NHS

National Cancer Peer Review Programme 2009-2010

Cancer Peer Review Report

3 Counties Cancer Network

Central Zone Peer Review Team

July 2010

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The Zonal Team would also like to thank the Network and its constituent Trusts and PCTs for the hard work put in to preparing for this round of Peer Review. Their openness, healthy debate and hospitality during the reviews is recognised and appreciated.

CONTENTS

1 INTRODUCTION....4
1.1 National Cancer Peer Review....4
1.2 Background and Context to National Cancer Peer Review Programme....4
1.3 The Peer Review Process....5
2 ORGANISATION OF THE REPORT....7
3 NETWORK LEVEL SUMMARY AND REPORTS....8
3.1 Overall Network Stucture....8
3.1.1 Summary of MDT Measures....9
3.1.2 Summary of Network and Locality Measures....10
3.2 Network Report....10
3.2.1 Contextual Information....10
3.2.2 Executive Summary....11
3.2.3 IOG Progress....12
3.2.4 Good Practice....12
3.2.5 Network Response to Immediate Risks/Serious Concerns at Network Level....12
3.2.6 IV Process....12
3.3 Summary of Compliance for Network Board/NSSG Measures....13
4 TRUST REPORTS....14
4.1 Gloucestershire Locality....14
4.1.1 GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST....14
4.1.1.1 Trust Report....14
4.1.1.2 Summary of Compliance for MDT Measures....16
4.1.2 Summary of Compliance for Gloucestershire Locality Measures....16
4.2 Hereford Locality....17
4.2.1 HEREFORD HOSPITALS NHS TRUST....17
4.2.1.1 Trust Report....17
4.2.1.2 Summary of Compliance for MDT Measures....18
4.2.2 Summary of Compliance for Hereford Locality Measures....18
4.3 Worcestershire Locality....19
4.3.1 WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST....19
4.3.1.1 Trust Report....19
4.3.1.2 Summary of Compliance for MDT Measures....21
4.3.2 Summary of Compliance for Worcestershire Locality Measures....21
5 PCT REPORTS....23
5.1 Summary of Compliance for PCTs....23
6 Glossary....24

Section 1 - INTRODUCTION

1.1 National Cancer Peer Review

The National Cancer Peer Review Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The outcomes of the National Cancer Peer Review Programme are:

- confirmation of the quality of cancer services;
- speedy identification of major shortcomings in the quality of cancer services where they occur so that rectification can take place;
- published reports that provide accessible public information about the quality of cancer services;
- timely information for local commissioning as well as for specialised commissioners in the designation of cancer services;
- validated information which is available to other stakeholders.

1.2 Background and Context to National Cancer Peer Review Programme

National Cancer Peer Review Programme 2001

The first national cancer peer review programme was in 2001. It was organised and operated on a regional basis. The first Manual for Cancer Services which covered 'standards' for the four common cancers Breast, Lung, Colorectal and Gynae was publish in 2001. A national evaluation of the 2001 programme was undertaken by Keele University. This recommended that national consistency was addressed and a new methodology was introduced in 2004.

National Cancer Peer Review Programme 2004-2008

In 2004 the second national programme commenced. This was delivered by 6 zonal teams; North West, North East, West South, East, London and South. The programme was coordinated by a national team. All teams/ services within a cancer network were asked to complete a self assessment once in the three year cycle, which was then followed by a comprehensive peer review visits.

A national independent evaluation of the 2004-2008 programme took place following its completion and it was also included in the review of national programmes by the Office of the Strategic Health Authorities. The continuation of peer review programme was supported but changes were recommended in order to meet: the annual requirements of the national regulator (CQC); reduce the perceived burden of inspection; encompass the principles of better regulation to only review what needs to be reviewed and to become more outcomes focused.

National Cancer Peer Review Programme 2009

In April 2009 a new methodology for National Cancer Peer Review was introduced. The new methodology has adopted an annual self assessment process supported by a targeted visit programme. This annual process, will allow more up to date information to be available to support the commissioning of cancer services and patient choice.

The National Cancer Peer Review Programme (NCPR) and the Care Quality Commission (CQC) are both committed to partnership working, sharing information and working together to determine compliance with standards of safety and quality. The intention is to submit data to CQC on an annual basis at the end of each full peer review cycle to inform CQC's monitoring of compliance with registration requirements.

1.3 The Peer Review Process

The process of peer review is carried out by specialist teams of professional peers and user/carer reviewers. Wherever possible the professional peers are those trained and working in the same discipline as those they are reviewing. Therefore peer review enables assessments to be made by those who understand the service, making them credible and commanding the respect of those being reviewed.

The peer review programme consists of the three key stages: (see figure 1)

- **Internally validated self assessments**

  Following completion of an annual self assessment by the team that delivers the particular cancer service, Internal Validation of the assessment is undertaken by the host organisation or co-ordinating body for that service. It is not mandatory to internally validate a service which is subject to a peer review visit but is seen as good practice.

  The purpose of Internal Validation is:

  - to ensure accountability for the self assessment within organisations and to provide a level of internal assurance;
  - to develop a process whereby internal governance rather than external peer review is the catalyst for change; hence the organisation is using the self assessments for its own assurance purposes;
  - to confirm that, to the best of the organisation's knowledge, the assessments are accurate and therefore fit for publication and sharing with stakeholders;
  - to identify areas of good practice that could be shared.

- **Externally verified self assessments**

  External Verification is a check of selected internally validated self assessments led by the zonal cancer peer review coordinating teams. This check takes the form of a desktop exercise. This process ensures that every team/service will be externally verified at least once every five years.

  The purpose of External Verification is to:

  - verify that self assessments are accurate and have been completed in a similar manner across organisations;
  - ensure that a robust process of self assessment and Internal Validation has taken place;
  - confirm self assessed performance against the measures and any associated issues relating to IOG implementation;
  - support identification of teams or services who will receive an external peer review visit in accordance with the selection criteria.

- **Peer review visits**

  Each year a targeted schedule of peer review visits takes place. The schedule of forthcoming peer review visits is agreed with each cancer network, and the teams/services informed, by the end of December each year. The visit cycle then commences the following May and is completed by March of the next year.

Figure 1

Each of the stages of the peer review process determines whether compliance with each peer review measure has been achieved and whether progress is being made towards those where it has not. Compliance with the measures is appraised as yes, no or not applicable according to the evidence available. If evidence is not available then the measures are considered as not met.

