

SECTION 6 - EFFECTIVE TREATMENT & CARE

Improvements in treatment and care have led to a steady increase in cancer survival in Northern Ireland over the last 10 years. The following standards are designed to build on those improvements by:

- ensuring the effective working of *multi-disciplinary teams*
- improving access to *clinical nurse specialists*
- improving access to new treatments
- the development of new models for the delivery of *chemotherapy*
- enhancing safety and quality of *chemotherapy* and *radiotherapy*
- improved identification and treatment of *lymphodema*.

Overarching standard 20:

All patients who have high clinical suspicion⁵ or have a diagnosis of cancer should have their care managed by an appropriately constituted⁶ and effective *multidisciplinary team* (MDT) which meets weekly or fortnightly (in accordance with the manual of Cancer Services Standards).

Rationale:

MDT working is the recognised model for providing care to cancer patients. MDTs bring all the relevant health care professionals together to ensure the patient gets the best care possible. While there have been big improvements in the number of patients being discussed at Multidisciplinary Team Meetings (MDMs), not *all* patients are being discussed at MDMs. Other areas for improvement include:

- the membership of the MDT;
- the frequency of meetings;
- the need for written operational or clinical guidelines; and
- the need to collect data that allows the MDT to audit its activity.

Evidence:

Department of Health (2004) Manual for Cancer Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090081

Responsibility for delivery / implementation

HSC Board

Public Health Agency

HSC Trusts

Tumour-specific multidisciplinary teams

Quality Dimension**Timely & Patient Centred**

Effective team working will ensure prompt investigation, diagnosis and management of all patients, in line with the individual's wishes.

Safe, Efficient & Effective

Evidence-based care is easier to guarantee in structured team practice. High volume patient services (within an institution and at the individual clinician level) have better outcomes for patients and deliver better value for money.

Equitable

All patients will have access to a specialist service. Teams will deliver care to regionally-agreed-standards so all patients will have the same access to drugs and therapies

⁵ Patients with a high suspicion of cancer are those who have been referred by their GP as a "red flag" or suspect cancer under the NICaN GP Referral Guidance for Suspect Cancer. It also includes patients whose referral forms have been upgraded to "red flag" by a consultant

⁶ For the constitution or core membership of each MDM please refer to Appendix 4.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of people with high clinical suspicion / diagnosed cancer who are discussed at an MDM	Minimum dataset for the MDM	95% 98%	March 2011 March 2012
Percentage attendance by individual core members or their agreed cover at the multidisciplinary meetings	Record of attendance	66% ⁷	March 2011
MDT performance against MDT measures outlined in the Manual for Cancer Services Standards	External peer review	Baseline to be established Trusts to evidence action against peer review recommendations	Implementation to be phased commencing with breast, lung, gynaecological and colorectal teams in 2010

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

⁷ Attendance is set at 66% to allow for allocated annual leave and study leave.

Overarching standard 21:

All patients should be assessed by a clinical nurse specialist (CNS) at the time of diagnosis, at the end of each treatment episode⁸ and as required throughout their cancer journey.⁹

Rationale:

Clinical nurse specialists carry out detailed assessment of patients' needs in order to provide, or coordinate, good care and support. This includes referring patients to other members of the multidisciplinary team. At the *Multidisciplinary Team Meeting*, their role is to actively represent the patient's interests.

Patients who have access to clinical nurse specialists are more satisfied with the information they have received, have a better understanding of their illness and care, and are more likely to maintain good levels of well being thereby reducing levels of referrals for psychological support. Other outcomes include better management of symptoms, less emergency hospital admissions, appropriate hospital discharge, a better patient experience and positive impact on the work of the multidisciplinary team.

Many patients in Northern Ireland do not have access to a Clinical Nurse Specialist. The cancer types that have the lowest numbers of CNSs when compared to the rest of the UK are urology, gynaecology, haematology, colorectal and upper gastro intestinal (calculated by mean average patient caseload per CNS).

