

Cancer Peer Review Report
Thames Valley 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 published 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 (%) | | | | | | | | | | | | |
|------------------------------------|----------------------------|-------------------------|--------------------------|-----------------------------|----------------------------|-------------------------|------------------------|----------------------|-----------------------|--------------------------|-------------------------|----------------------|-------------------------------|
| | 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 |
| Peer Review Compliance (%) | 66G | 100G | 77 | 100 | 82 | 70 | 100G | 100G | 80 | 75 | 100 | 81 | |
| Internal Validation Compliance (%) | | | | | | | | | | | | | |
| External Verification assessment: | | | | | | | | | | | | | |
| G - IV Confirmed | | | | | | | | | | | | | |
| A - IV Confirmed with Exceptions | | | | | | | | | | | | | |
| R - IV Unconfirmed | | | | | | | | | | | | | |
| PBCN | | | | | | | | | | | | | |
| 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 Structure

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 (%) | | | | | | | | | | | | |
|---------------------------|----------------------------|--------------------|---------------------------|---------------------------|------------------------------|------------------------------|----------------------------|-----------------------------|-----------------------------|--------------------------|--------------------------|-------------------------|--------------------------|
| | 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 | 08-2J-1 - Local Skin MDT | 08-2J-2 - Spec Skin MDT | 08-6A-1j - Skin for PCTs |
| Berks East | | | | | | | | | | | | | |
| Heatherwood & Wexham | 86G | 97G | 85 | | 86G | | | 84 | 82 | | 60 | 50 | |
| Berks West | | | | | | | | | | | | | |
| Royal Berkshire | 94G | 84G | 61 | | | 76 | | 91 | | | 74 | | |
| Mid & South Bucks | | | | | | | | | | | | | |
| Bucks Hospitals | 77R | 97R | 91G | | 71 | | | 89G | | | 56 | | |
| Milton Keynes General | | | | | | | | | | | | | |
| Milton Keynes General | 97G | 81A | 76 | | 91 | | | 67 | | | 15 | | |
| Oxford Radcliffe | | | | | | | | | | | | | |
| Oxford Radcliffe | 94G | 90G | | 85 | | 84 | 81 | | 94 | 90 | 58 | 30 | |
| Swindon & Marlborough | | | | | | | | | | | | | |
| Great Western Hospitals | 83G | 74G | 79 | | 83 | | | 87 | | | 63 | | |
| Berkshire East PCT (tvcn) | | | | | | | | | | | | | 0 |
| Berkshire West PCT (tvcn) | | | | | | | | | | | | | 100 |
| Buckinghamshire PCT | | | | | | | | | | | | | 0 |
| Milton Keynes PCT | | | | | | | | | | | | | 50 |
| Oxfordshire PCT | | | | | | | | | | | | | 0 |
| Swindon PCT | | | | | | | | | | | | | 100 |

3.1.2 Summary of Network and Locality Measures

| KEY | Peer Review Compliance (%) | | | | | | | | | | | | |
|-----------------------|----------------------------|-------------------------|--------------------------|-----------------------------|----------------------------|-------------------------|------------------------|----------------------|-----------------------|--------------------------|-------------------------|----------------------|-------------------------------|
| | 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 |
| TVCN | 100G | 100G | 67 | 86 | 94 | 82 | 100G | 100G | 90 | 67 | 56 | 56 | |
| Berks East | | | | | | | | | | | | | 100 |
| Berks West | | | | | | | | | | | | | 100 |
| Mid & South Bucks | | | | | | | | | | | | | 0 |
| Milton Keynes General | | | | | | | | | | | | | 0 |
| Oxford Radcliffe | | | | | | | | | | | | | 100 |
| Swindon & Marlborough | | | | | | | | | | | | | 100 |

3.2 Network Report

3.2.1 Contextual Information

The Thames Valley Cancer Network was established in 2001 and serves a population of approximately 2.4 million people residing in the surrounding areas of Berkshire, Buckinghamshire, Oxford and Swindon. Some patient flows cross network boundaries, with London and Leicestershire, Northampton and Rutland, particularly for oncology services. The network comprises the following organisations:

Acute Hospital Trusts:

- Buckinghamshire Hospitals NHS Trust
- Great Western Hospitals NHS Foundation Trust
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Milton Keynes Hospital NHS Foundation Trust
- Oxford Radcliffe Hospitals NHS Trust
- Royal Berkshire NHS Foundation Trust

Primary Care Trusts:

- NHS Berkshire East
- NHS Berkshire West
- NHS Buckinghamshire
- NHS Milton Keynes
- NHS Oxfordshire
- NHS Swindon

In summary, the 2009/2010 annual peer review programme for the Thames Valley Cancer Network included the following:

External Peer Review Visits:

Local and specialist MDTs for skin cancer, urology, gynaecology and upper gastro-intestinal cancers and the network site specific groups (NSSGs) for these tumour sites.