A phased introduction

As a result of national consultation on the new methodology it was agreed that the programme would have a phased introduction. In particular cancer networks and trusts had been concerned that the implementation of the annual Internal Validation cycle across the nine cancer sites would be too onerous, but that this would be manageable with the phased introduction.

In 2009/2010 the programme included six cancer sites, five of which had previously been reviewed - Breast, Lung, Gynaecological, Upper Gastro-Intestinal and Urology and one new site, Skin.

Section 2 - ORGANISATION OF THE REPORT

This report contains:

- an overall summary diagram of the structure of the Network
- an overall Network Report which contains
    - contextual information about the Network
    - an Executive Summary
    - progress against Improving Outcomes Guidance
    - Good Practice
    - a summary of Immediate Risks and Serious Concerns at Network level and
    - comments on the robustness of the IV process across the Network.

There is a similar summary report for each Trust in the Network, and links to the PCT Skin Reports in the final section.

Reports on individual teams may be accessed via hyperlinks both in the Network Summary Table and also in the summaries of compliance within the individual Trusts' sections.

To access these individual reports when online, please click on the links as shown in the example diagrams below. These will take you to the reports as PDF documents which can then be saved or printed.

KEY
Peer Review Compliance (%)
Internal Validation Compliance (%)
External Verification assessment:
G - IV Confirmed
A - IV Confirmed with Exceptions
R - IV Unconfirmed

	08-1A-2b - Breast Network	08-1A-2c - Lung Network	08-1A-2e - Gynae Network	08-1A-2f - Upper GI Network	08-1A-2g - Urology Network	08-1A-2j - Skin Network	08-1C-1b - Breast NSSG	08-1C-1c - Lung NSSG	08-1C-1e - Gynae NSSG	08-1C-1f - Upper GI NSSG	08-1C-1g - Urology NSSG	08-1C-1j - Skin NSSG	08-1D-1j - Skin Locality Msrs
PBCN	66G	100G	77	100	82	70	100G	100G	80	75	100	81	
Birmingham East and North													0
Sandwell and West Birmingham													0
South Birmingham													0
Walsall													0

Click on any of the squares to be taken to an individual Report

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2F-2	Specialist Upper GI MDT	86%			Specialist Upper GI Report
08-2G-2	Specialist Urology MDT	89%			Specialist Urology Report

Click on the text in the column 'Link to Report' to be taken to an individual Report

Section 3 - NETWORK LEVEL SUMMARY AND REPORTS

3.1 Overall Network Stucture

The following table shows the structure of the Network, ie the Multi-Disciplinary Teams (MDTs) for the cancers treated at each Trust, and the compliance with the Peer Review Measures for that MDT.

If there has been a Peer Review of those services the percentage compliance is shown as a dark green percentage in the following table. If a service has been internally validated and also externally verified the IV percentage is shown in purple and the EV rating indicating the robustness of the IV process is shown as a red R, Amber A or Green G in the table. If there has been Internal Validation of self-assessment, but no External Verification of this, only the purple Internal Verification compliance is shown.

As referred to in the introduction Internal Validation (IV) is the process by which the Trust or Network uses its own governance processes to assure the accuracy of its self assessment of compliance against the Peer Review measures. External Verification (EV) is undertaken on a large sample of the IVs by the NCPR Zonal Team to confirm, based on documentary evidence, that the IV was performed effectively. The outcome of EV is a traffic light coded system that reflects the Zonal Team's confidence in the IV process, and is not an indication of whether the compliance with the NCPR measures is satisfactory or otherwise.

The three possible outcomes for EV are 'Green - IV confirmed', 'Amber - IV confirmed with exceptions' and 'Red - IV unconfirmed'. The allocation of the different ratings results from applying a combination of criteria including the degree of difference between the IV compliance and that found at EV, and the identification of potential Immediate Risks or Serious Concerns at EV that were not identified by the IV process. The parameters and algorithm for determining how these criteria lead to the red, amber, or green coding are published each year in a Delivery Specification Guide.

Individual Reports may be accessed via hyperlinks contained within the percentage compliances.

3.1.1 Summary of MDT Measures

KEY

Peer Review Compliance (%)
Internal Validation Compliance (%)
External Verification assessment:
G - IV Confirmed
A - IV Confirmed with Exceptions
R - IV Unconfirmed

	08-2B-1 - Breast MDT	08-2C-1 - Lung MDT	08-2E-1 - Local Gynae MDT	08-2E-2 - Spec. Gynae MDT	08-2F-1 - Local Upper GI MDT	08-2F-2 - Spec. Upper GI MDT	08-2G-1 - Local Urology MDT	08-2G-2 - Spec. Urology MDT	08-2J-1 - Local Skin MDT	08-2J-2 - Spec Skin MDT	08-6A-1j - Skin for PCTs
Gloucestershire											
Cheltenham General	77G	90G			83						
Gloucester Royal	94G	91G				81					
Gloucestershire Hospitals NHS Foundation Trust				85				86		65	
Hereford											
Hereford	82A	90G	82		69		71		56		
Worcestershire											
Kidderminster Hospital	85G		82								
Redditch	94G	87A	94		82		87				
Worcestershire Acute Hospitals NHS Trust					91				76		
Worcestershire Royal Hospital	91G	90G	88				87				
Gloucestershire PCT											100
Herefordshire PCT											100
Worcestershire PCT (3ccn)											50

3.1.2 Summary of Network and Locality Measures

KEY Peer Review Compliance (%) Internal Validation Compliance (%) External Verification assessment: G - IV Confirmed A - IV Confirmed with Exceptions R - IV Unconfirmed	08-1A-2b - Breast Network	08-1A-2c - Lung Network	08-1A-2e - Gynae Network	08-1A-2f - Upper GI Network	08-1A-2g - Urology Network	08-1A-2j - Skin Network	08-1C-1b - Breast NSSG	08-1C-1c - Lung NSSG	08-1C-1e - Gynae NSSG	08-1C-1f - Upper GI NSSG	08-1C-1g - Urology NSSG	08-1C-1j - Skin NSSG	08-1D-1j - Skin Locality Msrs
3CCN	100A	100G	67	57	71	100	100A	100G	70	100	67	88	
Gloucestershire													100
Hereford													0
Worcestershire													0

3.2 Network Report

3.2.1 Contextual Information

The 3CCN covers Gloucestershire, Herefordshire, parts of Powys and South Worcestershire. The Network serves a catchment population of just over one million.

