NHS

National Cancer Peer Review Programme 2009-2010

Cancer Peer Review Report

Lancashire & South Cumbria Cancer Network

North Zone Peer Review Team

July 2010

DH INFORMATION READER BOX	
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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.

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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	08-2F-3 - Spec. Pancreatic	08-2F-4 - Pancreatic / Liver	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
Blackpool													
Blackpool, Fylde And Wyre Hospitals	80G	81A	70		76				69		47		
Central Lancashire													
Lancashire Teaching Hospitals	75G	75A		67								66	
LSCCN Specialist UGI						78							
LSCCN Specialist Urology										71			
East Lancashire													
East Lancashire Hospitals	79R	94A	55		79		95	56	80		54		
Morecambe Bay													
Morecambe Bay Hospitals	75G	74G	55		61				76		39		
Blackburn With Darwen PCT													60
Blackpool PCT													20
Central Lancashire PCT													100
East Lancashire Teaching PCT													80
North Lancashire Teaching PCT													100

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
LSCCN	100A	100G	100	86	71	82	93A	100G	90	100	100	69	
LSCCN - HPB				71						100			
Blackpool													
Central Lancashire													0
East Lancashire													
Morecambe Bay													

3.2 Network Report

3.2.1 Contextual Information

The Lancashire and South Cumbria Cancer Network (LSCCN) was formed in March 2001 and links together the organisations that provide care for cancer patients in the areas of Barrow-in-Furness, Blackburn, Blackpool, Burnley, Chorley, Fylde, Kendal, Lancaster, Morecambe, Preston, South Ribble, Ulverston and Wyre.

The network covers a population of 1.6 million people and encompasses six Primary Care Trusts, four Acute Hospital Trusts and seven hospices:

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Trust
East Lancashire Hospitals NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust

Blackburn with Darwen PCT
Blackpool PCT
Central Lancashire PCT
East Lancashire PCT
North Lancashire PCT
Cumbria PCT

Specialist services are provided for skin, urology, upper GI and gynaecology and are hosted at Lancs Teaching Hospital with HPB at East Lancs.

3.2.2 Executive Summary

The 2009/10 CPR (Cancer Peer Review) Programme comprised targeted peer review of Gynaecology, Urology, Upper GI, HPB MDTs (Multidisciplinary Teams) and all Skin Cancer MDTs, including Community Skin Cancer Services. The NSSGs (Network Site Specific Groups) for these topics were also peer reviewed. External Verification was undertaken by the Zonal Team for all Breast and Lung MDTs and NSSGs, in order to determine the robustness of internal validation and to identify which teams should be subject to peer review during the 2010/11 cycle of visits.

A robust peer review visit programme has assisted the Network to make significant progress with regard to implementing IOG (Improving Outcomes Guidance) compliant services for Gynaecology, Urology and Upper GI

Cancer and reviewers were impressed with the evolving Skin Cancer teams and PCTs that are in the process of establishing fully constituted and functioning MDTs/Community Services.

The deadline for implementation of the Skin Cancer IOG was December 2009 and therefore most of the services, both acute and community were still in the development stage. All referring PCTs were reviewed alongside their associate MDTs to determine whether network guidelines were agreed and being adhered to and also if there were appropriate governance arrangements in place or being developed. Models of community Skin Cancer services were at varying stages of development and peer review provided an opportunity to discuss the different models and how they could be implemented to ensure safe quality care.

All the teams reviewed are supported by NSSGs that demonstrated commitment to developing high quality care for all patients through robust guidelines, protocols and pathways that reflect evidence based/best practice, although there were instances where full participation from partner organisations in NSSG meetings could be better.

A key theme arising from the reviews focused on the complex geography that makes it difficult to ensure equitable care/treatment across the network including the provision of local chemotherapy and also CNS (Clinical Nurse Specialists) support.

Gynaecology NSSG

The NSSG gynaecology guidance states that all cancer patients (except ovary /peritoneum RMI less than 200) should be discussed by the Specialist MDT. It was agreed that this does not happen in all cases therefore the NSSG need to decide if they continue to have local MDTs (with oncology input) or change to diagnostic centres as appropriate.

The NSSG has no assurance arrangements to confirm compliance with referral and clinical guidelines due to the lack of data collection across the units.

Upper GI NSSG

A centralised surgical service has recently opened at Preston, when responsibility for hosting the MDT transferred from Morecambe Bay to Central Lancs. There is generally good organisation with more outreach than is ideal, but with sound pairing arrangements. The transition from three trusts into one central team has been a huge achievement in bringing a centralised Upper GI service together; however, reviewers were concerned that commissioners were slow to respond to lack of Upper GI IOG compliance for this network.

