Trust Name:	Date of Review
Western Health & Social Care Trust	Friday 19 October 2018

Structure and Process

Number	Indicator	SA	PR	Comments
A08/SC/LS-16-001	There is a named lead clinician	Y	Y	
A08/SC/LS-16-002	There is an MDT	N	N	Only one consultant dermatologist rather than the two required No CNS core member.
A08/SC/LS-16-003	There is a weekly MDT meeting for treatment planning	N	N	MDT meetings held on first and third weeks of the month – this is in line with NICaN guidance. No MDT meetings have been quorate due to the lack of a CNS.
A08/SC/LS-16-004	There are clinical guidelines in place.	Y	Y	
A08/SC/LS-16-005	There are agreed patient pathways in place	Y	N	The team has agreed to the NICaN pathways but have not adapted them to include the local contact points. .
A08/SC/LS-17-001	The MDT participates in clinical governance arrangements for community practitioners	N	N/A	GPs who excise skin tumours do send all the specimens to the histopathology department and the MDT are aware of these specimens

Comments

The Western Health and Social Care Trust (WHSCT) provides health and social care services across the council areas of Derry City and Strabane District Council, Fermanagh and Omagh District Council and Limavady in the causeway coast and Glens Borough Council. The Trust has a catchment population of approximately 300,000 and provides a wide range of health and social care services from a number of hospitals and community facilities.

The Trust is undertaking an extensive upgrade of facilities on the main site at Altnagelvin Area Hospital which includes a brand new state-of-the art Cancer Centre which enables their local residents to avail of systemic therapy and radiotherapy services closer to home.

The reviewers met with the clinical lead for the local skin cancer service, some of the surgical and non-surgical core members of the MDT admin and clerical staff and representatives from the Trust management team. The reviewers appreciated the full, open discussion about all aspects of the local service.

The skin cancer service is currently delivered by one consultant dermatologist who is also the clinical lead for the service, together with one Associate Specialist. An outreach service is delivered by the consultant dermatologist across two sites and by the associate specialist at two sites; however, the reviewers noted that this means that at one of the clinics the associate specialist is not supported at any time by the consultant.

The core membership for the skin cancer Multi-Disciplinary Team (MDT) is incomplete as there is only one consultant dermatologist member. The Trust advertised for a second consultant dermatologist in 2010, but this was not successful. There is currently 1 session of an SPR per week in training and a SHO GP who have an interest in Dermatology; the Trust therefore plans to re-advertise for a consultant post in Spring 2019. The clinical lead is undertaking additional clinics which are being run on “good will” to meet the demand for the service. The reviewers were concerned that as the service is being delivered by a single handed consultant dermatologist there is no one able to provide cover during periods of leave; also there is no other dermatologist present within the MDT meetings who would be able to provide expert professional challenge to discussions regarding treatment options. The reviewers were concerned about the health and well-being of the consultant dermatologist who is undertaking the continuous additional workload. During the review discussion it was unclear if the locum pathologist supporting the MDT is participating in an External Quality Assurance (EQA) scheme which includes skin pathology samples. The reviewers encourage the locum pathologists and their cover to ensure that they are regularly participating in a recognised EQA scheme which includes skin pathology samples to ensure reliability and consistency.

Although the plans for further developments of the local radiotherapy service are progressing, other service areas are taking precedence over the expansions to the skin cancer service so as yet, this modality of treatment is not being delivered locally; patients still have to travel to the cancer centre at the Belfast Health and Social Care Trust. The core membership of the MDT includes a consultant clinical oncologist that allows for discussion about this mode of treatment to be undertaken locally.

There is currently no clinical nurse specialist (CNS) named for the service. The Trust has in the last two years attempted to recruit to this post but has not been successful. The General Manager for Cancer Services informed the reviewers of plans to hold a workshop for the members of

the skin cancer service to help identify the requirements for the CNS role from a clinical aspect. Consideration will also be given for the appointment of a band 6 nurse who could be developed to provide cover for the CNS. The lead clinicians secretary performs a coordinator role including amending appointment times for patients. There are significant risks with this process as noted in the Supreme Court ruling in the case of Darnley v Croydon Health Services NHS Trust. The team discussed the possibility of introducing a patient flow coordinator to work alongside a CNS to allow for some of the more administrative tasks to be completed by them, so freeing up the time for the CNS once appointed to focus on clinical aspects of the service. The appointment of a CNS will create capacity in areas of nurse lead diagnostic clinics as supportive care and continuity to patients.