The NHS organisations in the Network are:

Acute Trusts:
Gloucestershire Hospitals NHS Foundation Trust (GHFT)
Herefordshire Hospitals NHS Trust (HHT)
Worcestershire Acute Hospitals NHS Trust (WAHT) 3CCN population are mainly served by Worcestershire Royal Hospital (WRH)

Primary Care Trusts:
NHS Gloucestershire
NHS Herefordshire
NHS Worcestershire.

The majority of non-surgical oncology services are managed by the Gloucestershire Oncology Centre from Cheltenham General Hospital.

Population in the Network:
Gloucestershire 602,000
Herefordshire 180,000
Worcestershire (South) 285,000
Powys (part) 60,000
Total 1,127,000

Patients also access supra-network services in Bristol and Birmingham.

The findings for all the Teams at WAHT are described in this report, although the services in Redditch and Bromsgrove serve populations in Greater Midlands and Arden Cancer Networks.

In this round of Peer Review, the following Network teams were subject to a full Peer Review visit:

Gynaecological Cancer Network Site Specific Group and related Network Board measures
Upper Gastro-Intestinal Cancer Network Site Specific Group and related Network Board measures
Urological Cancer Network Site Specific Group and related Network Board measures
Skin Cancer Network Site Specific Group and related Network Board measures.

The following Network teams underwent Internal Validation (IV) which was Externally Verified (EV) by the NCPR Zonal Team:

Breast Cancer Network Site Specific Group and related Network Board measures

Lung Cancer Network Site Specific Group and related Network Board measures.

3.2.2 Executive Summary

The Network has been through a period of change with most of the senior team having changed since the last peer review:

Medical Director has been in post since November 2007

Service Improvement Lead commenced 3rd October 2009

Network Nurse Director commenced 17th December 2009

Network Director commenced 25th January 2010.

Prior to these appointments there was also a significant period when interim arrangements were in place. The effects of this are that in some key areas of work the 3CCN has not made sufficient progress and needs to hasten its developments.

The 3CCN is focused on implementing the Cancer Reform Strategy (CRS) and is utilising the CRiSCRoS system as the tool to monitor implementation. In response to the CRS the 3CCN is further developing its relationship with commissioners.

The Network is responding to the NRAG report by developing a strategic radiotherapy group. Previous plans for satellite radiotherapy at Hereford and Worcester are being revisited because of the current economic situation and the strategic review of cancer services by the PCT in Worcestershire. The 3CCN also needs to accelerate its development of plans for chemotherapy and acute oncology services following the publication of the NCAG report.

The Network has been successful in making a bid for a project to better inform patients about chemotherapy and increase their involvement in their own care. By enabling patients to use a variety of technologies to record their own chemotherapy related toxicities it is hoped to reduce clinical time with patients.

The Peer Review visits to the skin cancer services in the Network demonstrated good progress in putting in place IOG compliant services. All services demonstrated compliance above 55% with the Peer Review measures. The reviewers commended a number of the administrative developments to improve the quality of care at the Hereford MDT and whilst no Immediate risks or Serious Concerns were noted at either of the local MDTs, both had concerns raised about skin CNS vacancies. An Immediate Risk was identified at the SMDT relating to only 16% attendance by the oncologist. When the reviewers met the NSSG, the found an NSSG with a number of challenges, including: NSSG attendance mainly from Gloucestershire Hospitals NHSFT, three different models of community skin cancer service are in place across the Network, natural flows of patients out of the Network affecting the authority and volume of cases for the SMDT and lack of availability of key staff such as CNSs and histopathologists. However, the reviewers believed the NSSG is committed to making the NSSG function effectively and addressing these challenges. No Immediate Risks or Serious Concerns were noted for the NSSG.

At their Peer Review visits, the separate Upper Gastro-Intestinal Cancer services at Cheltenham (Local MDT) and Gloucester (Specialist MDT) both achieved more than 80% with the Peer Review measures, whilst the Local team at Hereford demonstrated 69% compliance. The Peer review visit to the NSSG found a sound, well functioning NSSG that was commended for its accrual to clinical trials and with few concerns and no Immediate Risks or Serious Concerns.

For the two Urology teams that were Peer reviewed, namely the Local MDT at Hereford and the SMDT at Gloucestershire Hospitals, compliance with the measures was more than 70%, and there were concerns about CNS capacity at both Trusts. The reviewers that visited the NSSG felt that the NSSG had not differentiated itself sufficiently from the SMDT leading to the NSSG role not being completely fulfilled. The reviewers commended the team on the efforts being made to offer a unified service at the SMDT, all be it that services were physically spread over two sites. Also the inreach model from Hereford for outpatients and operating was seen as offering

good continuity of care for patients. No Immediate Risks or Serious Concerns were noted, however the service configuration and oncology protocols in Redditch were concerns.

No Local or Specialist Gynaecological cancer MDTs were visited in the Network in this round of Peer Review, however, the NSSG was visited. This visit found a fairly well organised NSSG, but one that did not seem to understand how it should interact with with or influence commissioning. There is a general shortage of CNS provision across the Network, and this lack of local cover is mitigated by cross organisational cover across the Network. The reviewers also found a lack of concordance between the written evidence submitted and the reported service delivered. However, no Immediate Risks or Serious Concerns were noted.

The Network self assessed against the Peer Review measures for Breast and Lung NSSGs and then Internally Validated those assessments. These were both Externally Verified by the NCPR Zonal team. The Lung NSSG was judged to be 'Green - IV confirmed' with good compliance and no Immediate Risks or Serious Concerns identified. The Breast NSSG was judged to be 'Amber - IV confirmed with exceptions' due to differences in the compliance found by the IV and EV assessments. No new Immediate Risks or Serious Concerns were noted at EV.

3.2.3 IOG Progress

For the four cancer areas that were subject to Peer Review visits in this cycle, the configurations for gynaecological and upper gastro-intestinal cancers are IOG compliant. For urological cancers, the site reconfigurations at Gloucestershire Hospitals will achieve a single site service for the SMDT. There is also a dispensation from the National Cancer Action Team for the Worcestershire Local MDT to undertake resectional surgery at Redditch.

