NHS

National Cancer Peer Review Programme 2009-2010

Cancer Peer Review Report

Avon, Somerset & Wiltshire Cancer Network

South Zone Peer Review Team

July 2010

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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	08-2G-1 - Local Urology MDT	08-2G-2 - Spec. Urology MDT	08-2G-3 - Testicular MDT	08-2G-4 - Penile MDT	08-2J-1 - Local Skin MDT	08-2J-2 - Spec Skin MDT	08-6A-1j - Skin for PCTs
North Bristol														
North Bristol	97G	90A							84		76		38	
RUH														
RUH	97G	84G		82	86			80				53		
Taunton														
Taunton	97G	94G		94	74			82				58		
UHB														
UHB	91G	80G		97G		86	81	82		84		61	22	
Weston														
Weston	89G	90G	85		91			93				72		
Yeovil														
Yeovil	86G	68A			89			87				50		
Bath And North East Somerset PCT														100
Bristol PCT														100
North Somerset PCT (aswcn)														100
Somerset PCT														40
South Gloucestershire PCT														100
Wiltshire PCT (aswcn)														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-1e - Gynae LOC Funct.	08-1D-1j - Skin Locality Msrs
ASWCN	67G	100G	100	100	88	76	93G	100G	100	100	100	60		
North Bristol													100	0
RUH														0
Taunton														100
UHB														0
Weston														0
Yeovil													100	0

3.2 Network Report

3.2.1 Contextual Information

Avon, Somerset and Wiltshire Cancer Network was established as one of the first cancer networks in the UK in 1997. It serves a population of approximately 2.1 million people living in the urban centres of Bristol and Bath, as well as the rural towns and villages in Somerset and Wiltshire. The network comprises the following organisations:

Acute Hospital Trusts:

North Bristol NHS Trust
Royal United Hospital Bath NHS Trust
Taunton and Somerset NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust
Yeovil District Hospital NHS Foundation Trust

Primary Care Trusts:

NHS Bath and North East Somerset
NHS Bristol
NHS North Somerset
NHS Somerset
NHS South Gloucestershire
NHS Wiltshire

In summary, the 2009/2010 annual peer review programme for the Avon, Somerset and Wiltshire Cancer Network included the following:

External Peer Review Visits:

Local and specialist MDTs for skin cancer, urology, upper gastro-intestinal and pancreatic cancers including the network site specific groups (NSSGs) for these tumour sites. Local diagnostic teams for gynaecological cancers were included.

External Verification of Internally Validated Self Assessments:

Breast and Lung MDTs and the NSSGs.

Internal Validation:

Some MDTs were subject to internal validation only. These included: local urology, upper gastro-intestinal and gynaecology MDTs, the specialist MDTs for gynaecology and the MDTs for penile and testicular cancers.

3.2.2 Executive Summary

The network management team is well established and the NSSGs are well supported by the team.

The local teams selected for review were visited between the 7th and 10th September 2009. The network visit took place on the 10th September when the skin, urology and upper gastro-intestinal NSSGs were reviewed.

A common theme to emerge across the NSSGs was that relationships with commissioners were at an early stage. There were plans to strengthen the links by having nominated PCT leads for NSSGs and PCT attendance at NSSG meetings. This should help ensure service developments are identified as network commissioning priorities and progressed through the appropriate mechanisms and planning cycles.

The reviews of the local and specialist skin MDTs and NSSG highlighted that network skin cancer services were at an early stage of development with further work required on ensuring IOG compliant patient pathways. In particular, the pathway for T-Cell Lymphoma patients was non compliant with the IOG and the MDT was not fully established with the result that patients were not benefiting from a fully functioning specialist MDT. There were also examples of inequitable service provision and access to services such as plastic surgery and sentinel node biopsy.

Good progress had been made on implementing the network agreed IOG plan for urology cancer services. However, the key issue to emerge from the review of the urology NSSG was that some patients were referred out of the network for radical cystectomy surgery which had not been ratified by the network or reflected in network guidelines. This was raised as a serious concern for the network to address in collaboration with the Peninsula Cancer Network.