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 and specialist urology MDTs, including testicular; local and specialist upper gastro-intestinal MDTs, including specialist pancreatic; and local gynaecology MDTs.

3.2.2 Executive Summary

The network had experienced significant staff changes with a new Director appointed in recent months prior to the review. Network staffing levels were reduced until this appointment, which had an impact on the level of support and resource available to prepare for the external peer review.

The local teams selected for review were visited between the 22nd June and 1st July 2009. The network visits took place on the 23rd June, when the NSSG for upper gastro-intestinal cancers was reviewed, and the 1st July when the NSSGs for skin, urology and gynaecology were reviewed.

A number of common themes emerged across the NSSGs. The CNSs involved in the NSSGs work well together, and meet regularly as network groups to share good practice and ensure consistency of approach and continuity of care for patients. There is good engagement and involvement from patients on the NSSGs which was highlighted in each NSSG review. Data collection and the review of outcomes is challenged by the use of different information systems and variable collection across the network, and this needs to be addressed. The NSSGs were also unclear about their relationships and links with commissioners and how they could influence commissioning priorities. This should improve with the planned establishment of a network cancer commissioning group. At the time of the review, staffing changes had impacted on the level of administrative support available to NSSGs. However, it was acknowledged this was improving with the appointment of additional staff.

The skin reviews involved six local and two specialist MDTs. In general, good progress has been made in implementing the IOG, however further work needs to be done on embedding the network clinical and referral guidelines to ensure all appropriate patients are referred and treated by the specialist MDTs, and there are compliant pathways in primary care.

One specialist and three local urology MDTs were reviewed. It was evident that clinical guidelines and pathways were being followed, however, the need to ensure that high risk superficial bladder cancer cases were discussed at the specialist MDT was reinforced by the review.

One local upper gastro-intestinal MDT was reviewed, together with the NSSG. Successful centralisation of services at the Oxford Radcliffe Hospitals NHS Trust and the Royal Berkshire NHS Foundation Trust has been achieved and comprehensive clinical guidelines are in place which were developed and agreed inclusively by all organisations concerned. However, there is variable consultant engagement in the NSSG which needs to be addressed if the NSSG is to function effectively.

The gynaecology reviews involved one of the local MDTs and the specialist MDT. Good progress has been made on centralising services and agreeing network wide IOG compliant pathways, however, it was apparent from the review that not all appropriate patients were being discussed at the specialist MDT or referred for radical surgery.

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 breast NSSG achieved 100% compliance with the cancer 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, indicates that reconfiguration and centralisation of services for gynaecological, upper gastro-intestinal, urology and skin cancers has been achieved. The evidence from the external peer review visits generally supports this.

Significant progress had been made in configuring services for gynaecological cancer, however, the network and commissioners should continue to monitor that network pathways are adhered to and that all appropriate patients are being referred to the specialist MDT for discussion and radical surgery.

The centralisation of specialist skin cancer services was at an early stage of development at the time of the review and further work was required to ensure referral guidelines and pathways were documented clearly and reflected in actual practice, to ensure all appropriate patients were referred and treated by the specialist MDT. In addition, the network primary care guidelines weren't fully implemented. The network and commissioners need to monitor implementation to ensure ongoing compliance with IOG requirements.

3.2.4 Good Practice

The external peer review elicited many examples of good practice. The cohesiveness and links between the CNSs in the network and the level of involvement of patients on the NSSGs were worthy of note. The "Go-Cart" referral form used to ensure effective transfer of patient information between local and specialist MDTs was also highlighted as good practice, as was the recruitment to clinical trials within the urology NSSG and the work done on raising cancer awareness.

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

There were no immediate risks or serious concerns identified at network level, however, the network has a key role to play in supporting its individual Trusts and MDTs to address the serious concerns raised and to ensure progress is monitored.

3.2.6 IV Process

The network internal validation process for the NSSGs involved a "desk top" review of the NSSG self assessment of compliance and supporting evidence, which was followed by a panel review meeting with NSSG representatives including the chair.

The panel comprised the following members:

- Network Director;
- Network Medical Director;
- Network Nurse Director;
- Network Clinical Groups Project Lead;
- Patient Representatives;
- Other NSSG chairs - for example from the Head and Neck NSSG.

This is a robust process, however, future reviews would benefit from commissioner involvement.