Networks did not have to be compliant with the skin cancer IOG until December 2009. The Network had made good progress in setting up the SMDT however, as can be seen from the report of the Peer Review team, there are a number of challenges that the SMDT has to face if it is going to be an effective team.

3.2.4 Good Practice

A number of items of good practice and significant progress were identified in the visits to the Network and its NSSGs.

For the skin cancer NSSG, the reviewers commended the engagement with Gloucestershire PCT, and the members' commitment to making the NSSG function. The gynaecological cancer NSSG had the recrutment to trials and cross covering of CNS roles identified as good practice, whilst for the urological cancer NSSG it was the development of the unified service across the SMDT's two sites, and the model of in-reach surgery. Finally, for the upper gastro-intestinal cancer NSSG, significant progress had been made in getting user involvement, as well as good accrual to clinical trials.

3.2.5 Network Response to Immediate Risks/Serious Concerns at Network Level

No Immediate Risks or Serious Concerns were identified at Network level.

3.2.6 IV Process

A panel review meeting was held with Clinical Leads. Unfortunately the Network did not identify the roles held by the panel members or the NSSG representatives. No further details of the process were described by the Network.

3.3 Summary of Compliance for Network Board/NSSG Measures

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-1A-2b	Breast Network		Amber	100%	Breast Network Report
08-1A-2c	Lung Network		Green	100%	Lung Network Report
08-1A-2e	Gynae Network Board	**67%**			Gynae Network Board Report
08-1A-2f	Upper GI Network Board	**57%**			Upper GI Network Board Report
08-1A-2g	Urology Network Board	**71%**			Urology Network Board Report
08-1A-2j	Skin Network Board	**100%**			Skin Network Board Report
08-1C-1b	Breast NSSG		Amber	100%	Breast NSSG Report
08-1C-1c	Lung NSSG		Green	100%	Lung NSSG Report
08-1C-1e	Gynae NSSG	**70%**			Gynae NSSG Report
08-1C-1f	Upper GI NSSG	**100%**			Upper GI NSSG Report
08-1C-1g	Urology NSSG	**67%**			Urology NSSG Report
08-1C-1j	Skin NSSG	**88%**			Skin NSSG Report

The above table indicates the percentage compliance with NSSGs and Network measures. If there has been a Peer Review of those services the percentage compliance is indicated in the Peer Review column. If a service has been Internally Validated and also Externally Verified the IV percentage compliance and the EV rating indicating the robustness of the IV process is shown in the table. If there has been Internal Validation of self-assessment, but no External Verification of this, only the Internal Validation compliance is shown.

Please refer to the Overall Network Structure Section for an explanation of IV and EV ratings.

Individual Reports may be accessed via the hyperlinks to the reports.

Section 4 - TRUST REPORTS

4.1 Gloucestershire Locality

4.1.1 GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

4.1.1.1 Trust Report

Contextual Information

The Trust was established in April 2002 to provide acute hospital services for the whole of Gloucestershire, and the trust manages two hospitals:
Gloucestershire Royal Hospital 713 plus 43 day beds (756)
Cheltenham General Hospital 483 plus 72 day beds (555)
The Trust became a Foundation Trust in July 2004

The Trust serves a population of around 560,000 for acute care and a population of over 1 million for cancer.

The Gloucestershire Oncology Centre is located on the Cheltenham General Hospital site and provides sub-regional cancer services for a catchment population of just over 1 million people living in Gloucestershire, Herefordshire, South Worcestershire and parts of Shropshire and Powys.

The purpose built Centre underwent major redevelopment, which was completed in Autumn 2009. It provides accommodation for all inpatient, daycase and outpatient non-surgical oncology episodes. The accommodation includes 2 oncology wards (44 beds), a patient hostel (4 beds), specialist palliative care services, chemotherapy suite, radiotherapy department, nuclear medicine department and cancer information centre.

The Centre received 4000 new referrals in 2008/9. There has been steady growth of 10% per year and it is anticipated that the workload will continue to increase due to the aging population and the increasing range of effective treatments.

In this round of Peer Review, the following teams were subject to a full Peer Review visit:
Upper Gastro-Intestinal Cancer Specialist MDT (Gloucester)
Upper Gastro-Intestinal Cancer Local MDT (Cheltenham)
Urological Cancer Specialist MDT
Skin Cancer Specialist MDT

The following Teams undertook Internal Validation and were Externally Verified by the Zonal Team:
Breats Cancer MDT (Cheltenham)
Breast Cancer MDT (Gloucester)
Lung Cancer MDT (Cheltenham)
Lung Cancer MDT (Gloucester)

The following team underwent Internal Validation only:
Gynaecological Cancer Specialist MDT.

Trust Executive Summary

The Trust is in the process of planning and implementing a number of site re-organisations and redevelopments that will improve the pathways for cancer patients. The Trust is also considering the advantages of bringing together MDTs for the same cancers that are held separately on the Cheltenham and Gloucester sites.

The implications of the NCAG report to providing an acute oncology service that supports the Trust's two Accident and Emergency Departments, as well as the other trusts to which it provides oncology services, are currently being considered.

The Peer Review visit to the Specialist Skin MDT noted that this was a relatively new and developing SMDT. The Review Team felt that the practice of initial delivery of significant news by the Clinical Nurse Specialists was

a well managed, innovative practice. However, it was felt by the review team that the very low attendance by the oncologist at the MDT could potentially affect the effectiveness and outcome of care for patients, and was identified as an Immediate Risk. In response to this risk being highlighted, the Trust committed to ensure that one of the oncologists would attend a minimum of 75% of SMDT meetings whilst the Trust decided how best to invest additional oncology funding that had been identified. In addition, the review team identified the arrangements for performing block dissections for skin cancer patients as a Serious Concern. In response, the Trust committed to alter referral guidelines and to undertake an audit of the skin cancer block dissections.

Both the local and specialist upper gastro-intestinal teams were reviewed. Even though these teams have separate identities they chose to be reviewed in the same meeting. The local team was seen to be functioning well, and the reviewers drew particular attention to the mobile chemotherapy service which was popular with patients and staff. With regard to the Specialist Upper GI team, the reviewers noted that the risk of surgery being postponed had significantly reduced due to improved HDU/ITU facilities in the Trust. The UGI reviewers had concerns that Specialist MDT was surgically dominated and did not benefit from gastroenterology input. No Immediate Risks or Serious Concerns were identified for either Upper GI team.