HPB NSSG

At 1.6 million the population of this network is too low to support a specialist pancreatic service, although it was commissioned through the Specialist Commissioning Group in response to lack of movement by GMCCN to designate a single site for HPB cancer services.

The NSSG have developed an effective network wide service that is coordinated and patient centred, however, attendance at NSSG meetings is low and is not representative of the partner organisations.

Urology NSSG

The significant improvement in implementing the IOG action plan was commended and reviewers were satisfied that most patients are cared for in accordance with network and supranetwork guidelines, but noted the supranetwork testicular guidelines were still not agreed by the other two Networks. The NSSG has endeavoured to resolve this and as an interim measure are using local guidelines across the Network. It was noted that this had a disproportionate impact on compliance for the group.

Skin NSSG

The NSSG was established in 2006 and publication of the peer review measures has been a strong impetus for NSSG and MDT development. A conventional network model has been established with a single specialist team at Preston and local teams in each of the other Trusts.

Although members did not highlight difficulties in obtaining radiotherapy input for the Specialist MDT, the deficit of provision in both medical and clinical oncology across the network was recognised. In addition the lack of clinical oncology input at local level was thought to influence the quality of MDT discussion.

3.2.3 IOG Progress

The Network has been slow to implement IOGs in a number of cancer sites and has welcomed the support from CPR in their efforts to do so. Competing claims of the Trusts in the network, the geographical distribution and the need for stronger commissioning have all contributed to these delays.

Upper GI, Gynaecology, haematology and skin are IOG compliant. HPB has NCAT (National Cancer Action Teams) approval, but is below the 2 million population; Urology comprises a specialist team, but there are 2 operating sites which is NCAT approved and head and neck reconfiguration, although agreed in principle, is still not signed up to by all localities.

3.2.4 Good Practice

Many examples of good practice were identified by reviewers and are recorded in the individual reports. The following are some of the highlights.

Gynaecology NSSG

Good practice was highlighted in pathology and radiology, which is centrally reviewed ensuring consistency of reporting. The introduction of laparoscopic services at the centre has reduced length of stay for patients and links with the Merseyside and Cheshire Cancer Network have resulted in provision of trachelectomy and fertility advice. It was also pleasing to see increased recruitment into clinical trials across the network.

Upper GI NSSG

Reviewers highlighted good practice, including the extensive audit programme; the development of network-wide patient information in collaboration with patients; the UGI Nurse Forum which has been instrumental in establishing coordinated referral pathways with the local UGI teams. Patient involvement in the UGI surgical unit development, in terms of facilities for patients and their families, was very impressive.

HPB NSSG

There is an extensive audit programme and reviewers also commended the development of network-wide patient information in collaboration with patients and the UGI Nurse Forum.

Urology NSSG

Reviewers were impressed with the huge increase in recruitment to clinical trials and the enthusiasm of the teams involved. User input is well integrated into NSSG working and the Group has supported the expansion of patient support groups and has also been active in health promotion/education activity around testicular and bladder cancer.

Skin NSSG

Reviewers noted the involvement of Plastic and ENT surgeons in both skin and head and neck MDTs in Preston, which facilitates optimal management of patients with skin cancer.

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

Gynaecology NSSG

There were two main issues raised, firstly an immediate risk regarding the lack of confidence in certain elements of Specialist Gynaecology MDT working from some localities, regarding communications and quality of care, which was compromising configuration plans and service development. Interim measures were taken to safeguard patient safety and quality of care pending an external review. The Zonal Team is pleased to report that action has been taken to resolve the risk and restore confidence in the service.

Secondly, reviewers expressed a serious concern about the excessive CNS workload across the network, who are working in isolation with no cover to support consistent quality care for all patients. Subsequent correspondence in the form of an action plan provided assurance that a workload analysis would be undertaken. In addition a structured approach to their personal and professional development is to be developed across the network.

Upper GI NSSG

East Lancashire Hospital Trust were continuing to undertake complex cancer surgery despite network agreed reconfiguration and this was raised as an immediate risk. The issue was raised with East Lancashire Hospital Trust and has since been resolved.

Urology NSSG

An immediate risk was raised regarding the potential for radical cystectomies to be undertaken outside the designated sites. Immediate steps were taken to review the guidelines and ensure all complex urology cases are referred into the Specialist MDT for discussion and treatment planning and surgery carried out in the designated sites.

Skin NSSG

A serious concern was raised regarding the inadequate provision of appropriately qualified and supported skin cancer CNSs across the network. An action plan was subsequently received that provided reassurance that a review of their role and responsibilities would be undertaken.

External Verification

No immediate risks or serious concerns were identified in either breast or lung NSSGs during the external validation process.