The network has successfully formulated, agreed and implemented its IOG plan for the centralisation of upper gastro-intestinal and pancreatic cancer surgery and should be congratulated on this. The local and specialist teams work well together to provide patient centred, quality care with speedy and responsive diagnosis and treatment of patients along the patient pathway. The NSSG has adopted a collaborative and inclusive approach, evident from the practice of rotating the NSSG meetings at each hospital site in the network to ensure there is good attendance and representation. The NSSG is leading the development of a national Map of Medicine Pathway for upper gastrointestinal cancer.

The breast and lung NSSGs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating. The lung NSSG achieved 100% compliance with the measures which is to be commended.

3.2.3 IOG Progress

The most recent update on progress with implementation of IOGs issued by the National Cancer Action Team in May 2010 suggests that good progress has been made in reconfiguring and centralising cancer services for urology and upper gastro-intestinal cancers. In particular, the network is to be commended on the successful reconfiguration of upper gastro-intestinal and pancreatic cancer services. Other services would benefit from sharing the learning from this reconfiguration.

Network skin cancer services were at an early stage of development at the time of the review with further work required on ensuring IOG compliant patient pathways.

Despite implementation of IOG plans for urology, referral guidelines between local and specialist teams need to reflect actual practice and should be agreed by the NSSGs and networks concerned to ensure patient flows are dictated by choice rather than location.

Considerable challenges exist to reconfiguring services for gynaecological cancers which has had a negative impact on progress. This looks set to continue to be a significant challenge for the network in the coming year.

3.2.4 Good Practice

The external peer review highlighted many examples of good practice including the development of innovative practices such as minimally invasive surgery and a high level of recruitment to clinical trials.

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

A serious concern was raised for the urology NSSG regarding the referral of some patients for radical cystectomy surgery outside of the network, without ratification and approval by the network.

The network is working in collaboration with the Peninsula Cancer Network to monitor the number of referrals and to ensure this referral pathway is reflected accordingly within both networks' guidelines.

The network also has a key role to play in supporting its individual Trusts and MDTs to address the serious concerns raised during the review and to ensure progress is monitored.

3.2.6 IV Process

The network internal validation process for the NSSGs involved panel reviews of the NSSGs' self assessments of compliance and supporting evidence. The chair of the NSSG was present at the panel review. The panel comprised a range of members including the following:

Network Director;
Network Nurse Director;
Associate Director Strategic Development (PCT representative)
Commissioner (PCT representative)
Network Project Consultant;
Network Associate Medical Director;
Chair of Network User Group;
Cancer Services Manager;
Patient Representative.

The final internal validation report was agreed and produced by the panel.

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		Green	67%	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	100%			Upper GI Network Board Report
08-1A-2g	Urology Network Board	88%			Urology Network Board Report
08-1A-2j	Skin Network Board	76%			Skin Network Board Report
08-1C-1b	Breast NSSG		Green	93%	Breast NSSG Report
08-1C-1c	Lung NSSG		Green	100%	Lung NSSG Report
08-1C-1e	Gynae NSSG			100%	Gynae NSSG Report
08-1C-1f	Upper GI NSSG	100%			Upper GI NSSG Report
08-1C-1g	Urology NSSG	100%			Urology NSSG Report
08-1C-1j	Skin NSSG	60%			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 North Bristol Locality

4.1.1 NORTH BRISTOL NHS TRUST

4.1.1.1 Trust Report

Contextual Information

North Bristol NHS Trust is a specialist acute trust providing hospital based medical and surgical services to a local population of approximately 500, 000 people living in North Bristol, South Gloucestershire and North Somerset. The majority of hospital care is provided from two main sites in Frenchay and Southmead. The Trust is a regional centre for neurosciences, burns and plastic surgery, orthopaedics, pathology and renal services for people living in the former Avon area, Gloucestershire, Somerset and Wiltshire and also throughout the South West peninsula. Its international reputation also attracts referrals from all over the UK and overseas increasing its catchment population to 2 million.

The 2009/2010 annual peer review programme for the North Bristol NHS Trust is outlined below:

External Peer Review Visits:

Specialist urology and skin cancer MDTs and the local diagnostic team for gyneaecological cancers.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The MDT for penile cancer was subject to an internal validation only.

Trust Executive Summary

The local teams selected for external review were visited on the 9th September 2009.

The specialist skin cancer MDT is one of two specialist MDTs providing skin cancer treatment for patients within the Avon, Somerset and Wiltshire Cancer Network. The MDT has a clear vision for an integrated skin cancer service supported by the pan Bristol strategy for cancer services. There are plans to establish a single Bristol wide skin cancer service with a single point of entry for all cancer referrals and combined dermatology and plastic clinics, offering patients a streamlined and responsive patient pathway.