The fourth team to be visited was the specialist Urology MDT. Since the previous Peer Review visit the Trust had combined its teams to form a fully functioning SMDT, and this had significantly improved compliance with the Peer Review measures. The Trust is looking to centralise its urology services on the Cheltenham site, however the timescale remains to be fixed. No Immediate Risks or Serious Concerns were highlighted for ths service.

Four teams (Lung and Breast at Cheltenham and Gloucester sites) had their Internal Validations confirmed ('green') when they were Externally Verified by the Zonal Team, and no Immediate Risks or Serious Concerns were demonstrated.

IV Process

The Trust set up a three member Internal Validation Panel led by the Trust's Cancer manager. The review was undertaken by reviewing the evidence and then meeting core members of the MDT team to discuss findings.

4.1.1.2 Summary of Compliance for MDT Measures

Cheltenham General MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	77%	Breast Report
08-2C-1	Lung MDT		Green	90%	Lung Report
08-2F-1	Local Upper GI MDT	**83%**			Local Upper GI Report

Gloucester Royal MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	94%	Breast Report
08-2C-1	Lung MDT		Green	91%	Lung Report
08-2F-2	Specialist Upper GI MDT	**81%**			Specialist Upper GI Report

Gloucestershire Hospitals NHS Foundation Trust MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2E-2	Specialist Gynae MDT			85%	Specialist Gynae Report
08-2G-2	Specialist Urology MDT	**86%**			Specialist Urology Report
08-2J-2	Spec Skin MDT	**65%**			Spec Skin Report

The above table indicates the percentage compliance of the MDTs within the Trust. If there has been a Peer Review of those services the percentage compliance is indicated in the Peer Review column. If a service has been Internally Validated and also Externally Verified the IV percentage compliance and the EV rating indicating the robustness of the IV process is shown in the table. If there has been Internal Validation of self-assessment, but no External Verification of this, only the Internal Validation compliance is shown.

Please refer to the Overall Network Structure Section for an explanation of IV and EV ratings.

Individual Reports may be accessed via the hyperlinks to the reports.

4.1.2 Summary of Compliance for Gloucestershire Locality Measures

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-1D-1j	Skin Locality Measures	**100%**			Skin Locality Measures Report

This table applies to the one skin locality measure relevant to the above Trust(s) which according to the network agreement should establish clinics for immunocompromised patients with skin cancer, in their locality. The table follows the same format as that for MDTs above. NB: As there is only ONE measure for skin, compliance can only be 0% or 100%.

4.2 Hereford Locality

4.2.1 HEREFORD HOSPITALS NHS TRUST

4.2.1.1 Trust Report

Contextual Information

Hereford County Hospital is the main provider of acute services across Herefordshire and parts of Wales, serving a population of approximately 230,000. The Trust has two main commissioners which account for 94% of the Trust's income. Herefordshire Primary Care Trust 85.4% and Powys Local Health Board 9.2%.

The Trust has single District General Hospital site housed in a new building that opened in 2002, with 287 beds.

There is a dedicated cancer facility, the Charles Renton Unit. The Trust has three visiting Oncologists from the Cancer Centre at Cheltenham. Day-case chemotherapy is delivered in the Charles Renton Unit, and plans are in place for the development of a new Cancer Unit facility on site by March 2011, part funded by the Macmillan Cancer Charity. In addition, it is anticipated that radiotherapy services will be available at the hospital from 2012.

In this round of Peer Review the following teams were subject to a full Peer Review visit:
Upper Gastro-Intestinal Cancer Local MDT
Urological Cancer Local MDT
Skin Cancer Local MDT

The following teams undertook Internal Validation (IV) and were Externally Verified (EV) by the Zonal team:
Breast Cancer MDT
Lung Cancer MDT

The following team underwent IV only:
Gynaecological Cancer Local MDT.

Trust Executive Summary

The Trust serves a diffuse and rural population. The Trust is developing plans for a new cancer facility, with improved imaging (the current single CT scanner will be unable to meet future demand and complexity) and a radiotherapy facility. One of the key challenges for the coming year will be establishing how an acute oncology service could be delivered.

The Peer Review visit to the Local Upper GI team was hampered by the Trust only putting forward one individual to meet with the review team, inevitably meaning that many lines of discussion could not be pursued and the MDT gained less benefit from the review than if it had engaged with the process. The team found there to be no Upper GI cancer Clinical Nurse Specialist (CNS) and no funding identified to appoint one. This was raised as a Serious Concern. In response to this, the Trust was putting together a bid to Macmillan for funding of this post, supported by the Cancer Network.

The Visit to the Local Urology MDT was also hampered by only the lead clinician attending, and a locum CNS who did not stay for the full discussion. The review team noted that the data collection for the British Association of Urological Surgeons was robust. However, a concern previously raised that the MDT only meet fortnightly, as this is how often the oncologist can attend, was found to still have not been resolved. This is outside the Urology Improving Outcomes Guidance and was therefore considered to be a Serious Concern by the review team.
In response, the Trust entered into negotiations with Gloucester Hospitals Trust to secure additional oncology resource for the MDT.

The third service to be reviewed was the Local Skin MDT. The consultants in the team were all relatively new in post and had made a great deal of progress in a short time. However the co-ordination of care and development of services was being hampered by difficulty in recruiting to the CNS vacancy. The review team did not consider there to be any Immediate Risks or Serious Concerns.

Of the two teams that the Trust Internally Validated and which were subsequently Externally Verified by the Zonal team, the Lung MDT had its IV confirmed ('Green'), whilst the Breast MDT had its IV confirmed with exceptions ('Amber'). This was due to a discrepancy of more than 20% (but less than 30%) in the compliance between that found at IV and EV. No additional Serious Concerns or Immediate Risks were identified by the Zonal team.

IV Process

The Trust undertook a desk top review of evidence by a panel consisting of the Lead Cancer Clinician, the Vice Chair of the User Group, the Trust's Cancer Manager, a Commissioner for Cancer Services and the Trust Cancer Data and Administration Manager. The results of the desk top review were discussed with the teams and the Director of the Cancer Network. The final internal validation was forwarded to the Chief Executive for approval.