Evidence:

Department of Health (2004) Manual for Cancer Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090081

Department of Health Cancer Action Team (2007) Holistic Common Assessment of Supportive & Palliative Care needs for Adults with Cancer Assessment Guidance p19

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076928

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Supportive and Palliative Care for Adults with Cancer

<http://guidance.nice.org.uk/CSGSP>

⁸ A treatment episode refers to any programme of chemotherapy, radiotherapy or surgery where this is given as a stand alone treatment

⁹ Excluding patients with a type of skin cancer called squamous cell carcinoma as these patients have good outcomes and are unlikely to require this type of support.

DHSSPS (2007) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland

http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

Department of Health (2006) Cancer Reform Strategy

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

Northern Ireland Cancer Network (NICaN) Nursing Group (2007) CNS Benchmarking exercise with English Networks

Haward et al (2003) Breast cancer teams: the impact of constitution, new cancer workload, and methods of operation on their effectiveness. *BJ of Cancer* (2003), 89, 15-22 <http://www.nature.com/bjc/journal/v89/n1/full/6601073a.html>

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts

Quality Dimension

Timely, Patient-Centred, Safe & Equitable

Patients will have a contact person who can assess their need and ensure they receive the right treatment, care and support. The clinical nurse specialist will play a key role in coordinating care and improving communication between patients, staff, services and organisations. Currently some patients do not have access to a CNS.

Effective/Efficient

Clinical nurse specialists will undertake work previously carried out by medical staff (e.g., diagnostic procedures, review clinics).

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients having a comprehensive assessment by a clinical nurse specialist at diagnosis	Case note audit	Establish baseline	March 2011
		Provisional target of 90%, dependent on baseline	March 2013

Overarching standard 22:

All patients being offered treatment should be given a realistic and meaningful explanation of the aim of their proposed treatment by appropriately skilled specialist healthcare professionals. This will also be communicated to other professionals involved in their care.

Rationale:

Cancer is increasingly becoming a chronic illness. If disease returns after initial treatment, other treatment options are now available. Should further problems arise, treatment can again be offered. However, the aim of treatment may now have changed from that of the original treatment and may no longer be aimed at cure. This situation can be repeated on a number of occasions, making it difficult for patients, their families and non cancer specialists to identify where a patient is on their journey. This can result in patients/carers having false hope which can impact on their decisions about having further treatment. To reduce this likelihood, there is a need for specialists to make the aim of treatment quite clear. This information should also be shared with the other professionals involved in the person's care (e.g. their GP) in a timely manner in order to allow the planning of the most appropriate care provision.

Evidence:

DHSSPS (2007) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland

http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

DHSSPS (2003) Good Practice in Consent, HSS (MD)7/2003 Circular

<http://www.dhsspsni.gov.uk/hssmd07-03.pdf>

DHSSPS (2003) Breaking Bad News... Regional Guidelines

http://www.dhsspsni.gov.uk/breaking_bad_news.pdf

Human Rights Act 1998

http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1

Mental Capacity Act 2005

http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1

Department of Health (2000) NHS Cancer Plan

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Supportive and Palliative Care for Adults with Cancer
<http://guidance.nice.org.uk/CSGSP>

Northern Ireland Cancer Network (NICaN) (2007) Northern Ireland Chemotherapy Service Standards
<http://www.cancerni.net/publications/northernirelandchemotherapy Servicestandard s>

Responsibility for delivery / implementation

HSC Board
 Public Health Agency
 HSC Trusts
 Primary care

Quality Dimension

Patient Centred

Patients that have the aim of their treatment intent communicated to them clearly and with care will be better placed to understand where they are at on their disease journey and to make informed choices about further treatment.

Effective, Efficient, Safety and Timeliness

The intent of treatment will be communicated to, or accessible by, key health care professionals involved with the patient. This allows proactive planning for the care requirements of the patient and their families, enabling its safe and timely delivery in the most appropriate place.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients whose treatment intent is recorded in the CaPPs system ¹⁰	Electronic databases such as CaPPs, COIS PallCare Patient notes	90%	March 2012

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

¹⁰ A new Cancer Patient Pathways System (CaPPs) is currently being developed for use during MDMs. The system will be phased in between 2008/2011. This system will record MDM decisions and will generate a letter to be sent to the patient's GP following the MDM. The letter will include information about the aim of treatment and will use wording agreed by the NICaN Regional Primary Care Network.

Overarching standard 23:

All patients who need *systemic cancer therapy* (i.e. *chemotherapy* and *hormone therapy*) should have aspects of their therapy provided closer to home in line with regional chemotherapy standards, where their treatment and disease allows this.