3.2.6 IV Process

Desk Top review undertaken with the following panel members:

Patient Representative (Chair of Panel)

Lead Cancer Nurse, Blackpool, Fylde and Wyre Hospitals Trust

Network Information Lead

Network Director

Network Admin Manager

A commissioner representative was due to attend but due to unforseen circumstances could not attend on the day.

The Zonal Team recommended that the panel should include a network medical director or NSSG chair from another tumour group for future reviews.

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	100%			Gynae Network Board Report
08-1A-2f	Upper GI Network Board	86%			Upper GI Network Board Report
08-1A-2f	Upper GI Network Board (LSCCN - HPB)	71%			Upper GI Network Board (LSCCN - HPB) Report
08-1A-2g	Urology Network Board	71%			Urology Network Board Report
08-1A-2j	Skin Network Board	82%			Skin Network Board Report
08-1C-1b	Breast NSSG		Amber	93%	Breast NSSG Report
08-1C-1c	Lung NSSG		Green	100%	Lung NSSG Report
08-1C-1e	Gynae NSSG	90%			Gynae NSSG Report
08-1C-1f	Upper GI NSSG	100%			Upper GI NSSG Report
08-1C-1f	Upper GI NSSG (LSCCN - HPB)	100%			Upper GI NSSG (LSCCN - HPB) Report
08-1C-1g	Urology NSSG	100%			Urology NSSG Report
08-1C-1j	Skin NSSG	69%			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 Blackpool Locality

4.1.1 BLACKPOOL, FYLDE AND WYRE HOSPITALS NHS FOUNDATION TRUST

4.1.1.1 Trust Report

Contextual Information

The Fylde Cancer Unit comprises Blackpool, Fylde and Wyre Hospitals NHS Trust together with two Primary Care Trusts of Blackpool and North Lancashire. Voluntary services are provided via Trinity Hospice in Fylde, Croston House at Garstang and Rosemere Cancer Foundation based in Preston.

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust provides acute, general medical and elderly services for a resident population of approximately 328,000 and in excess of 16 million annual visitors to the resort. The services are delivered from several sites but for cancer patients from Blackpool Victoria Hospital.

Victoria Hospital is a large acute hospital that treats more than 73,000 day-case and in-patients and more than 177,000 outpatients from across Blackpool, Fylde and Wyre every year. The A and E Department is one of the busiest in the country.

In 2007/08 the Healthcare Commission rated the Trust fair for the quality of services and excellent for use of resources. The Trust fully met both the core standards and existing national targets but was weak on the new national targets.

The following services were reviewed during the 2009/10 review programme.

External peer Review

Local Gynaecology MDT (Multidisciplinary Team)

Local UGI MDT

Local Urology MDT

Local Skin MDT

PCT Community Skin

External Verification of Internally Validated Self assessments

Breast MDT

Lung MDT

Trust Executive Summary

The Locality has many strengths including progress in Going Further on Cancer Waits; robust cancer data and good levels of recruitment into clinical trials. Oncology trackers for patients undergoing subsequent cancer treatments have been appointed, along with dedicated cancer audit facilitators to undertake LuCaDa (Lung Cancer Database), NBOCAP (National Bowel Cancer Audit Programme), NOCGA and DAHNO (Data for Head and Neck Oncology) cancer audits.

Challenges included implementation of recommendations from the NCAG (National Chemotherapy Advisory Group) report in terms of acute oncology and also developing supportive and palliative care services in line with NICE (National Institute for Clinical Excellence) guidance. There are pressures around achieving the 62 ww target and the breast symptomatic 2ww target (from January 2010).

Key points from each of the teams reviewed are highlighted below and include just some of the many examples of good practice commended by reviewers.

Local Gynaecology MDT

This is a cohesive team with well documented policies and well established and effective leadership. Good management support from the directorate enhances service development, along with effective support from histology and radiology that influences MDT decision making. The review team were very impressed with the excellent, well detailed operational policy which covers all aspects of care.

Good practice included a CNS (Clinical Nurse Specialists) led follow up clinic to improve patient communication post MDT/investigations. Also, the pathologist sends complex cases to the specialist team for review, before issuing a report, so that the patient can be listed for the next available Specialist MDT meeting and all significant changes to radiology/pathology reports are recorded electronically on the local system.

There were no immediate risks or serious concerns raised.

Local Upper GI MDT

A strong MDT that is pragmatic, flexible and driven to deliver an excellent service. Good practice included the effective infrastructure to support patients through the pathway with excellent CNS input for both MDT working and for patients; good data recording and communication of MDT discussion and outcomes and the monthly meeting with gastroenterologists and histopathologists to discuss interesting cases, those of concern and also high grade dysplasia.

There were no immediate risks, but reviewers were concerned about the lack of the core histopathologist's attendance at MDT meetings which led to a complex system for double reporting and seeking a 2nd opinion. This issue has since been resolved.