While staff within the Trust are aware of who they should contact when patients require additional services such as cosmetic camouflage; the prosthetic service, and lymphoedema service; their names and contact details are not readily available. The reviewers encourage the service to collate a list of contact details for the leads of the extended services which could be used for induction purposes should here be any new members of the skin cancer team. The skin team reported excellent access to the extended services and stated that patients requiring cosmetic camouflage can be seen on the same day as the referral. The reviewers considered this demonstrates available expertise within the nursing team which could be used as temporary support to the service until the formal appointment of the CNS.

The MDT meets at Altnagelvin Hospital site on the first and third Tuesday of the month with video links to the other two sites where the skin cancer clinics are held. The Northern Ireland Caner Network (NICaN) skin cancer guidelines reflect the MDT meetings are to be held every two weeks. However, the data within the annual report showed that there were occasions when the MDT meetings only occurred once with a month, which resulted in only 20 meetings held between 17 January and 19 December 2017. The skin team reported that there are no delays to patient pathways due to the frequency of the MDT meetings; the operation policy includes the procedures governing urgent planning decisions. If patients require urgent decisions, the agreed treatment options are discussed retrospectively at the MDT meeting. Due to the lack of a CNS core member of the MDT, none of the meetings held within the reporting period have been quorate. The clinical lead and associate specialist in dermatology have individually attended 90% of the MDT meetings. There are four maxillo facial surgeons named as core members of the skin MDT: one surgeon has attended 70% of MDT meetings with the other three attending 20%, 10% and 0% respectively. One of the maxillofacial surgeons reported that there are a number of challenges with attendance at MDT meetings including the competing range of services, demands for videoconferencing facilities and the need to be physically in a different part of the Trust. This challenge is further compounded by the fact that two of the maxillo facial surgeons job plans have not yet been agreed. There has been a business meeting to look at the membership of the skin cancer MDT and to consider different ways that some of the speciality consultants can link into the service. Following the appointment of the clinical oncologist in June 2017, they are now regularly attending the skin cancer MDT meetings. The MDT coordinator reported that they support the haematology MDTs as wells as the skin cancer service; cross cover for periods of absence is provided by other members of the MDT coordinator team. The skin cancer coordinators will also act as the tracker with details of all patients with a positive skin cancer pathology being forwarded to them. A failsafe process can then be implemented ensuring that all appropriate patients are listed for discussion by the MDT.

In NI there is no central register of GPs with special interests providing input in any clinical area. However a dermatology workforce review has been started and will identify any Model 2 practitioners. The NICaN have instigated another audit of GPs carrying out excisions; junior doctors at

the WHSCT are coordinating this locally. The audit will be helped by all samples taken locally being processed by the laboratory at WHSCT and so all positive pathology will be available. The audit had been completed previously and the MDT confirmed that there had been a reported reduction in the number of excisions being undertaken within the community. Irrespective of where the excision was performed, all patients are still discussed by the local MDT.

Patients locally who require level 5 and 6 care will be discussed by the specialist skin MDT which is held weekly at the Belfast Health and Social Care Trust each Thursday. The clinical lead and associate specialist in dermatology will video-conference in to the specialist skin MDT when any of the local patients are due for discussion. On occasions, treatment as discussed and agreed by the specialist skin MDT is provided locally, in order to prevent patients traveling some distance to the centre at Belfast. There is currently no chemotherapy or radiotherapy delivered locally for the care of skin cancer patients. The reviewers were assured that the appropriate levels of care are being delivered by the local team; however, considered that there needs to be a formalisation of the care pathways described within the review meeting.

Patients requiring Mohs surgery will be referred to the specialist team at Belfast; there is currently a six to eight month waiting list.

The skin cancer team has agreed the NICaN guidelines which are available via the Trust`s intranet. These guidelines are reviewed and updated centrally with the cancer management team providing the informal local oversight to ensure the most up to date versions only are available electronically.

Comprehensive pathways have also been developed by the NICaN and are available on the Trust intranet; however, the network document has not been adapted to include the locally relevant contact details for the services at the WHSCT. The reviewers encourage the local team to ensure that all relevant contact details are included on the documents stored on the Trust intranet. This will provide ease of reference when NHS professionals are accessing the information.

Patient Experience

Number	Indicator			Comments
A08/SC/LS-17-201	There is information for patients and carers	Y	N	No information regarding local service provision.