A number of significant achievements were highlighted by the review including patients being offered an excision of suspected skin cancer on the same day as their consultation. There was good access to local radiology services and rapid reporting of histopathology results. The team is clearly committed to engaging and involving patients who had been involved with service developments such as reviewing outpatient accommodation.

No immediate risks or serious concerns were identified, however, there were gaps in MDT membership at the time of the review which the team was addressing. There was also a need to ensure better communication with local MDTs and that all skin cancer patients were discussed at the specialist MDT, particularly those seen by other MDTs, such as the head and neck team.

The review of the specialist urology MDT demonstrated that effective pathways of care were in place with patients benefiting from rapid access prostate assessment clinics and haematuria clinics. There is a good surgical skill mix in the team and consultant members work cohesively and provide cover for each other, which was considered a significant achievement. The level of recruitment and entry to clinical trials and the research and medical opportunities provided by the specialist MDT were notable.

A key theme to emerge from the review was the capacity of the team to deal with an annually increasing workload. It was noted the number of cases and workload had doubled since 2006. Additional consultant and CNS support

was planned and workload should be monitored regularly to ensure sufficient capacity is maintained. Lack of communication between the specialist and local MDTs was also a recurring theme. There were no immediate risks or serious concerns.

The local diagnostic team for gynaecological cancers demonstrated cohesive teamworking and there were effective, responsive referral pathways and communication with the MDT at the University Hospitals Bristol NHS Foundation Trust. Of particular note was the efficient, nurse led colposcopy service which was considered good practice. However, the increase in colposcopy workload is impacting on clinical capacity and this needs to be monitored to ensure sustainability of the service.

The breast and lung MDTs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for both MDTs.

IV Process

The Trust undertook a robust internal validation process which involved a panel review of the MDTs' self assessments and evidence. The internal validation panels included the following members:

Commissioner;
Patient Representative;
Lead Cancer Clinician;
Lead Cancer Nurse and Cancer Manager;
Assistant Lead Nurse and Cancer Project Manager.

The outcomes of the panel reviews were fedback to the Medical Director to approve before the internal validation reports were signed off by the Chief Executive.

4.1.1.2 Summary of Compliance for MDT Measures

North Bristol MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	97%	Breast Report
08-2C-1	Lung MDT		Amber	90%	Lung Report
08-2G-2	Specialist Urology MDT	**84%**			Specialist Urology Report
08-2G-4	Penile MDT			76%	Penile Report
08-2J-2	Spec Skin MDT	**38%**			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 North Bristol Locality Measures

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-1D-1e	Gynae Locality Functions	100%			Gynae Locality Functions Report
08-1D-1j	Skin Locality Measures	0%			Skin Locality Measures Report

This table applies to the six Gynaecological diagnostic services measures relevant to those localities which have agreed to provide diagnostic services in a hospital or hospitals in their locality. The table follows the same format as that for MDTs above.

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 RUH Locality

4.2.1 ROYAL UNITED HOSPITAL BATH NHS TRUST

4.2.1.1 Trust Report

Contextual Information

The Royal United Hospital Bath NHS Trust provides a comprehensive range of medical and surgical treatment, including cancer services. It has around 687 beds and serves a population of approximately 500, 000 people living in Bath, and the surrounding towns and villages in North East Somerset, Somerset and Wiltshire.

The 2009/2010 annual peer review programme for the Royal United Hospital Bath NHS Trust is outlined below:

External Peer Review Visits:

Local skin, urology and upper gastro-intestinal MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The specialist MDT for gynaecological cancers was subject to an internal validation only.

Trust Executive Summary

The local teams selected for external review were visited on the 9th September 2009.

The review highlighted a local skin cancer MDT committed to providing patient focused care with aspirations to develop skin cancer provision within the wider dermatology service. Prior to the review there had been an away day to look at developing future services, which also involved patients. There was a need for both the Trust and the PCT to work together to proactively manage the potentially significant changes in workload due to the reconfiguration of skin cancer services and the cessation of skin cancer surgery by community practitioners. A number of developments had been progressed by the team which were considered significant achievements. These included weekly MDT meetings, real time data collection at meetings, and the level of histology input and support to the team. The MDT also offers patients with suspected skin cancers the opportunity to have them excised on the same day as their consultation which is considered good practice.