Local Urology MDT

The team is well established and are cohesive in their thinking and there is strong support for the MDT from the core member radiologist. Histopathology attendance has now improved at the MDT but there is a shortfall in histopathology within the Trust which reflects on MDT cover.

Reviewers were impressed with the patient discovery interviews, which give extremely detailed feedback to the team that inform service development/improvement.

Three immediate risks were raised regarding complex Urology cancer cases as follows. Radical cystectomies still being undertaken in Blackpool which is not a designated site for complex Urology surgery. In addition one consultant was providing an in-reach service in the host Trust, but was not operating on the requisite number of radical cystectomies which must be a minimum of six per year. Finally there was a lack of assurance that all complex Urology cases were referred to the Specialist MDT for discussion and treatment planning decisions. The Zonal team is pleased to report that all three risks were addressed promptly.

Local Skin MDT

This is an evolving MDT whose members, through developing MDT working, have improved the quality of care for patients, e.g.100% of patients fulfilling the cancer two week wait pathway criteria.

Good practice includes the MDT awareness of all BCC histology, which provides a comprehensive picture of skin cancer surgical activity in the locality; several GPs have been stopped from excising skin cancer lesions using this alert system. The correlation of dermoscopy and histology appearances have been appreciated by the clinicians involved.

No immediate risks were raised, but reviewers were seriously concerned about the lack of a skin cancer CNS, which has a serious impact on the quality of care/support for patients, IOG (Improving Outcomes Guidance) compliance and future service development. Following initial rejection of a business case seeking funding for this post, verbal agreement was given at the feedback session to ensure it would be accepted. The Zonal Team subsequently received a written statement confirming this will happen.

Blackpool PCT and North Lancs PCT were reviewed alongside the MDTs to determine whether network guidelines were agreed and being adhered to and also if there were appropriate governance arrangements in place or being developed. Models of community skin cancer services were at varying stages of development and peer review provided an opportunity to discuss the different models and how they could be implemented to ensure safe quality care.

Good practice included the PCT audits of primary care excisions of skin cancers and screening and prevention initiatives that are having a positive impact on the local population.

No immediate risks or serious concerns were raised at PCT level.

Breast and Lung MDTs were externally verified which resulted in a green rating for Breast and amber for Lung; this was because a serious concern was raised by the Zonal Team relating to lack of palliative care attendance at MDT meetings. The Lung MDT was therefore selected for external peer review.

IV Process

Desk Top Assessments were undertaken for the internal validation process in 2009/10. The panels consisted of the Cancer Service Improvement Facilitator, Lead Cancer Nurse, Patient representative, Lancashire and South Cumbria Cancer Network representative, Commissioners and divisional representation from within the Trust. The learning from the process has demonstrated that the methodology used for the next round of internal validation panels will be that of a small panel review due to the need for MDT members to be included to facilitate discussion and clarify key issues.

4.1.1.2 Summary of Compliance for MDT Measures

Blackpool, Fylde And Wyre Hospitals MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	80%	Breast Report
08-2C-1	Lung MDT		Amber	81%	Lung Report
08-2E-1	Local Gynae MDT	70%			Local Gynae Report
08-2F-1	Local Upper GI MDT	76%			Local Upper GI Report
08-2G-1	Local Urology MDT	69%			Local Urology Report
08-2J-1	Local Skin MDT	47%			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 Central Lancashire Locality

4.2.1 LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

4.2.1.1 Trust Report

Contextual Information

Lancashire Teaching Hospitals NHS Foundation Trust comprises Chorley and South Ribble Hospital and Royal Preston Hospital. The Rosemere Cancer Centre which, provides Radiotherapy and Chemotherapy treatment, is located on the Royal Preston campus. The Central Lancashire locality includes the Lancashire Teaching Hospitals, Central Lancashire Primary Care Trust, St Catherine's Hospice, Vine House and Tender Nursing Care.

The catchment population for the locality is around 449,000

In 2007/08 the Healthcare Commission rated the Trust good for the quality of services and excellent for use of resources. The Trust fully met the core standards and almost met the existing national targets and was good on the new national targets.

During the 2009/10 cycle the following services were externally peer reviewed.

Specialist Gynaecology MDT (Multidisciplinary Team)

Specialist Upper GI MDT

Specialist Urology MDT

Specialist Skin MDT

PCT Skin.

The Breast and Lung teams were subject to external verification following internal validation of self assessments.

Trust Executive Summary

The Trust has made significant progress in resolving issues raised during peer review including implementation of the key worker policy trust wide, along with the policy for GP notification of a serious diagnosis. In addition a lead cancer nurse is now appointed to the trust to support all CNSs (Clinical Nurse Specialists) and the head of surgical nursing has also been appointed to support all nursing staff within the surgical directorate.