4.2.1.2 Summary of Compliance for MDT Measures

Hereford MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Amber	82%	Breast Report
08-2C-1	Lung MDT		Green	90%	Lung Report
08-2E-1	Local Gynae MDT			82%	Local Gynae Report
08-2F-1	Local Upper GI MDT	**69%**			Local Upper GI Report
08-2G-1	Local Urology MDT	**71%**			Local Urology Report
08-2J-1	Local Skin MDT	**56%**			Local Skin Report

The above table indicates the percentage compliance of the MDTs within the Trust. If there has been a Peer Review of those services the percentage compliance is indicated in the Peer Review column. If a service has been Internally Validated and also Externally Verified the IV percentage compliance and the EV rating indicating the robustness of the IV process is shown in the table. If there has been Internal Validation of self-assessment, but no External Verification of this, only the Internal Validation compliance is shown.

Please refer to the Overall Network Structure Section for an explanation of IV and EV ratings.

Individual Reports may be accessed via the hyperlinks to the reports.

4.2.2 Summary of Compliance for Hereford Locality Measures

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-1D-1j	Skin Locality Measures	**0%**			Skin Locality Measures Report

This table applies to the one skin locality measure relevant to the above Trust(s) which according to the network agreement should establish clinics for immunocompromised patients with skin cancer, in their locality. The table follows the same format as that for MDTs above. NB: As there is only ONE measure for skin, compliance can only be 0% or 100%.

4.3 Worcestershire Locality

4.3.1 WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

4.3.1.1 Trust Report

Contextual Information

Worcestershire Acute Hospitals NHS Trust was established on 1 April 2000 to cover all acute services in Worcestershire and is now in the final stage of application to become a Foundation Trust. The Trust provides a wide range of services to a population of around 550,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield. The Trust has three hospital sites, Worcestershire Royal Hospital (WRH), Alexandra Hospital in Redditch and the Kidderminster Treatment Centre (KTC).

Historically the population has been derived from three cancer networks:
3 Counties Cancer Network -- oncology provider, Cheltenham
Arden Cancer Network -- oncology provider Coventry
Greater Midlands Cancer Network -- Wolverhampton.

Worcestershire's cancer services therefore relate to all of the three cancer networks with all relevant clinical and referral protocols being agreed by separate Network Site-Specific Groups. The pattern of oncology service provision in the Trust includes oncology out-patient clinics and chemotherapy services available at all three hospital sites, and patients travel to their nearest oncology centre for radiotherapy, in-patient chemotherapy and, usually, for admission for complications of chemotherapy.

Across the Trust there are seventeen Cancer Multidisciplinary Teams based at two hospital sites involving patients from all parts of the county and from the three networks. As part of the new Trust structure that is in place the Trust is now working towards county wide services for all tumour sites to provide greater consistency of service

In this round of Peer Review the following team was subject to a full Peer Review visit:
Skin Cancer Local MDT.

The following teams undertook Internal Validation (IV) and were Externally Verified (EV) by the Zonal Team:
Breast Cancer MDT (Worcester)
Breast Cancer MDT (Kidderminster)
Breast Cancer MDT (Redditch)
Lung Cancer MDT (Worcester)
Lung Cancer MDT (Redditch)

The following teams underwent Internal Validation only:
Gynaecological Cancer Local MDT (Redditch)
Gynaecological Cancer Local MDT (Kidderminster)
Gynaecological Cancer Local MDT (Worcester)
Upper Gastro-Intestinal Cancer Local MDT (Redditch)
Upper Gastro-Intestinal Cancer Local MDT (Worcester)
Urological Cancer MDT (Redditch)
Urological Cancer MDT (Worcester)

Trust Executive Summary

The Trust has a history of MDTs based on two or even three of its sites. The Trust has a strategy to combine MDTs, offering countywide services where appropriate, and to have no stand alone MDTs at Kidderminster by the end of 2010. The Trust has recently renewed its Cancer Team and at the time of the visit on May 2009 has a number of new appointments in place.

Patients may currently attend any of three centres for radiotherapy depending on where they live. There has been a plan for both 3 Counties Cancer Network and Arden Cancer network to post linear accelerators in Worcestershire

in response to local need and national initiatives. The Trust is also planning a significant expansion of imaging capacity across all three sites.

The Trust is at the early stages of considering the implications of the requirement to introduce an acute oncology service.

The Skin Cancer MDT had been a single Team for about six months prior to the review, and many issues raised at previous Peer Review assessment had been resolved. The reviewers noted a number of areas of good practice, in particular the resources for providing information about cancer for patients and staff. The review team did not identify any Immediate Risks or Serious Concerns. The reviewers were concerned about the difficulty the Trust was experiencing in recruiting a skin cancer CNS and the complexity of pathways resulting from the Trust's relationship with three cancer networks.

Of the five MDT IVs that were EVed four (Worcester, Redditch and Kidderminster Breast and Worcester Lung) had the robustness of their IV process confirmed ('Green'). One team (Redditch Lung) had its IV confirmed with exceptions ('Amber) due to a discrepancy of more than 20% (but less than 30%) between the compliance with the Peer Review measures declared by the IV panel compared with that found by the Zonal Team at EV.

IV Process

A desktop review of each team was undertaken by the Trust's Cancer Management Team which was returned to the MDT. Panels were then set up consisting of the Trust Lead Cancer Clinician, a Commissioner from the PCT, the Trust Cancer Manager/Lead Cancer Nurse, the Trust Peer Review Quality Manager, The Chief Operating Officer, a user representative and the Cancer Data Information Manager, and meetings held with MDT representatives. Feedback was given to the MDTs and the reports written.

4.3.1.2 Summary of Compliance for MDT Measures

Kidderminster Hospital MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	85%	Breast Report
08-2E-1	Local Gynae MDT			82%	Local Gynae Report

Redditch MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	94%	Breast Report
08-2C-1	Lung MDT		Amber	87%	Lung Report
08-2E-1	Local Gynae MDT			94%	Local Gynae Report
08-2F-1	Local Upper GI MDT			82%	Local Upper GI Report
08-2G-1	Local Urology MDT			87%	Local Urology Report

Worcestershire Acute Hospitals NHS Trust MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2F-1	Local Upper GI MDT			91%	Local Upper GI Report
08-2J-1	Local Skin MDT	**76%**			Local Skin Report

Worcestershire Royal Hospital MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	91%	Breast Report
08-2C-1	Lung MDT		Green	90%	Lung Report
08-2E-1	Local Gynae MDT			88%	Local Gynae Report
08-2G-1	Local Urology MDT			87%	Local Urology Report

The above table indicates the percentage compliance of the MDTs within the Trust. If there has been a Peer Review of those services the percentage compliance is indicated in the Peer Review column. If a service has been Internally Validated and also Externally Verified the IV percentage compliance and the EV rating indicating the robustness of the IV process is shown in the table. If there has been Internal Validation of self-assessment, but no External Verification of this, only the Internal Validation compliance is shown.

