Histopathologist already identified and attending. • Mentorship and support in place for the lead breast surgeon. • Deputising arrangements in place for lead surgeon.	3. Full IOG compliance anticipated following joint appointment and the risks will be monitored in the meantime via CMB	SNEYT Director of Clinical Services Denise Potter	1. March 2010

4.7	The Trust must ensure that all breast surgeon training is in accordance with the policy document published by the breast surgeons group at the British Association of Surgical Oncology (BASO) and for all surgeons to have received training in communication skills.	Requirement reflected in consultant job plan and job description New appointee has provided evidence of training in accordance with BASO Communications skills training completed by Lead Breast Clinician Oct 2009 Breast Care Nurses work to agreed protocols to assess new patients under direction of Lead Breast clinician in clinics. Commenced Oct 2009	1. Annual appraisal due in March 2010. 2. Agree with York and Hull Trusts management of capacity, until second substantive joint post appointed to	SNEYT Medical Director Mark Andrews SNEYT Medical Director Mark Andrews	1. March 2010 2. Jan 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
5.	**Treatments**				
5.1	Ensure that national (BASO) guidelines and the (NHSBP) surgical guidelines for treatment with regard to widespread DCIS are followed	• Network guidelines in place. • Mentorship and support in place for the lead breast surgeon. • Audit completed of DCIS guidelines with satisfactory outcome • Local operational policy developed in line with network guidelines	1. Evidence to be presented to CMB	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
6.	**Trust Management Actions**				
6.1	The Cancer Network, lead commissioning PCT and SHA need to ensure that SNEYT breast service complies with national standards and guidelines and that a clear governance strategy is in place.	• Compliance against standard national peer review measures and reported to Network board, PCT and SHA April 2009 • Commissioner representation invited as member of Trust Cancer Steering Group Sept 2009 • Recently undergone Peer Review as an assessment of compliance with NICE guidelines Oct 2009 • Quarterly performance monitoring and management meetings between commissioners and providers, subsequent to	1. Peer Review external validation in 2010 2. Development of specification for service as part of wider programme of service specifications – to include service quality issues and appropriate links to Contract Board.	SNEYT Director of Clinical Services Denise Potter NHS NYY Director of Strategy David Cockayne	1. March 2010 2. March 2010

		cancer services review completion.			

6.2	The SNEY Medical Director should ensure that the new lead breast clinician provides written diagnostic protocols and surgical management guidelines for the Trust. The Medical Director should ensure that Trust clinical governance procedures are in place and are followed with regular audit. Protected time outside of regular service commitments must be provided for audit sessions for all personnel.	• Diagnostic protocols and surgical management guidelines are completed • All consultants have half a day per month dedicated to audit. • Governance procedures are in place March 2009 • Annual Audit Programme completed, incorporating recommendations and key priorities as identified by QARC.			

6.3	Regular post-graduate updates should be encouraged for all members of the MDT and all members should be encouraged to attend the North Yorkshire Breast Screening Service (NYBSS) MDT on a regular basis to provide updates on screen detected cancers treated at SNEYT.	• All Consultants appraised on an annual basis • A training programme is in place for all members of the MDT • All members of the MDT have received extra training • Training/ education issues are identified at Clinical Governance Committee and there is performance management of individuals by Lead Consultant with support from Medical Director • All members of MDT regularly attend the MDT.	1. All evidence of actions to date to be presented to the commissioner via the Contract Management Board Meetings	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010
6.4	The SNEYT Medical Director should ensure through regular appraisals that clinicians are undertaking audit and that evidence is provided of attendance at post-graduate breast education meetings.	• Monthly half day sessions for Clinical Governance / audit area already available for all clinicians. As part	1. All evidence of actions to date to be presented to the commissioner via the Contract Management Board Meetings	SNEYT Director of Clinical Services Denise Potter	1. Jan 2010

		of the improvements to the governance arrangements, each Division now has an agreed Clinical Audit programme that reflects the Corporate prioritised programme • All monthly audit sessions are minuted and attendance registers completed • PCT are members of Trust Clinical Governance Committee which reflect audit plans. • Clinicians attending post graduate breast education meetings	2 Clinical audit programme, results and recommendations to be reviewed as part of the CMB meetings	SNEYT Director of Clinical Services Denise Potter	2. Jan 2010