Key points from each of the teams reviewed are highlighted below and include just some of the many examples of good practice commended by reviewers.

Specialist Gynaecology MDT

This is a long-standing cohesive MDT that functions well at a local level, but has not fully implemented the IOG (Improving Outcomes Guidance) Network plan regarding centralisation of complex surgery. Documented concerns from two of the three referring Trusts led to a breakdown in relationships with those Local MDTs and this situation constituted a significant risk to patient care.

Good practice included the development of laparoscopic surgery; patient involvement to inform service improvement and the development of a link system between ward and clinic nurses to enhance continuity of support for patients and carers..

An immediate risk was raised regarding the lack of confidence in certain elements of Specialist Gynaecology MDT working by some localities. The reviewers concerns centred around communications and quality of care that were felt to be compromising configuration plans and service development. The immediate risk was also raised with the Network to ensure a comprehensive, authoritative review would be undertaken to resolve the issues. Action was taken immediately to address any immediate risk to patient safety and an external review was undertaken. The issues have since been resolved.

Specialist Upper GI

The Team continues to make progress with the development of a well balanced group of committed members with the expertise required from a specialist team.

Good practice included the clinic following the MDT meeting to inform patients of the outcome of the MDT discussion and the CNSs have pioneered the establishment of a local upper GI support group which has facilitated the implementation of an excellent patient experience survey and high quality patient information.

An immediate risk was raised regarding the low number of cases per specialist Upper GI surgeon in the host Trust and reviewers also urged the Team not to be over-dependant on in-reach surgeons which would result in further dilution of cases per surgeon. Steps have been taken to monitor the situation by both the Trust and the Network.

Reviewers also raised serious concerns relating to the need for robust clinical governance arrangements to be developed with the Local MDTs to ensure all complex cancer cases are referred to the Specialist MDT for discussion and treatment planning. Regular audits should also be undertaken to ensure complex surgery is carried out in the designated host Trust. The low attendance of the Gastroenterologist at MDT meetings, with no cover arrangements in place, has had an impact on the quality of MDT discussion and finally there was an urgent need to introduce endoscopic ultrasound into the diagnostic pathway for this group of patients.

Correspondence from the Trust confirmed that action was being taken to resolve the serious concerns and progress is being monitored by the Network.

Specialsit Urology MDT

This continues to be a well led, cohesive team with evidence of significant major progress since the last review. Although technically not compliant, the two site surgery has been agreed by the NCAT (National Cancer Action Team) and communication and coordination across the two sites is good.

Good practice included evidence of huge improvement in the numbers recruited to clinical trials by centralising the process and the development of patient centred care is evident through preparation of user friendly patient summary record.

Serious Concerns were raised by reviewers relating to the lack of assurance that all complex urology cases were being referred to the Specialist MDT for discussion and treatment planning decisions. There was also evidence that a small number of radical cystectomies were being undertaken in Blackpool. This issue was also raised with the Blackpool Trust. It was confirmed that all all complex surgery would take place in the designated sites with immediate effect and that robust clinical governance arrangements that are subject to regular audit would be developed with the referring Trusts.

Specialist Skin MDT

This is a well led and cohesive team whose members are enthusiastic about the service provided to both the locality and other units in the Network.

Good practice included the 'Direct listing' from Dermatology to Plastic Surgery; the improvement in the selection of patient for trials and the Sentinel Lymph Node Biopsy service.

A serious concern was raised concerning the five surgeons performing block dissections all of whom were undertaking less than the required 15 per year. The number of surgeons involved in this procedure was subsequently reduced to 3.

Central Lancs PCT:

The PCT has a well organised primary skin care service with a GPwSI (GPs with Special Interests) working to agreed SLAs (Service Level Agreements). These contain well defined guidelines for practice, including the excision of level 1 and 2 Skin Cancer lesions.

Good practice included the joint support initiatives with financial and psychological services and the specific patient information from GPs at the point of referral.

There were no immediate risks or serious concerns identified.

Both the Breast and Lung MDTs were externally verified following internal validation of self assessments.

Breast RAG rating was Green, but this team was identified for an external visit in 2010/11 due to the lack of provision for all newly diagnosed patients to be reviewed by the MDT prior to surgery for discussion of treatment options/treatment plan. The Zonal Team was impressed that the risk was highlighted through the internal quality assurance process and steps taken to try to resolve the issue.

Lung RAG rating was Amber, due to serious concerns about the lack of attendance at MDT meetings by the Thoracic Surgeon and Palliative Care CNS and also the lack of a cytopathologist as a core MDT member. For these reasons the team was also chosen for external review in 2010/11.