Rationale:

New developments mean that more patients will be able to receive some of their care closer to home. The ability to receive care closer to home increases patient choice and convenience and is a more efficient use of health care resources.

Providing some aspects of care closer to the patient will be helped by the development of clinical management guidelines (CMGs) and care pathways for systemic therapy. These will outline appropriate treatments and locations of care for patients with various types of cancer. They will require the development of new working practices and roles and greater integration and robust information flows between healthcare teams working in hospital and community settings.

It is also important that when new treatments are going to be introduced that this happens in a planned way. This will help to ensure that there is enough space, time and staff to provide the necessary care. A regional planning tool should therefore be adopted across the Northern Ireland Cancer Network.

Evidence:

Northern Ireland Cancer Network (NICaN) (2007) Northern Ireland Chemotherapy Service Standards

<http://www.cancerni.net/publications/northernirelandchemotherapyservicestandards>

Cancer Service Collaborative Improvement Partnership (2004) Chemotherapy Service Improvement: Modernising Chemotherapy Services - A practical guide to redesign

<http://www.cancerimprovement.nhs.uk/documents/chemotherapy/Chemotherapy%20Guide.pdf>

DHSSPS (2005) A Healthier Future: A twenty year vision of health and wellbeing in Northern Ireland 2005 – 2025 <http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>

DHSSPS (2007) Regional Cancer Framework: A Cancer Control Programme for Northern Ireland

http://www.dhsspsni.gov.uk/eeu_cancer_control_programme_eqia.pdf

Audit Commission (2002) A Spoonful of Sugar – Medicines Management in NHS Hospitals <http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/nrspoonfulsugar.pdf>

HPSS (2005) Controls Assurance: Medicines Management Standard (Safe and secure handling of medicines) http://www.dhsspsni.gov.uk/medicines_05.pdf

Report of the RMSC Working Group (2003) Pharmaceutical Resource for Oncology in Northern Ireland

Department of Health (2007) Cancer Reform Strategy http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts
Primary and community care, including pharmacy

Quality Dimension

Safety

Use of CMGs means that high quality, safe care will be provided regardless of the location of care.

Timely, efficient & effective

Patients move through care settings more quickly. Delivering care safely in the most appropriate setting allows best use of staff and facilities and ensures high quality of care.

Equitable & Patient Centred

Patients are able to access some parts of their treatment and care closer to their home.

Performance indicator	Data Source	Anticipated Performance Level	Date to be achieved by
Development of CMGs and care pathways for systemic treatments	NICaN Tumour Groups Website	CMGs and care pathways developed for breast, lung, upper gastro intestinal, colorectal, urological, gynaecological, skin & haematological cancers	March 2011
Activity figures	New locality teams	Annual improvement from zero baseline	March 2012

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 24:

All patients with cancer who require *radiotherapy* should have equitable and timely access to complex radiotherapy techniques in line with tumour group specific recommended best practice.

Rationale:

It is estimated that by 2016, Northern Ireland will need to increase the availability of radiotherapy treatments by up to 70%.

Modern radiotherapy uses accurately targeted, high dose radiation. This improves cancer cure outcomes and reduces normal tissue complications. At present Northern Ireland does not have the full range of modern radiotherapy techniques including: a *brachytherapy* service for patients with lung and localized prostate cancer, high dose rate gynaecological brachytherapy, *stereotactic radiotherapy*, *image guided radiotherapy (IGRT)* and *intensity modulated radiotherapy (IMRT)*. This means that some patients have to travel to England to get treated. Some patients who do not wish to or who are too unwell to travel cannot access treatment.