A serious concern was identified in relation to skin cancer surgery being undertaken by clinicians who were not members of the skin MDT. The Trust has implemented actions to address the issue. A protocol was developed to ensure the attendance of the ENT/ maxillo facial team at the MDT and for Trust wide IOG compliant excision of skin cancers. One consultant maxillofacial surgeon had started to attend the MDT meetings with immediate effect following the review.

The review of the local urology MDT demonstrated that effective pathways of care were in place with patients benefiting from rapid access prostate, haematuria and joint oncology clinics. It was evident the MDT had undertaken a high number of laparoscopic radical prostatectomies and these had yielded good outcomes which was commendable. Clear protocols were used for active surveillance of most patients with prostate cancer which was considered good practice.

There were no immediate risks or serious concerns, although the increasing workload of the team was a key issue, which impacted on consultant attendance at the specialist MDT and compromised the opportunity to undertake specialist cystectomy surgery at the cancer centre. It was acknowledged plans to recruit an additional consultant were at an advanced stage at the time of the review.

The local MDT for upper gastro-intestinal cancers demonstrated it had successfully reconfigured and centralised surgery for upper gastrointestinal cancer and had developed an integrated service with the specialist centre at the University Hospitals Bristol NHS Foundation Trust. There were clearly defined, network agreed guidelines in

place for the referral and management of upper gastrointestinal cancer patients between the local and specialist MDTs. The pathways indicated a high level of quality care for patients including consultant vetting and triage of all referrals that went into a central appointment centre. A rapid access clinic provides a responsive service for newly diagnosed and follow up patients ensuring timely treatment and referral to local and specialist treatment. It was clear from the guidelines and review discussion that all patients are discussed at both the local and specialist MDTs.

No immediate risks or serious concerns were identified, although there was a lack of CNS support for patients with hepatobiliary and pancreatic cancer.

The breast and lung MDTs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for both MDTs. A serious concern was identified by the internal validation of the lung MDT which was related to the availability of the thoracic surgeon and surgical waiting times. It was acknowledged this was a job planning issue and this should be addressed within the MDT's work programme.

IV Process

The Trust undertook a robust internal validation process which involved a "desk top" review of the MDTs' self assessments and evidence. This was completed by the Trust's cancer manager to highlight issues to be discussed at further panel review meetings with MDT representatives. The panels included the following members:

Trust Cancer Lead;
Patient Representative;
Commissioner Representatives (NHS Bath and North East Somerset, and NHS Wiltshire);
Cancer Services Manager;
Director of Operations;
Executive Cancer Lead.

The final internal validation reports were signed of by the Chief Executive. The Trust is to be congratulated on the inclusive panel review with good patient and commissioner involvement.

4.2.1.2 Summary of Compliance for MDT Measures

RUH MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	97%	Breast Report
08-2C-1	Lung MDT		Green	84%	Lung Report
08-2E-2	Specialist Gynae MDT			82%	Specialist Gynae Report
08-2F-1	Local Upper GI MDT	**86%**			Local Upper GI Report
08-2G-1	Local Urology MDT	**80%**			Local Urology Report
08-2J-1	Local Skin MDT	**53%**			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 RUH 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 Taunton Locality

4.3.1 TAUNTON AND SOMERSET NHS FOUNDATION TRUST

4.3.1.1 Trust Report

Contextual Information

Taunton and Somerset NHS Foundation Trust has approximately 770 beds and provides a comprehensive range of medical, surgical and diagnostic services to a local population of 340, 000 living primarily in Somerset and the surrounding areas. The Trust provides cancer services and opened the new cancer centre, the Beacon, in 2009.

The 2009/2010 annual peer review programme for the Taunton and Somerset NHS Foundation Trust is outlined below:

External Peer Review Visits:

Local skin, urology and upper gastro-intestinal MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The specialist MDT for gynaecological cancers was subject to an internal validation only.

Trust Executive Summary

The local teams selected for external review were visited on the 8th September 2009.

It was evident the opening of the Beacon Cancer Centre was a significant development for the Trust and the MDTs reviewed. The service enables MDTs to provide radiotherapy and chemotherapy treatment on site so patients can be repatriated and treated closer to home.