IV Process

2009/10 Internal Validations were undertaken by a panel of multidisciplinary professionals both internal and external to the Trust. Patient representatives were present on each panel and contributed to the discussions. The panel took a lead from the actual peer review visiting teams and spent a couple of hours reviewing evidence against the measures. Following this they met with the team to discuss their evidence. The panel spent an hour following this writing up the report.

4.2.1.2 Summary of Compliance for MDT Measures

Lancashire Teaching Hospitals MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	75%	Breast Report
08-2C-1	Lung MDT		Amber	75%	Lung Report
08-2E-2	Specialist Gynae MDT	67%			Specialist Gynae Report
08-2J-2	Spec Skin MDT	66%			Spec Skin Report

LSCCN Specialist UGI MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2F-2	Specialist Upper GI MDT	78%			Specialist Upper GI Report

LSCCN Specialist Urology MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2G-2	Specialist Urology MDT	71%			Specialist 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.

4.2.2 Summary of Compliance for Central Lancashire 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 East Lancashire Locality

4.3.1 EAST LANCASHIRE HOSPITALS NHS TRUST

4.3.1.1 Trust Report

Contextual Information

The East Lancashire Cancer Unit covers over 500,000 people and consists of The Royal Blackburn Hospital, Burnley General Hospital, Pendle Community Hospital, Rossendale Hospital and Accrington Victoria Hospital together with two Primary Care Trusts, East Lancashire and Blackburn with Darwen. The Locality is served by three hospices and each hospice offers an early diagnosis programme. The Rosemere Cancer Foundation based in Preston offers radiotherapy for patients. The Royal Blackburn Hospital opened in July 2006.

In 2007/08 the Healthcare Commission rated the Trust excellent for the quality of services and good for use of resources. The Trust fully met both the core standards and existing national targets and was excellent on the new national targets.

The following teams were externally peer reviewed:
Local Gynaecology MDT (Multidisciplinary Team)
Local UGI MDT
Specialist HPB MDT
Local Urology MDT
Local Skin MDT
PCT Skin.

Breast and Lung MDTs were subject to external verification following internal validation of self assessments.

Trust Executive Summary

Key points from each of the teams reviewed are highlighted below and include just some of the many examples of good practice commended by reviewers.

Gynaecology MDT

This is a strong Local Gynaecology MDT with reliable diagnostic systems to support treatment planning discussion. Considerable improvement since the last peer review was noted by reviewers specifically in the organisation and provision of treatment/care. Previously there were two Gynaecology MDTs that have now merged, incorporating Blackburn and Burnley into a single fully integrated team. The use of the Somerset Cancer Register and video-conferencing have helped to develop a fully functioning MDT. Reviewers also noted the good internal referral process between Gynaecologists and effective working relationships with Colorectal surgeons to enhance continuity and consistency of care/treatment.

An immediate risk was raised regarding lack of confidence in certain aspects of the Specialist MDT, which was causing problems with implementation of IOG (Improving Outcomes Guidance).This issue was raised with the Network to ensure a comprehensive, authoritative review was undertaken as a matter of urgency. Confirmation was subsequently received that an interim action plan had been implemented, ensuring that all complex surgery for ovary, cervix, vaginal, vulval and locally advanced endometrial cancer would be undertaken by a specialist team. An external review was also carried out and the situation has been resolved.

A serious concern was also identified relating to the the health and well being of the single handed Gynae CNS (Clinical Nurse Specialist), who had returned to work on a phased basis following a three month period of absence. There was evidence to suggest that the Gynae CNS from the Specialist Team was providing support, but to the detriment of her own workload. Assurance was received that additional support and cover would be provided to ensure all patients receive a consistent level of care and support and also that the CNS would have a personal and professional development plan, alongside a programme of clinical supervision.

UGI MDT

There was evidence of a strong and enthusiastic team whose members are passionate about providing comprehensive patient centred care. However the Local MDT is not compliant with the core membership attendance at meetings and relationships with the Specialist MDT are poor.

Good practice included the EUS service including cytology presence at the procedures requiring FNA and the impressive level of support from the Nutritional Team.

An immediate risk was raised by reviewers who were very concerned that surgical care had not transferred to the designated specialist host site as per IOG Network Implementation Plan. Complex Upper GI surgery continued to be undertaken in the Trust and the Local MDT had no action plan for the transfer or evidence of an anticipated start date. During the feedback session it was announced that complex surgical cases would transfer immediately to the Specialist Team in Preston. Written confirmation was recived to show that this had happened.

Specialist HPB MDT

This is an enthusiastic and cohesive team with strong clinical leadership and excellent support from a network of CNSs and from imaging and oncology.The Team is established and functioning in line with commissioner requirements and reviewers noted that pancreatic cancer resection rates have improved since centralisation of pancreatic cancer services. The population at 1.6 million is below that required within IOG guidance; however, the suggested pancreatic cancer resection rates of between 10 - 15% are being achieved. Reviewers commended the in house patient information and the joint educational meetings that are held with other specialist HPB teams.