Please refer to the Overall Network Structure Section for an explanation of IV and EV ratings.

Individual Reports may be accessed via the hyperlinks to the reports.

4.3.2 Summary of Compliance for Worcestershire Locality Measures

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-1D-1j	Skin Locality Measures	**0%**			Skin Locality Measures Report

This table applies to the one skin locality measure relevant to the above Trust(s) which according to the network agreement should establish clinics for immunocompromised patients with skin cancer, in their locality. The table

follows the same format as that for MDTs above. NB: As there is only ONE measure for skin, compliance can only be 0% or 100%.

Section 5 - PCT REPORTS

5.1 Summary of Compliance for PCTs

NB. It should be noted that the NICE Improving outcomes for people with Skin tumours was updated in May 2010 in relation to the management of low-risk basal cell carcinomas in the community. The Peer Review measures will be revised to reflect these changes. Therefore, the compliance shown in this report does not reflect the current position, but is the position against the previous version of the NICE guidance. The commentary of the report does however show the extent to which community skin cancer services have been established but the compliance cannot be confirmed.

PCT	Peer Review	Link to Report
Gloucestershire PCT	100%	Gloucestershire PCT Report
Herefordshire PCT	100%	Herefordshire PCT Report
Worcestershire PCT	50%	Worcestershire PCT Report

The table above indicates the percentage compliance related to the provision of community skin cancer services for all PCTs within the Network. The PCT may relate to more than one Trust and therefore the Reports for the PCTs are all contained within this section, but may also be cross referenced within the Skin Reports for individual Trusts. All relevant PCT community skin cancer services will have been subject to Peer Review.

Individual Reports may be accessed via the hyperlinks to the reports.

Section 6 - Glossary

GLOSSARY	
Acute	Description of any intense sensation such as pain or the description of a disease with rapid onset, severe symptoms and short duration.
Acute Hospital	Provides surgery, investigations, operations, serious and other treatments in a hospital setting.
Adjuvant Therapy	Therapy (usually chemotherapy) given after all visible tumour has been removed, usually by surgery or radiotherapy. Used to improve cure rates and reduce recurrence.
AHP	Allied Health Professional.
ARSAC	Administration of Radioactive Substances Advisory Committee (license use of radioactive materials).
BASO	British Association of Surgical Oncologists (includes breast surgeons).
BCS	Breast Conserving Surgery.
Benign	Tumour that is not malignant. Also used of a condition or disorder that does not produce harmful effects.
Biopsy	Removal of small sample of tissue to aid diagnosis. Biopsied tissue is usually prepared for microscopic examination.
Brachytherapy	Treatment which involves placing a source of radiation directly within the tumour and employs radioactive plaques, needles, tubes, wires, or small "seeds" made of radionuclides. These radioactive materials are placed over the surface of the tumour or implanted within the tumour, or placed within a body cavity surrounded by the tumour.
Breast cancer	Cancer of the breast tissue, the commonest malignant disease in women.
Bronchial cancer	Cancer of the lung. Cigarette smoking is responsible for most cases of bronchial carcinoma.
Cancer	Abnormal and unregulated proliferation of cells that result in invasion and destruction of surrounding healthy tissue. Cancer cells arise from normal cells whose nature has been permanently changed. Cancer cells are spread by blood and lymphatics to other parts of the body to form metastases.
Cancer Network	Cancer Networks were organisations originally created in response to the NHS Cancer Plan. They have a remit to drive change and improve cancer services for the population in specific areas.
Cancer Registries	Collect information on what cancers occur, how advanced they are and where they are diagnosed The availability of information may be variable at different cancer registries, depending on local practices and the completeness of the reporting of staging information by clinicians.
Carcinoma	Any cancer that arises from epithelial tissue.
Care Pathway	A description of the journey taken (or intended to be taken) through a clinical service.
Care Quality Commission (CQC)	National body authorised by parliament to regulate healthcare in both public and private sectors. The NHS Cancer Peer Review Programme works in partnership with the CQC.

GLOSSARY	
CEO	Chief Executive Officer (CEO), also Chief Executive (CE).
Chemotherapy	Chemotherapy is the use of anti-cancer (cytotoxic) drugs to destroy cancer cells. They are usually given by IV infusion (slowly injected into a vein), but can be given orally (in pill form).
Chronic	Describing a disease of long duration, usually with slow progression.
Clinical audit	The continuous evaluation and measurement by health professionals of the extent to which they are meeting standards that have been set for their service.
Clinical Governance	Process by which an organisation ensures its clinical care is of high quality and is both safe and effective.
Clinical network	A group of services which work together across organisational boundaries to provide better patient care.
CNS	Clinical Nurse Specialist – a nurse with specialist training and experience in a particular area of cancer.
Colorectal Cancer	Cancer of the colon and/or rectum.
CPA	Clinical Pathology Accreditation run by Royal College of Pathologists.
CT Scanner	Computerised tomography scanner which uses x-rays to generate detailed cross sections of internal body structures.
Cytotoxic Drug	Drugs that destroy cells and are used to treat cancer. Also affect normal rapidly dividing cells such as hair follicles and lining of gut.
Digital Mammography	Digital Mammography is the digital capture of mammographic images, providing greater resolution and clarity than conventional mammography.
EQA	External Quality Assurance (EQA) scheme to promote high quality histological reporting.
EV	External Verification is a check of selected internally validated self assessments led by the zonal cancer peer review coordinating teams, in order to confirm that the Internal Validation (IV) was performed effectively. This check takes the form of a desktop exercise.
ERP	Enhanced Recovery Programme; a programme of pre- and post- operative care designed to improve patient outcomes and speed up a patient's recovery after surgery.
FNA	Fine Needle Aspiration.
Gynaecological Cancer	Cancer relating to the ovaries, cervix, vulva, endometrium and associated structures.
HDU	High Dependency Unit, usually for very sick patients. It forms an intermediate stage between an intensive care unit and a ward.
HER2	Human Epidermal growth factor Receptor 2 (HER2) is a protein found on the surface of certain cancer cells. Some breast cancers have a lot more HER2 receptors than others. In this case, the tumour is described as being HER2-positive.
Hospice	Institution specialising in care of patients with advanced cancer.
HPB	Hepato-Pancreato-Biliary.