The review of the local skin cancer MDT found that patient pathways were complex with specialist skin services provided by both The Royal Devon and Exeter NHS Foundation Trust in the Peninsula Cancer Network and the University Hospitals Bristol NHS Foundation Trust within the network. It was apparent the team has intentions to develop a specialist skin MDT which has been identified in the network configuration. This was at an early stage of development at the time of the review and there was a need for greater clarity of the pathways, in particular for those patients requiring specialist services such as T-Cell lymphoma treatment and Mohs surgery. It was unclear whether all patients requiring specialist services were being discussed at a specialist MDT prior to treatment and this was raised as a serious concern.

As a result, the Trust updated the operational policy to clarify all patients who should be referred from the local MDT to the specialist MDT and ensured MDT documentation was used to track all patients.

A number of developments were considered good practice including the use of colour coded stickers to fast track pathology reports, and the level of patient information provided in the hand held records.

It was apparent from the review of the local urology MDT that some patients were being referred for radical cystectomy surgery to the specialist MDT at the Royal Devon and Exeter NHS Foundation Trust which is located in the Peninsula Cancer Network. At the time, this referral pathway was not reflected in the Avon, Somerset and Wiltshire Cancer Network clinical and referral guidelines and had not been formally ratified by either network. Further work was required to ensure this practice did not affect the viability of the specialist urology MDT within the network.

A number of significant achievements were highlighted by the review. Patients benefit from the opportunity of accessing high dose and low dose rate brachytherapy as a treatment option which is considered good practice. It was noted rapid access prostate, haematuria and joint uro-oncology clinics are also provided. In addition, feedback from the patient questionnaire viewed the accessibility of the CNS team as a strength.

The local MDT for upper gastro-intestinal cancers had fully embraced the centralisation of upper gastrointestinal cancer surgery and established effective links with the specialist MDT at the University Hospitals Bristol NHS Foundation Trust. There were clear and established network agreed guidelines in place for the referral and management of patients. It was evident the local and specialist MDT worked well together to ensure timely and responsive treatment along the patient pathway, although this was hindered at times by not using videoconferencing to facilitate MDT discussions. There is fast track access to triage following referral and the MDT coordinators and CNSs play an integral role in the coordination of care which was noted as a significant achievement. The patient hand held record was also considered worthy of note.

The breast and lung MDTs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for both MDTs.

IV Process

The Trust undertook an internal validation process which involved a panel review of the MDTs' self assessments, key documents and supporting evidence. The panel was comprised of the following members:

Lead Cancer Clinician;
Cancer Services Redesign Lead;
Clinical Governance Representative.

The outcomes of the review were documented in the internal validation reports which were signed off by the Chief Executive. Future reviews would benefit from a more inclusive approach with commissioner and patient involvement on the internal validation panels.

4.3.1.2 Summary of Compliance for MDT Measures

Taunton MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	97%	Breast Report
08-2C-1	Lung MDT		Green	94%	Lung Report
08-2E-2	Specialist Gynae MDT			94%	Specialist Gynae Report
08-2F-1	Local Upper GI MDT	**74%**			Local Upper GI Report
08-2G-1	Local Urology MDT	**82%**			Local Urology Report
08-2J-1	Local Skin MDT	**58%**			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.

4.3.2 Summary of Compliance for Taunton 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%.

4.4 UHB Locality

4.4.1 UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

4.4.1.1 Trust Report

Contextual Information

University Hospitals Bristol NHS Foundation Trust has eight hospital sites in the centre and south of Bristol and provides a range of general medical and surgical services to the local population of Central and South Bristol, and a broad range of specialist services, including cancer care across a region that extends from Cornwall to Gloucestershire, into South Wales and beyond.

The 2009/2010 annual peer review programme for University Hospitals Bristol NHS Foundation Trust is outlined below:

External Peer Review Visits:

Local MDTs for skin and urology and specialist MDTs for skin, upper gastro-intestinal and pancreatic cancer.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs and the specialist MDT for gynaecological cancer.

Internal Validation:

The MDT for testicular cancer was subject to an internal validation only.

Trust Executive Summary

The local teams selected for external review were visited on the 10th September 2009.