There were no immediate risks or serious concerns raised.

Urology MDT

The use of video conferencing for MDTs facilitates increased participation by members of this local team.

There was evidence of good clinical guidelines for most areas of the service but problems remain for patients referred to the Supra Regional site. The Clinical Oncologist is very clear about the pathways but the Supra Regional pathway for testicular cancer has not been formally agreed by the two Networks involved.

Good practice included double reporting of all new urological cancers and the testicular cancer awareness initiative (Talking Balls and Small Steps for the Young Asian Community) was commended

There were no immediate risks or serious concerns.

Skin MDT

This was a relatively newly formed MDT, with strong leadership and the majority of required core members. Strong cancer management leadership and direction from a newly established management team was evident, which should have a positive impact on engagement with the MDT to help realise their development plans.

Good practice included rapid reporting enableing prompt management decisions and the patient education package for transplant patients including a video on sun protection advice and self-examination tips. Reviewers were also impressed with the educational events for GPs which reinforce the need for adherence to referral guidelines.

No immediate risks or serious concerns were identified.

Blackburn with Darwen PCT:

There was good evidence of local community skin cancer services being developed. Documentation demonstrated robust clinical governance systems and integrated planning processes between the Acute Trust and PCT, including performance management arrangements.

Good Practice included the clear and concise documentation from the PCT regarding SLAs (Service Level Agreements) and clinical governance arrangements and the good alert systems for identifying non-accredited GPs excising skin cancer lesions in the community.

No immediate risks or serious concerns were raised.

East Lancs PCT

A model 1 service is in place for the PCT and documentation demonstrated robust clinical governance systems and integrated planning processes between the acute trust and PCT.

Reviewers commended the integrated approach to developing services and the effective alert systems for identifying non-accredited GPs excising skin cancer lesions in the community.

No immediate risks or serious concerns were identified.

The Breast and Lung MDTs were subject to external verification following internal validation of self assessment.

Breast RAG Rating was Red, due to an immediate risk relating to no evidence of attendance at the MDT meetings for 2 of the surgeons. This team will be externally reviewed during the 2010/11 cycle.

Lung RAG rating was Amber, due to serious concerns relating to lack of attendance at MDT meetings by the Pathologist and Thoracic Surgeon (or their cover).The Zonal Team noted that following the recent merger of the two Lung MDTs, there is an expectation that attendance at the meetings by the Histopathologist and Thoracic Surgeon will improve. This team will be externally reviewed during the 2010/11 cycle.

IV Process

The method used to validate the internal assessment of the Lung MDT was that of a panel review.
The first part was dedicated to reviewing the internal assessment matrix and supporting evidence. Listed below are the panel members present for this review:
Patient representatives
Senior cancer commissioner on behalf of East Lancs and Blackburn with Darwen PCT
Consultant Surgeon and Clinical Director - Cancer Services, ELHT
Business Manager, Cancer Services, ELHT
Lead Cancer Nurse - Chair
Representative - Lancashire and South Cumbria Cancer Network
The above panel members were joined by MDT colleagues for the second part of the meeting, when they were able to provide additional assurances and comment.

4.3.1.2 Summary of Compliance for MDT Measures

East Lancashire Hospitals MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Red	79%	Breast Report
08-2C-1	Lung MDT		Amber	94%	Lung Report
08-2E-1	Local Gynae MDT	55%			Local Gynae Report
08-2F-1	Local Upper GI MDT	79%			Local Upper GI Report
08-2F-3	Specialist Pancreatic MDT	95%			Specialist Pancreatic Report
08-2F-4	Pancreatic / Liver MDT	56%			Pancreatic / Liver Report
08-2G-1	Local Urology MDT	80%			Local Urology Report
08-2J-1	Local Skin MDT	54%			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.

4.4 Morecambe Bay Locality

4.4.1 UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS TRUST

4.4.1.1 Trust Report

Contextual Information

Morecambe Bay is a large Acute Trust, which serves a population of 310,000 within a geographical area of 1,000 square miles. The patient catchment area encompasses South Cumbria and North Lancashire. In addition, the area has 17 million visitors a year, mainly to the South Lakeland area.

The Trust has three main hospital sites, two of which provide full District General Hospital facilities at Furness General Hospital (Barrow in Furness) and the Royal Lancaster Infirmary (Lancaster), with a smaller unit at Westmorland General Hospital (Kendal). All clinical specialities are available across the Trust with tertiary services provided in Manchester, Blackpool and Preston.