GLOSSARY	
Immediate Risk	An Immediate Risk is an issue that is likely to result in harm to the patient or staff or have a direct impact on patient outcome and requires immediate action.
Immuno-compromised	Condition where the immune system is inhibited, either due to disease or the administration of immuno-suppressive drugs. Some drugs, e.g. most chemotherapeutic agents, have immuno-suppression as a side effect.
Intrathecal Chemotherapy	Chemotherapy administered via spinal injection. Subject to enhanced clinical governance arrangements due to historical problems.
IOG	Improving Outcome Guidance – guidance drawn from an evidence base to indicate how services should be organised to improve clinical outcomes.
ITU	Intensive Therapy Unit.
IV	Internal Validation (IV) is the process by which the Trust or Network uses its own governance processes to assure the accuracy of its self assessment of compliance against the National Cancer Peer Review measures.
Linac	Colloquial name for a Linear accelerator - major capital equipment used to generate radiation used in external beam radiotherapy.
LIT	Local Implementation Team.
Locality	Sub unit of organisation of a cancer network. Usually consists of an NHS (Hospital) Trust and the Primary Care Trusts within that trusts patient catchment area, although other arrangements are possible.
LUCADA	National Lung Cancer Data Audit Project.
Lymphoedema	Swelling due to abnormal accumulation of lymph where lymph vessels are blocked, damaged or removed.
Malignant	Tumour that is invasive and destroys the tissue in which it originates.
Mammography	X-ray procedure for examining the breast. Used diagnostically and as a screening procedure to detect breast cancer.
MDT	Multi-disciplinary Team.
MDTM	Multi-disciplinary Team Meeting.
Minimum Data Set	A standard set of data items, concepts and definitions to enable the production of national and nationally comparable information. These data items will meet the needs of clinical audit, assist in the generation of National Performance Indicators and will allow outcome assessment.
Morbidity rates	Information relating to disease, expressed as a rate (for example number of cases per 1M population).
Mortality rates	The number of deaths in a given period and for a given size of population.
Mohs Surgery	Mohs surgery is microscopically controlled surgery used to treat common types of skin cancer. It is a precise surgical technique that is used to remove all parts of cancerous skin tumours, while preserving as much healthy tissue as possible.
MRI Scanner	Magnetic Resonance Imaging Scanner – also known as MR scanner. An imaging technique with particular value in certain clinical presentations.
NCAG	National Chemotherapy Advisory Group.

GLOSSARY	
NCEPOD	National Confidential Enquiry into Peri Operative Death – A long running national audit of surgical practice and organisation designed to reduce preventable mortality.
NCIN	National Cancer Intelligence Network.
NCRN	National Cancer Research Network.
Neutropenia	Decrease in the number of neutrophils (a white blood cell). This occurs following chemotherapy.
NICE	National Institute for Health and Clinical Excellence.
NMC	Nursing and Midwifery Council (Regulatory body for registered nurses and midwives).
NSSG	Network Site Specific Group. A sub group of a cancer network which co-ordinates the care delivered across the network for a given tumour site (e.g. breast).
NRAG	National Radiotherapy Advisory Group.
OG	Oesophago-gastric.
Oncology	Study and practice of treating cancer. Can be divided into medical, surgical and radiation oncology.
PACS	Picture Archiving and Communications System – Computer system used to store and share digital radiographic images across a local or wide area network.
PALS	Patient Advice and Liaison Service.
Palliative	Medication, treatment or care that gives temporary relief of symptoms but does not cure disease.
PCT	A Primary Care Trust (PCT) is a local organisation that commissions services from Hospital Trusts, local authorities and other agencies that provide health and social care locally in order to meet the health needs of the local community.
PET	Scanner Positron Emission Tomography – a relatively new scanning technique that is particularly useful in certain clinical presentations.
PFI	Private Finance Initiative – a method for procuring new services, building or equipment that involves the private sector providing the required capital and the leasing the facility back to the NHS over a substantial period e.g. 25 years.
PPI	Patient and Public Involvement.
Radiotherapy	Treatment of disease using radiation to inhibit the disease process, especially the destruction of tumours. Radiation may come from an external beam focused on the tumour or small quantities of radioactive material may be inserted directly into the tumour.
RAG	A rating system that uses the colours of traffic lights; Red, Amber, Green.
RPLND	Retro-peritoneal lymph node dissection.
Serious Concern	A Serious Concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or outcome of patient care and requires urgent action to resolve.
SIF	Service Improvement Facilitator.
SIL	Service Improvement Lead, part of the core membership of a cancer network.
SHA	Strategic Health Authority.

GLOSSARY	
SHO	Senior House Officer.
SLA	Service Level Agreement.
SMDT	Specialist Multi-Disciplinary Team.
SNB/SLNB	Sentinel Node Biopsy/Sentinel Lymph Node Biopsy.
SpR	Specialist Registrar.
Supranetwork	Specialised services for rarer cancers provided by a group of networks from whom the multi-disciplinary expertise is drawn.
TRUS	Trans Rectal Ultrasound – an imaging technique of value in urology.
Tumour	Abnormal swelling or lump. A tumour may be malignant (when it is cancer) or benign.
Upper GI	Upper Gastro-Intestinal.
Workforce Development Confederation	Local bodies charged with the following responsibilities.Increasing workforce numbers (particularly consultants and GPs) to meet NHS Plan workforce and service delivery targets.Implementing national policies and local activity to make the NHS a model employer.Modernising processes and roles and the development of skill mix to increase productivity and capacity.Modernising learning and personal development.
WTE	Whole Time Equivalent.
ZAG	Zonal Advisory Group.

Cancer Peer Review Report
3 Counties Cancer Network

Central Zone Peer Review Team

July 2010

NHS

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