The review highlighted a local skin cancer MDT committed to providing high quality, patient focused care, however there was a lack of clarity in the pathways for skin cancer patients. In particular, the pathways to and from the specialist teams and for patients for Mohs surgery, who are referred to Cardiff. It was unclear whether these patients were discussed at the specialist MDT prior to referral. The introduction of the CNS role had improved the patient experience and service delivery. For example, the nurse led surveillance and follow up care provided was acknowledged as a significant achievement. The MDT also offers patients with suspected skin cancers the opportunity to have them excised on the same day as their consultation which is considered good practice.

The specialist skin MDT was also reviewed as the supra network MDT for T Cell lymphoma patients. It was apparent the MDT was very much in its infancy and this was reflected in the lack of robust referral pathways. Despite the aspirations to develop a supra network lymphoma service, these had not been channelled through the appropriate service development processes to secure agreement locally, at both network and specialist commissioning levels. Both the constitution and functioning of the MDT and the patient pathways were found to be non compliant with IOG requirements at the time of the review. However a combined lymphoma clinic was provided immediately following the MDT meeting which was considered to be worthy of note.

The review of the local urology MDT demonstrated that effective pathways of care were in place with patients benefiting from one stop clinics for prostate and haematuria, although it was noted the clinics had only been a 'true' one stop service for approximately 75% of patients due to lack of capacity within radiology. Workload was a key issue for the team, which impacted on MDT attendance and was raised as a serious concern for the CNS team. The Trust assured that continued funding for the additional CNS post would be requested through the normal business planning processes, whilst plans for a benchmarking review of the urology CNS service were planned to determine the requirements for the service. This was due to be reported in December 2009. A number of good practices were highlighted including the team's surgical skill mix, its success in recruiting patients to clinical trials, the access to on site psychological support and the Trust wide development of a cancer patients' forum.

The specialist MDT for upper gastro-intestinal cancers had successfully reconfigured and centralised upper gastro-intestinal cancer services in the network. There were clearly defined, network agreed guidelines in place for the

referral and management of local and specialist upper gastrointestinal cancer patients and these were reflected in practice. It was evident there was a clear ethos of providing patient centred, quality care with speedy and responsive diagnosis and treatment of patients along the patient pathway. For example, it emerged there were no delays of scans and staging for patients. Communication between the the local and specialist MDTs was effective ensuring the patient pathway is well coordinated. Among the practices worthy of note were the national recognition of the team for its work on quality of life assessments and its strong research and clinical trials portfolio and its development of innovative practices such as minimally invasive oesophagectomy.

It was clear that pancreatic cancer services had been successfully reconfigured with a highly skilled, patient focused specialist team demonstrating full engagement and commitment to delivering a high quality local and network wide service. The specialist MDT was efficient and well run with with good representation from referring hospitals which demonstrated the inclusive and outward looking approach adopted by the lead clinician. Clearly defined, network agreed guidelines were reflected in practice. A number of good practices were highlighted which included the comprehensive audit programme and the adoption of innovative practices, an example of which was laparoscopic ultrasound in staging of cancer.

The breast and lung MDTs and the specialist MDT for gynaecological cancer were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for all MDTs.

IV Process

The Trust undertook a robust internal validation process which involved a combination of "desk top" panel review of the teams' self assessements, documentation and supporting evidence, and panel review meetings with representatives of the MDTs. The range of panel members included the following:

Head of Division/ Lead Cancer Clinician;
Divisional General Manager;
Deputy Divisional Manager;
Divisional Manger;
Cancer Service Improvement Lead;
Lead Doctor for Obstetrics and Gynaecology;
Gynaecology Services Manager;
Cancer Service Manager;
Network Development Manager.

The internal validation reports were agreed by the MDTs and panel members before final approval and sign off by the Chief Executive. Future reviews would benefit from involving commissioners and patients.

4.4.1.2 Summary of Compliance for MDT Measures

UHB 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	80%	Lung Report
08-2E-2	Specialist Gynae MDT		Green	97%	Specialist Gynae Report
08-2F-2	Specialist Upper GI MDT	**86%**			Specialist Upper GI Report
08-2F-3	Specialist Pancreatic MDT	**81%**			Specialist Pancreatic Report
08-2G-1	Local Urology MDT	**82%**			Local Urology Report
08-2G-3	Testicular MDT			84%	Testicular Report
08-2J-1	Local Skin MDT	**61%**			Local Skin Report
08-2J-2	Spec Skin MDT	**22%**			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.