Comments

Patients are able to access the Macmillan information hub, which is located within the main entrance of the cancer centre at the Altnagelvin site. There is also a stand-alone Macmillan Support Centre on the same site which was opened in March 2018. The centre provides signposting to

local services including counselling, hairdressing, complementary therapies, gentle exercise and welfare benefits advice. It was unclear what support is available to patients attending clinics at the other two hospital sites.

The reviewers were provided with examples of the written information which is available to patients. While these were comprehensive in terms of general information about skin cancer, there was no written information available about the local service. The skin cancer team acknowledge that once a CNS is appointed, this was an area of work which they could lead on.

The clinical lead acts as the key worker for local patients and continues to support any patients who may be referred to the specialist team at Belfast. Specialist dermatology nurses will offer support to patients when they are being given bad news locally: again this is an area which could be progressed by the appointment of a CNS. Both the dermatology nurses and the consultant will provide written information to patients.

The Trust has participated in the Northern Ireland Cancer Patients Survey for 2018; at the time of the review meeting the results had not been published. A local survey has not been undertaken to encourage feedback from the patients accessing the skin cancer service specifically. The reviewers encourage the team to consider ways to obtain feedback from their local patients about their experience as this may help inform future service development.

There are no local patients support groups specifically for skin cancer patients. There are generic patients support groups such as The Pink Ladies and the well woman group, but it was unclear what support would be available to male patients. The skin cancer service has not yet developed the survivorship agenda to help people living with and beyond cancer. Again, it was thought that this may be an area that the new CNS could take the lead on developing.

The Trust has developed the teenage and young adult service locally with the appointments of 0.2 WTE nurse. The post is being supported by the Teenage Cancer Trust.

Data within the annual report showed that of the 10 consultants involved with the skin cancer service, five have attended the advanced communications skill training. Unfortunately, there was no information relating to plans for attendance by the remaining five consultants. The Trust has the facilities and expertise to deliver the communication skill training locally; the reviewers encourage any consultant members of the team who have not yet completed the course to ensure they arrange dates within the near future to complete this.

Clinical Outcomes

Number	**Indicator**	Descriptor	**Comments**

Comments

The clinical oncologist core member for the team leads on trial recruitment and reported that the resources locally were a challenge to developing a portfolio. The Trust has recently appointed band 7 research manager to work alongside the band 6 nurse. Currently, the only clinical trials open to skin cancer patients are open at Belfast and patients have been reluctant to join the trial due to the extended travel which would be required. The team reported that they received regular updates as to new trials being opened.

Data within the annual report showed that there had been 255 new referrals to the service in 2017; 125 of which were on a 62 day pathway and 130 were on a 31 day pathway. There were no breaches for patients on the 31 day pathway and 2 surgical breaches (1%) for patients on a 62 day pathway. In the 20 meetings held within 2017, there were 822 discussion regarding 323 patients. The average number of discussion per week was therefore 16.

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Good Practice / Significant Achievements

Cohesive and cooperative team.

Timely access for patients referred to the service as evidenced by the low proportion of breeches against national target for waiting times.

Responsive extended services as described by the same day referrals for the cosmetic camouflage.

Failsafe process undertaken by MDT coordinator to ensure all appropriate skin cancer patients are listed for discussion by the MDT.

Specify Immediate Risks
Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the zonal team.
An "Immediate Risk" is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

None identified

Specify Serious Concerns
A "Serious Concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

1. There is currently no skin cancer clinical nurse specialist (CNS) in post, this is a long standing issue highlighted in the previous peer review. Whilst the reviewers appreciated attempts have been made previously to recruit to this post, this gap in key core MDT personnel for the service means patients may not be fully supported at all key stages of their pathway and do not benefit from the skills, knowledge and expertise of a CNS.

2. There is a single handed consultant dermatologist who continues to provide a number of additional clinics on a good will basis in order to meet the demands of the service. The reviewers were concerned this may not be sustainable as a long term solution and could impact on the health and well-being of all MDT members.

Areas for Improvement / General concerns

Clinical lead to review their additional duties once a CNS has been appointed to ensure appropriate use of their clinical time.

Role of the clinical leads secretary in relation to a coordinating role to be reviewed.

Review the frequency of the MDT meetings to ensure they are occurring at the correct rate which is in line with NICaN guidelines. .

Review the MDT core membership to optimise attendance for and staff utilisation.

Review network pathways to ensure local contact details are included and they are formalise for those patients being referred between the specialist and local teams.

Written information to be developed regarding local service provision.