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 | 100% | Breast Network Report |
| 08-1A-2c | Lung Network | | Green | 100% | Lung Network Report |
| 08-1A-2e | Gynae Network Board | 67% | | | Gynae Network Board Report |
| 08-1A-2f | Upper GI Network Board | 86% | | | Upper GI Network Board Report |
| 08-1A-2g | Urology Network Board | 94% | | | Urology Network Board Report |
| 08-1A-2j | Skin Network Board | 82% | | | Skin Network Board Report |
| 08-1C-1b | Breast NSSG | | Green | 100% | 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 | 67% | | | Upper GI NSSG Report |
| 08-1C-1g | Urology NSSG | 56% | | | Urology NSSG Report |
| 08-1C-1j | Skin NSSG | 56% | | | 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 Berks East Locality

4.1.1 HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST

4.1.1.1 Trust Report

Contextual Information

Heatherwood and Wexham Park Hospitals NHS Foundation Trust provides a full range of hospital services to a large and diverse population of over 400,000 which includes Ascot, Bracknell, Maidenhead, Slough, south Buckinghamshire and Windsor. The Trust has approximately 550 beds and delivers medical, surgical and outpatient services from its two main sites, Heatherwood Hospital in Ascot and Wexham Park Hospital, 1.5 miles to the north of Slough. The Trust also runs a breast screening and diagnostic service at the King Edward VII Hospital site.

The 2009/2010 annual peer review programme for Heatherwood and Wexham Park Hospitals NHS Foundation Trust is outlined below:

External Peer Review Visits:

Local and specialist skin and urology cancer MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The local MDTs for gynaecological and upper gastro-intestinal cancers were subject to internal validation only.

Trust Executive Summary

The local teams selected for review were visited on the 23rd June 2009.

Both the local and specialist skin cancer MDTs were reviewed at Heatherwood and Wexham Park Hospitals NHS Foundation Trust, as the Trust hosts the specialist MDT which comprises membership from the three local skin MDTs in the east of the network. These include Buckinghamshire Hospitals NHS Trust and Milton Keynes Hospital NHS Foundation Trust.

The local skin MDT had made good progress in a relatively short space of time and was proactive in developing the service for local patients and in establishing effective links with primary care. A number of good practices were noted. In particular, the level of patient involvement was excellent, with constructive use of the patient forum to inform service delivery. There was cohesive team working with plastic surgery colleagues, with parallel clinics and surgery offered on site within a week of referral which is beneficial to patients, and "see and treat" clinics reducing the need for additional visits to hospital for patients. Both the MDT and PCT demonstrated effective collaborative working to develop a robust system for monitoring and reporting of inappropriate excisions of skin cancer by GPs.

No immediate risks or serious concerns were identified, although the network guidelines and referral pathways required further work to reflect the referral and treatment of patients out of area, specifically for radiotherapy at the Mount Vernon Hospital in Middlesex. There was also concern regarding the equity of access to clinical trials for patients who are referred out of area.

The specialist skin MDT was at an early stage of development at the time of the review and had worked hard to bring the three local skin cancer MDTs together, despite the logistics and timetabling difficulties of working across multiple hospital sites at different geographical locations. The record keeping of the team needed improvement and the issue regarding equity of access to clinical trials was also relevant to this MDT. There were no immediate risks or serious concerns.

It was evident the local urology MDT provided a good service to its local population demonstrated by a number of developments and good practices. There was effective team working; joint clinics, including haematuria and joint oncology clinics; patients were well supported by the CNS; and the MDT was committed to involving patients which was reflected in the patient focus groups that had been held. There were no immediate risks or serious concerns, although the level of data collection and recruitment to clinical trials were areas for improvement.

The specialist urology MDT is hosted by Heatherwood and Wexham Park Hospitals NHS Foundation Trust and comprises membership from the local MDT, in addition to the local MDT at the Royal Berkshire Hospital NHS Foundation Trust. It is still in the early stages of establishing itself, although there is commitment to ensuring joint arrangements progress and considerable efforts have been made to ensure the timetabling of meetings allows for all to participate. This was viewed as a significant achievement in itself. The system for capturing MDT attendance and treatment decisions needs further work and referral pathways should be audited to ensure all patients are referred appropriately to the specialist MDT for treatment.

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.

IV Process

The Trust undertook a robust internal validation process which was based on recommendations from the Thames Valley Cancer Network. Firstly, the lead cancer team met with each MDT following their initial self assessment to identify areas for improvement ahead of the internal validation panel meeting. This was followed by the panel review meeting with MDT representatives. The validation panels comprised a range of members including:

- Lead Cancer Nurse;
- Patient Representatives;
- Network Clinical Groups Project Lead;
- Lead Cancer Clinician;
- Director of Strategy and Marketing (Executive Lead);
- Assistant Director of Commissioning (PCT representative);
- Public Health Representatives;
- Lead Cancer Manager;
- Acting Chief Operating Officer (Executive Lead).

The internal validation reports were discussed and agreed with the panel and MDT representatives and approved by the Medical Director and Director of Nursing before final sign off by the Chief Executive. Service developments and concerns raised by the internal validation will be monitored through the Trust Clinical Governance structure and Cancer Board. The integration of the process into the Trust's overall governance and assurance mechanisms is to be commended.