4.4.2 Summary of Compliance for UHB 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%.

4.5 Weston Locality

4.5.1 WESTON AREA HEALTH NHS TRUST

4.5.1.1 Trust Report

Contextual Information

Weston Area Health NHS Trust runs Weston General Hospital which has over 370 beds and provides acute surgical and medical services, including a range of cancer services, to the population of North Somerset and Somerset.

The 2009/2010 annual peer review programme for the Weston Area Health NHS Trust is outlined below:

External Peer Review Visits:

Local skin MDT.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The local urology, gynaecology and upper gastro-intestinal cancer MDTs were subject to an internal validation only.

Trust Executive Summary

The local skin cancer MDT selected for the external peer review was visited on the 8th September.

It was apparent from the review, that clear patient pathways and clinical guidelines were in place and understood by all team members. The pathways include rapid onward referral to plastic surgeons for discussion at the specialist MDT which was considered good practice. Other significant achievements and developments progressed by the team included a dedicated CNS skin surgery clinic and same day excision for most suspected melanoma patients and a stamp system for fast tracking of pathology specimens. Good progress had been made on working with the PCT to ensure a robust governance and reporting system was implemented to manage inappropriate excisions of skin cancers by GPs.

There were no immediate risks or serious concerns, however, the pathway for patients with T-Cell lymphoma was found to be less well defined with some patients potentially receiving treatment prior to discussion by the specialist MDT. This should be reviewed and addressed by the network. The lack of access to psychological support was a concern raised by the review and should be taken forward in the team's annual work programme.

The breast and lung MDTs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for both MDTs.

IV Process

The Trust undertook a robust internal validation process which involved a "desk top" review of the MDTs' self assessments of compliance and supporting documents and evidence. The "desk top" review was completed by a panel involving the following members:

Chief Executive/Executive Lead for Cancer (all specialities) - Chair
Trust Lead Cancer Clinician (gynae, breast and Upper GI)
Consultant Colorectal Surgeon (lung, urology and skin)
Cancer Lead Nurse (gynae, breast and Upper GI)
Upper GI Specialist Nurse (lung, urology and skin)
Quality Manager (all specialities)
Patient representative (all specialities)
PCT Service Improvement Manager (all specialities)

Cancer Services Manager (in advisory capacity)

In addition to the "desk top" panel review, a panel review meeting was held with most of the core members of one of the MDTs (upper gastro-intestinal) before completion of the final internal validation reports which were approved by the MDT leads before final sign off by the Chief Executive.

The Trust is to be commended on its inclusive approach and the level of commitment and involvement in the process by the Chief Executive.

4.5.1.2 Summary of Compliance for MDT Measures

Weston MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	89%	Breast Report
08-2C-1	Lung MDT		Green	90%	Lung Report
08-2E-1	Local Gynae MDT			85%	Local Gynae Report
08-2F-1	Local Upper GI MDT			91%	Local Upper GI Report
08-2G-1	Local Urology MDT			93%	Local Urology Report
08-2J-1	Local Skin MDT	72%			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.

4.5.2 Summary of Compliance for Weston 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%.

4.6 Yeovil Locality

4.6.1 YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

4.6.1.1 Trust Report

Contextual Information

Yeovil District Hospital NHS Foundation Trust has 345 beds and provides acute and specialist surgical and medical care, including cancer services for a population of approximately 180, 000, mostly in South Somerset, North and West Dorset, and parts of Mendip.

The 2009/2010 annual peer review programme for Yeovil District Hospital NHS Foundation Trust is outlined below:

External Peer Review Visits:

Local skin and local diagnostic gynaecology MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The local urology and upper gastro-intestinal cancer MDTs were subject to an internal validation only.

Trust Executive Summary

The local teams selected for external review were visited on the 7th September 2009.

The review of the local skin MDT found them to be committed to moving their service forward and a number of developments were worthy of note. For example, the hand held patient records were considered informative and beneficial to patients. There was also an easily identifiable, colour coded checklist in the patient record identifying the key worker which was good practice. The pathology reports were compliant with the pathology minimum dataset and the customised layout of these complex reports was thought to be user friendly.