6.5	The Humber and Yorkshire Coast Cancer Network (HYCCN) Board needs to ensure adequate clinical governance occurs in all Network Hospitals with regard to diagnosis and treatment of cancer patients. A robust mechanism for validating how well Trust action plans are being implemented and to ensure compliance with the national IOG needs to be developed by HYCCN.	• In Nov 09 new board assurance framework agreed for HYCCN for all trusts in HYCCN area. • The Governance arrangements for SNEYT were comprehensively reviewed in early 2008/09. A revised Risk Management Strategy was approved by the Trust Board in October 2008. Clinical Governance Committee has met monthly since then. A Clinical Governance Strategy has also been approved by this committee • In November 09 SNEYT signed up to the revised HYCCN board assurance Framework	1. Further detailed development of HYCCN Risk assurance framework to be agreed. SNEYT will contribute to the risk assurance framework being developed for HYCCN 2. SNEYT to be assessed against new assurance framework	HYCCN DIRECTOR Julie-Taylor Clark SNEYT Director of Clinical Services Denise Potter	1. Jan 2010 2 March 2010

6.6	The lead commissioning Primary Care Trust and the Strategic Health Authority need to monitor arrangements and ongoing audit activities at SNEYT to ensure governance is adequate.		1. Clinical audit programme, results and recommendations to be reviewed as part of the CMB meetings. 2. Exception Reporting to SHA	NHSNYY Director of Quality and Clinical Assurance Gary Hardman NHSNYY Director of Quality and Clinical Assurance Gary Hardman	1. Jan 2010 2. Jan 2010

6.7	Lead cancer clinician and lead breast clinician to ensure all significant deviations from IOG compliance are corrected, with this action to be monitored by the Trust Medical Director.	• Monthly meeting held between Trust Cancer lead and lead breast clinician. Feedback provided to Medical Director by Trust Cancer Lead. • Internal peer review undertaken in 2009 • Monthly review with medical Director, Trust Cancer Lead and Lead Clinician Breast	1. Preparation for external peer review 2010	SNEYT Director of Clinical Services Denise Potter	1. March 2010

6.8	In future peer reviews, any issues identified which require correction should be carried out without delay and have a time limited period for remedial action. Failure to achieve progress on agreed action plans should lead to withdrawal of funding until a timetable for change is agreed and resolved. Failure to achieve agreement must also lead to the Strategic Health Authority being involved to achieve resolution.	• Locality Board undertakes the performance monitoring of peer review action plans, reporting by exception to the Cancer Commissioning Group and Cancer Network Board as per Network policy and PCT and SHA as appropriate • QUARC action plan at SNEY monitored via Clinical Governance Committee • Feedback of peer review feedback to NHSNYY and Cancer Locality Board. Ongoing progress reporting to Cancer Locality Board. • Quarterly performance monitoring/ management meetings and commissioner representation on Trust cancer	1. Further reporting of issues via Contract Management Board. 2. Progress reports of implementation of action plan to SHA	SNEYT Director of Clinical Services Denise Potter NHSNYY Director of Quality and Clinical Assurance Gary Hardman	1. July 2010 following completion of external peer review 2010 2.Oct 2010 following completion of external peer review 2010 and quarterly therafter

		steering group will support this requirement.			

6.9	Minutes of all cancer audit meetings should be copied in to the Humber and Yorkshire Coast Cancer Network Medical Director, the Trust lead cancer clinician and the Director of Public Health at the lead commissioning Primary Care Trust.	• Meeting convened by Mr Mainprize with all Lead Cancer Clinicians 8th October 2009. • Minutes of meetings are copied as described.			

6.10	All breast MDT clinicians must participate in the screening MDT and the North East and Yorkshire Quality Assurance Reference Centre (QARC) quality assurance visits. Data must be provided in a timely manner from pathology, surgery and radiology to comply with national guidelines. The breast team should be familiar with and comply with data recording through a recognised national IT programme online.	Teleconferencing arranged and clinicians attend screening MDT Oct 2009 Clinicians are regularly attending Screening MDTs in York in person or via Videoconferencing			

6.11	The lead cancer clinician and lead breast clinician must ensure that the recommendations of the screening pathology Quality Assurance review are complied with.	• Meeting held end of May 2009. Discussed QA review, audits undertaken regarding weighing of samples etc, following meeting and compliance assured.			

Key:

NHSNYY	NHS North Yorkshire and York
SNEYT	Scarborough and North East Yorkshire Trust
HEYNHST	Hull and East Yorkshire NHS Trust
PCT	Primary Care Trust
QARC	Quality Assurance Reference Centre
SHA	Strategic Health Authority
HYCCN	Humber and Yorkshire Coast Cancer Network
QA	Quality Assurance
IOG	Improving Outcomes Guidance
MDT	Multi-Disciplinary Team
NYBSS	North Yorkshire Breast Screening Service
CMB	Contract Management Board
EQA	European Quality Assurance
BASO	British Association of Surgical Oncology
NEQAS	National External Quality Assessment Service
DCIS	Ductal Carcinoma in Situ
NHSBP	NHS Business Partner
NICE	National Institute for Health and Clinical Excellence