Evidence:

National Institute for Health and Clinical Excellence (NICE) (2008) Prostate Cancer: Diagnosis and Treatment <http://www.nice.org.uk/guidance/CG58>

Department of Health (2004) Manual for Cancer Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090081

Department of Health (2006) Advice on the development of Low Dose

Radiotherapy (permanent seed implant) brachytherapy services for localized prostate cancer in England <http://www.prostatebrachytherapyinfo.net/PCT31.html>

National Radiotherapy Advisory Group (2007) Radiotherapy: developing a world class service for England. Report to ministers from National Radiotherapy Advisory Group

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074575

American Association of Physicists in Medicine (2006) The Management of Respiratory Motion in Radiation Oncology. Report of AAPM Task Group 76

http://www.aapm.org/pubs/reports/RPT_91MPSynopsis.pdf

Responsibility for delivery / implementation

DHSSPS
HSC Board
Public Health Agency
HSC Trusts
Multidisciplinary teams
Department of Medical Physics
Regional radiotherapy service manager

Quality Dimension**Safe, Efficient & Effective**

Medium dose rate brachytherapy for gynaecological cancer (as currently delivered) requires a general anaesthetic and 20 hours of inpatient nursing care. High dose rate brachytherapy does not. Better targeted therapies (IMRT and IGRT) will allow reduced dose to normal tissues, potentially reducing tissue damage and complications. This will make treatment safer and reduce the side effects suffered by patients. Prostate brachytherapy is recommended for patients with low or medium risk localised prostate cancer. It is a very effective and minimally invasive treatment. Patient outcomes with modern radiotherapy techniques are improved.

Timely

All patients with cancer have prompt access to delivery of optimal radiotherapy, preferably within Northern Ireland.

Equitable & Patient Centred

Many patients prefer to receive treatment within Northern Ireland. Travelling to elsewhere in the UK may mean some patients cannot get treatment.

Performance Indicators	Data Source	Anticipated Performance Level	Date to be achieved by
Development of cervical brachytherapy service	Cancer Centre report	Establish service	March 2010
Percentage of eligible patients for radical treatment for cervical cancer who choose to receive high dose rate brachytherapy and who have access to it	Cervical brachytherapy service audit undertaken	100%	March 2011
Development of prostate brachytherapy service	Cancer Centre report	Establish service	March 2010
Percentage of eligible patients with localised prostate cancer who want to have high dose rate brachytherapy and who have access to it	Prostate brachytherapy service audit undertaken	100%	March 2011
Development of IMRT Service	Cancer Centre Report	Establish service	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 25:

As a safety measure, all *radiotherapy treatment plans* should be checked for accuracy by a second person from an agreed list of staff before treatment begins.

Rationale:

Best practice in the planning of radiotherapy treatment includes treatment plans being double checked by a person authorised to do so (dual reading) before a patient's treatment begins. This ensures that treatment planning is in line with *protocols* for the type of cancer that the patient has. This ensures that radiotherapy dosage achieves the best possible balance between desired *therapeutic effect* and potentially harmful side effects.

Services should be organised such that they allow the development and delivery of *standardised processes* for prescribing and checking of radiotherapy treatments. These processes should be based on standard principles for delivery, and supported by *quality assurance* mechanisms.

Evidence:

Department of Health (2004) Manual for Cancer Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090081

Halvorsen PH, Das IJ, Fraser M *et al.* (2005) AAPM Task Group 103 report on peer review in clinical radiation oncology physics. *J App Clin Med Phys*, 6 (4): 50-64. <http://www.jacmp.org/index.php/jacmp/article/view/2142/1231>

Ola Holmberg, O. and McClean, B. (2002) Preventing treatment errors in radiotherapy by identifying and evaluating near misses and actual incidents. *Journal of Radiotherapy in Practice*, 3 (1): 13-25

<http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=448220&fulltextType=RA&fileId=S1460396902000122>

Responsibility for delivery/ implementation

HSC Trusts

Quality Dimension			
Safe & effective			
All treatment courses are agreed by a relevant <i>multidisciplinary team</i> to ensure treatment is as safe and effective as possible. All treatment courses are designed by groups of clinicians to ensure the best outcomes (cure, disease control) for the patient.			
Timely			
Peer review should be resourced and scheduled so that it will not affect the delivery of treatment.			
Equitable			
All patients have access to the same quality of service, no matter where and by whom they are treated.			
Performance Indicators	Data Source	Anticipated Performance Level	Date to be achieved by
Percentage of radical and adjuvant radiotherapy plans that are checked for accuracy by a second member of staff before treatment begins	Minutes of meetings and radiotherapy booking data	66% 75% 85%	March 2011 March 2012 March 2013

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 26:

All patients who are eligible¹¹ for an existing *clinical trial* should be offered the opportunity to take part in a clinical trial by the multidisciplinary team.