There were serious concerns raised regarding the constitution and functioning of the MDT. There was a lack of full membership and as a result, serious concerns that not all appropriate patients were benefiting from a full MDT discussion. Given the difficulties with achieving core membership and existing links with the local MDT at Taunton and Somerset NHS Foundation Trust, the MDT was advised to consider a full merger with the Taunton local MDT which would have facilitated a full MDT discussion for patients and enabled the sharing of good practice between sites. A further serious concern was identified in relation to the manner in which bad news concerning diagnosis of cancer was communicated to patients, with some receiving this by letter.

The Trust took action to address these issues. There were plans to recruit to substantive posts for the consultant dermatologist and pathologist and a business case was developed for additional medical and clinical oncology sessions, to ensure complete membership of the MDT and that patients benefit from a full MDT discussion. The communication of diagnosis to melanoma patients was modified and a user involvement survey was planned to monitor and review practice.

It was apparent from the review of the local diagnostic team for gynaecological cancers that effective pathways and systems were in place to provide coordinated patient care. This included robust video-conferencing links with the specialist MDT and recording of data live at MDT meetings by both MDT coordinators which enabled treatment decisions to be recorded accurately in the patient notes without delay. Many initiatives were identified as good practice. The GOSSIP (Gynae Oncology Somerset Support Involvement Participation) support group set up by the CNS was regarded as a valuable resource to patients. The CNS led trial of long term ascitic drains and the positive impact it would have on patients' quality of life was worthy of note and the patient questionnaire had yielded an impressive 76% response rate with positive feedback in terms of the service received, particularly in terms of communication with the CNS and patient information.

The breast and lung MDTs were subject to an internal validation process and external verification by the zonal team. The robustness of the internal validation process was confirmed and given a "Green" rating for the breast MDT. The internal validation panel raised a serious concern regarding the lack of consultant cover for radiology, histopathology and surgery and this was being addressed by the Trust with a number of positions being recruited to at the time of the validation. External verification identified a serious concern for the lung MDT regarding its configuration and functioning which resulted in an "Amber" rating. In addition, the overall compliance threshold was rated "Amber" as it fell between the 50%-65% mid range compliance. As a result, this team will be visited in the 2010/2011 annual peer review programme.

IV Process

The Trust undertook a robust internal validation process which involved a "desk top" review of the MDTs' self assessments of compliance and supporting documents and evidence, which was completed by a panel. The MDTs were given the opportunity to respond to initial feedback and a further review was undertaken in response to the feedback. The range of panel members included the following:

Lead Clinician for Cancer Services and Consultant Gastroenterologist;
Lead Nurse and Improvement Coordinator for Cancer Services;
General Manager for Cancer Services and Access;
Private Patient and Cancer Services Manager;
PALS Officer (patient representative);
Director of Strategy;
Director of Operations;
Consultant Radiologist;
Senior Clinical Governance Assistant;
Bereavment Officer (patient representative);
Programme Manager (previous Associate Director of Nursing, Cancer Services Manager and Lead Nurse for Cancer Services, palliative care CNS).

The internal validation reports were presented to the Trust's Risk and Delivery and Clinical Governance Assurance committees before final sign off by the Chief Executive.

The Trust demonstrated its commitment to improve and make the process more robust in the future and is to be commended on integrating the process with the Trust's overall governance mechanisms. Future reviews would benefit from commissioner involvement.

4.6.1.2 Summary of Compliance for MDT Measures

Yeovil MDTs

Code	Team	Peer Reviewed	Externally Verified	Internally Validated	Link to Report
08-2B-1	Breast MDT		Green	86%	Breast Report
08-2C-1	Lung MDT		Amber	68%	Lung Report
08-2F-1	Local Upper GI MDT			89%	Local Upper GI Report
08-2G-1	Local Urology MDT			87%	Local Urology Report
08-2J-1	Local Skin MDT	50%			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.

4.6.2 Summary of Compliance for Yeovil Locality Measures

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

This table applies to the six Gynaecological diagnostic services measures relevant to those localities which have agreed to provide diagnostic services in a hospital or hospitals in their locality. The table follows the same format as that for MDTs above.

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
Bath And North East Somerset PCT	100%	Bath And North East Somerset PCT Report
Bristol PCT	100%	Bristol PCT Report
North Somerset PCT	100%	North Somerset PCT Report
Somerset PCT	40%	Somerset PCT Report
South Gloucestershire PCT	100%	South Gloucestershire PCT Report
Wiltshire PCT	100%	Wiltshire 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
Avon, Somerset & Wiltshire Cancer Network

South Zone Peer Review Team

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NHS

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