In 2007/08 the Healthcare Commission rated the Trust good for both the quality of services and for use of resources. The Trust fully met the core standards and almost met the existing national targets and was good on the new national targets.

The following topics were externally peer reviewed;
Local Gynaecology MDT (Multidisciplinary Team)
Local UGI MDT
Local Skin MDT
PCT Skin.

Breast and Lung MDTs were subject to self assessment, internal validation and external verification.

Trust Executive Summary

Gynaecology MDT
Very good progress had been made by the Team since the last peer review visit in 2005 specifically with the merger of two MDTs and the development of excellent links with the Specialist Team. Members were beginning to form a cohesive unit focusing on effective working relationships and the development of agreed operational documents.

Many areas of good practice were identified including radiology participation in national audit on the imaging of endometrial cancer using MRI (Magnetic Resonance Imaging), the introduction of fast track clinics on two sites, interrogation of local IT systems to identify cancer patients and the effective use of video conferencing to support MDT working.

There were no immediate risks, but a serious concern was raised relating to the CNS (Clinical Nure Specialist) workload, which was excessive. The issue was raised in 2005 and therefore reviewers thought that it needed to be addressed as a matter of urgency to safeguard her health and well being and also ensure that all women receive consistent quality support service. Action was taken in a timely manner to resolve the issue.

Upper GI
The region has developed a single centre OG surgical site with good video conferencing facilities linking with local MDTs. Although the agreed model for HPB services is yet to be fully implemented, working with one surgical centre in the network is in operation.

Good Practice included the introduction of parallel clinics in oncology, medicine and surgery with CNS input; timely out patients appointments to discuss diagnosis and treatment plans and the CNS links with the Specialist Team.

There were no immediate risks or serious concerns identified.

Skin MDT
This is a newly formed team who had only one MDT meeting at the time of the review. There is basic core membership with some identified gaps in both the core and extended teams. The core nurse member has started

to develop the CNS role over and above her current role and responsibilities, which is less than ideal and in order to establish a fully functioning skin cancer MDT a capacity and demand study is required for medical, nursing, A and C and pathology staff. Robust methodology is also needed to help identify those skin cancer patients for discussion at the MDT.

Good practice included the two week wait skin cancer one-stop clinics supported by primary care clinicians. The core nurse member has very effective links with the NSSG (Network Site Specific Groups), which helps to develop the service through a partnership approach.

There were no immediate risks identified, but the lack of a skin cancer CNS, with the time and necessary experience to provide high quality care for skin cancer patients who need this specialist level of support, has serious implications for the quality of care/support for patients, IOG (Improving Outcome Guidance) compliance and future service development. There were plans in place to address the problem and subsequent correspondence assure the Zonal Team that an appointment would be made.

Blackpool PCT and North Lancs PCT were reviewed alongside the MDTs to determine whether network guidelines were agreed and being adhered to and also if there were appropriate governance arrangements in place or being developed. Models of community skin cancer services were at varying stages of development and peer review provided an opportunity to discuss the different models and how they could be implemented to ensure safe quality care.

Reviewers were impressed with the screening and prevention initiatives that are having an impact on the local population and also the PCT audit of primary care excisions of skin cancers.

No immediate risks or serious concerns were identified.

External Verification following Internal Validation of Self assessments

Breast and Lung MDTs were externally verified by the Zonal Team and rated 'green' with no immediate risks or serious concerns.

Internal Validation.

Urology was the only other team involved in internal validation.

IV Process

A table top review of Operational Policy, Annual Report and Work Programme was undertaken in conjunctionwith an additional MDT file of evidence and case note review. Panel views were fed back to the MDTs for comment and document amendment, prior to final agreement.

Panel Members:

Trust Lead Cancer Nurse

PCT Cancer Comisisoning Lead

PCT Quality Manager

Trust Cancer Service Improvment Facilitator.

The Zonal Team recommended that a lead clinician and patient representative should, in future, be involved in the process.

4.4.1.2 Summary of Compliance for MDT Measures

Morecambe Bay Hospitals MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	75%	Breast Report
08-2C-1	Lung MDT		Green	74%	Lung Report
08-2E-1	Local Gynae MDT	**55%**			Local Gynae Report
08-2F-1	Local Upper GI MDT	**61%**			Local Upper GI Report
08-2G-1	Local Urology MDT			76%	Local Urology Report
08-2J-1	Local Skin MDT	**39%**			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.

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
Blackburn With Darwen PCT	60%	Blackburn With Darwen PCT Report
Blackpool PCT	20%	Blackpool PCT Report
Central Lancashire PCT	100%	Central Lancashire PCT Report
East Lancashire Teaching PCT	80%	East Lancashire Teaching PCT Report
North Lancashire Teaching PCT	100%	North Lancashire Teaching 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.

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North Zone Peer Review Team

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