Rationale:

The quality of cancer patient care and outcomes are enhanced by participation in clinical trials and other clinical research studies. It has been demonstrated in cancer and other human disease areas that high quality, protocol-driven care delivered by trained research staff standardises care and improves patient outcomes for patients being treated in a research active hospital (Bertelsen, 1991; Lennox et al, 1979; Boros et al, 1985, Brown et al, 1999). This improved outcome occurs for the population of patients treated irrespective of the particular therapy that a patient receives in their clinical trial. In addition several studies have shown that patients managed in a setting where clinical trials were an established part of care also benefited compared with those cared for in hospitals that were not research active, whether or not they were participating in a research study.

The EURO CARE-2 study published in 1999 suggested that survival rates for 18/25 cancers studied were poorer in the UK than in most other European countries (Berrino et al, 1999). An NHS strategic review (Cancer Working Group, 1999) noted that accrual or recruitment into clinical trials was poor and suggested that the low levels of research activity were probably contributing to the poorer outcomes for cancer patients in the UK and also to the variability of outcomes across the country.

Accrual targets for inclusion of cancer patients into clinical trials and other well-designed clinical research studies are now included in the NHS Constitution for England and the Cancer Action Plan for Scotland and Cancer Service Framework for Wales.

Evidence:

N. Ireland Cancer Registry <http://www.qub.ac.uk/research-centres/nicr/Data/OnlineStatistics>

¹¹ Each study's protocol has guidelines for who can or cannot participate in the study. These guidelines, called eligibility criteria, describe characteristics that must be shared by all participants. The criteria differ from study to study. They may include age, gender, medical history, and current health status. Eligibility criteria for treatment studies often require that patients have a particular type and stage of cancer.

Berrino F, Capocaccia R, Esteve J *et al.* (1999) Survival of Cancer Patients in Europe: the EURO CARE-2 Study, International Agency for Research on Cancer publication No. 151

<http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=73&codcch=151>

Bertelsen K. (1991) Protocol allocation and exclusion in two Danish randomised trials in ovarian cancer. *Br J Cancer*, 64(6): 1172 – 6.

<http://www.ncbi.nlm.nih.gov/pubmed/1764383>

Lennox EL, Stiller CA, Jones PH, Wilson LM. Nephroblastoma: treatment during 1970-3 and the effect on survival of inclusion in the first MRC trial. *Br Med J* 1979, 2 (6190): 567 – 9 <http://www.bmj.com/cgi/content/abstract/2/6190/567>

Boros L, Chuang C, Butler FO, Bennett JM. Leukaemia in Rochester (NY). A 17 year experience with an analysis of the role of co-operative group (ECOG) participation. *Cancer* 1985, 56 (9): 2161 – 9

<http://www.ncbi.nlm.nih.gov/pubmed/3902204>

Brown N, Melville M, Gray D, Young T, Skene AM, Wilcox RG, Hampton JR. Relevance of clinical trial results in myocardial infarction to medical practice: comparison of four year outcome in participants of a thrombolytic trial, patients receiving routine thrombolysis, and those deemed ineligible for thrombolysis. *Heart*. 1999, 81 (6): 598 – 602

<http://heart.bmj.com/cgi/content/abstract/81/6/598>

Responsibility for delivery / implementation

HSC Trusts
N. Ireland Cancer Clinical Trials Unit (NICCTU)
N. Ireland Cancer Trials Network (NICTN)

Quality Dimension

Effective & efficient

Each clinical trial answers scientific questions and tries to find better ways to prevent, screen for, diagnose, or treat a disease. People who take part in cancer clinical trials have an opportunity to contribute to knowledge of, and progress against, cancer. They also receive up-to-date care from experts. The value of cancer clinical trials lie in providing the careful evidence base for new and better treatments, allowing us to discard less effective ones.

Equity

NICCTU has run since 1999, but trial participation was only offered in Belfast. The advent in 2007 of the NICTN allows delivery of care in cancer clinical trials closer to patients' homes in the four Cancer Units as well as the Cancer Centre, and includes all five HSC Trusts.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients entered into clinical trials	NICCTU and NICTN Trial Registers; NI Cancer Register	10% of patients entered into trials with at least 5% of patients entered into randomised controlled trials for 2010/11	March 2011
		At least 10% of patients entered into trials with at least 6.75% entered into randomised controlled trials for 2011/12	March 2012
		At least 10% of patients entered into trials with at least 7.5% into randomised controlled trials for 2012/13	March 2013

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 27:

All patients who are at risk of¹², or who have lymphoedema, should have timely access to information, diagnosis and treatment. This should be given within the Lymphoedema Network using the CREST Lymphoedema Guidelines.

Rationale:

Lymphoedema is swelling, usually in the arms or legs. It occurs because the lymph vessels are damaged or blocked, often as a result of cancer or cancer treatment. Lymphoedema can become a chronic condition that impacts on people's day-to-day functioning.

Around 2500-3000 people suffer from lymphoedema in Northern Ireland each year. Access to services can still vary a lot depending on where the patient lives.

Implementation of the CREST Guidelines for the prevention, diagnosis, assessment and management of lymphoedema will:

- reduce patients' risk of developing lymphoedema;
- ensure that patients are diagnosed early; and
- ensure that all patients will have access to high quality treatment.

This will reduce the problems that patients can have with day-to-day activities (e.g. getting in /out of car or bath). It will also reduce the social and emotional impact of lymphoedema. Finally, it will reduce infection and the resulting hospital admissions.

This standard is linked to standards 42 (skin) and 45 (urology) as well as head and neck cancer and sarcoma.

Evidence:

CREST (2008) Guidelines for the diagnosis, assessment and treatment of lymphoedema <http://www.gain-ni.org/Guidelines/CrestGuidelines.pdf>

CREST (2005) Guidelines on the Management of Cellulitis in Adults http://www.gain-ni.org/Guidelines/Management_Cellulitis_Adults.asp

DHSSPS (2004) Regional Review of Lymphoedema Services <http://www.dhsspsni.gov.uk/lymphoedema.pdf>

¹² Patients most commonly at risk of developing lymphoedema after cancer treatment are:

- patients who have had treatment to the arm pit for breast cancer
- patients who have had treatment affecting nodes in the groin area or pelvis (e.g. gynaecological and urological cancers).

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Supportive and Palliative Care for Adults with Cancer
<http://guidance.nice.org.uk/CSGSP>

National Institute for Health and Clinical Excellence (NICE) (2002) Improving outcomes in Breast Cancer
<http://guidance.nice.org.uk/CSGBC>

Responsibility for delivery / implementation

HSC Trusts

Quality Dimension

Safe, Timely, Efficient, Effective and Patient Centred

Prevention, early diagnosis and treatment means that fewer people need to be treated for chronic lymphoedema; which needs intensive, long term management. It also means that patients experience less disability and a better quality of life. Direct, local access to services is essential as the management of lymphoedema requires daily treatments over long periods of time.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of 'at risk' patients offered information (verbal and written) by the cancer treatment teams on lymphoedema and how to reduce their risk	Service (Trust and regional results) audit – 2010 Patient note review	Establish baseline Performance level to be determined once baseline established	March 2011
Percentage of patients with lymphoedema offered more in depth lymphoedema and how to aid self care information (verbal and written) during their lymphoedema management	Service (Trust and regional results) audit – 2010 Patient note review	Establish baseline Performance level to be determined once baseline established	March 2011

<p>Percentage of patients having surgery which involves the removal of regional lymph nodes who have</p> <ul style="list-style-type: none"> • their limbs measured (by the surgical team) before and after surgery; and, • have lymphoedema discussed in the surgical consent process 	<p>Service audit (Trust and regional results) – 2011</p> <p>Patient note review</p>	<p>Establish baseline</p> <p>Performance level to be determined once baseline established</p>	<p>March 2011</p>
<p>Percentage of patients diagnosed with lymphoedema being offered <i>Complex Decongestive Therapy</i> (CDT) or modified CDT (intensive and maintenance)</p> <p><u>*Reasoning behind treatment choice should be recorded if CDT is modified</u></p>	<p>Service audit (Trust and regional results) – 2010</p> <p>Lymphdat</p>	<p>Establish baseline</p> <p>Performance level to be determined once baseline established</p>	<p>March 2011</p>

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.