4.1.1.2 Summary of Compliance for MDT Measures

Heatherwood & Wexham 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 | | Green | 97% | Lung Report |
| 08-2E-1 | Local Gynae MDT | | | 85% | Local Gynae Report |
| 08-2F-1 | Local Upper GI MDT | | Green | 86% | Local Upper GI Report |
| 08-2G-1 | Local Urology MDT | 84% | | | Local Urology Report |
| 08-2G-2 | Specialist Urology MDT | 82% | | | Specialist Urology Report |
| 08-2J-1 | Local Skin MDT | 60% | | | Local Skin Report |
| 08-2J-2 | Spec Skin MDT | 50% | | | 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 Berks East Locality Measures

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

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

4.2 Berks West Locality

4.2.1 ROYAL BERKSHIRE NHS FOUNDATION TRUST

4.2.1.1 Trust Report

Contextual Information

The Royal Berkshire NHS Foundation Trust has over 800 beds and provides acute medical and surgical services to Reading, Wokingham and West Berkshire. Specialist services, including cancer services are provided to a wider population across Berkshire and areas of South Oxfordshire.

The 2009/2010 annual peer review programme for the Royal Berkshire NHS Foundation Trust is outlined below:

External Peer Review Visits:

Local skin, urology and gynaecological cancer MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The specialist MDT for upper gastro-intestinal cancers was subject to internal validation only.

Trust Executive Summary

The local teams selected for review were visited on the 30th June 2009.

The local skin MDT was found to be dynamic and progressive and continually striving to provide high quality services to its local population. The pathways of care are well established and continue to be developed to meet IOG requirements for the benefit of patients. The CNS plays a pivotal role in the team and has enhanced the patient pathway, for example by establishing good quality patient information and a nurse led clinic in response to patient feedback. The MDT is part of the newly developed joint specialist MDT hosted by the Oxford Radcliffe Hospitals NHS Trust and also involving the local skin MDT at the Great Western Hospitals NHS Foundation Trust.

Although there were no immediate risks or serious concerns identified, there were concerns regarding the histopathology cover arrangements for the MDT which needed to be reviewed. There was also a need to ensure patients had access to clinical trials available at the specialist MDT, in addition to those available locally.

The local urology MDT provides a comprehensive choice of treatment options for patients who are well supported by the CNS team at key points during the patient pathway. The team is well integrated with the local MDT at Heatherwood and Wexham Park Hospitals NHS Foundation Trust to provide a fully centralised joint specialist service, with prostatectomy surgery performed on both sites and cystectomy surgery performed at the Heatherwood and Wexham Park Hospitals NHS Foundation Trust. A number of good practices were highlighted by the review including the dedicated consultant time to discuss all treatment options with patients. An audit demonstrated that patients receive up to four hours of one-to-one sessions with a consultant and CNS which is commendable. The MDT also benefits from a bank of patients who are available to provide support to fellow patients who are newly diagnosed with cancer.

There were concerns regarding access to psychosexual counselling with CNSs no longer able to refer to these services directly, however no immediate risks or serious concerns were raised.

The review of the local MDT for gynaecological cancers demonstrated that significant progress had been made since the last peer review, with agreement to centralise surgery and specialist services at the Oxford Radcliffe Hospitals NHS Trust. The progress made was viewed as a significant achievement, together with the excellent communication between the local and specialist MDT CNSs who work well together and meet regularly as a network group. A patient support group had been established which received positive feedback from the patient representative present at the review.

Despite the good progress made, patient pathways were still in development at the time of the review and further work was needed to ensure alignment of local and network guidelines and clear referral processes between the local and specialist MDT. The review highlighted that the clinical oncologist was providing treatment to patients, however was not a core member of the specialist MDT and was not referring these patients for specialist MDT discussion. This and the lack of appropriate referral of patients requiring radical surgery to the specialist MDT were raised as serious concerns.

The Trust responded with plans to align the local and specialist MDT meetings on the same day via video link from September 2009, to facilitate the attendance of the clinical oncologist at the specialist MDT meeting. This was also reflected in the job plan. Further evidence was submitted of referral data to the specialist MDT indicating appropriate treatment of all patients from 1st April 2009.

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.

IV Process

The Trust undertook a robust internal validation process which was based on recommendations from the Thames Valley Cancer Network. This involved a panel review of the MDTs' self assessments of compliance and the supporting evidence. This was then followed by a review meeting with representatives from the MDTs.

The internal validation panels consisted of the following members:

- Cancer Manager;
- Lead Cancer Nurse;
- Lead Cancer Clinician;
- Patient Representative;
- Cancer Commissioner;
- Network Clinical Groups Project Lead.

The internal validation report was drafted and signed off by the Chief Executive.

4.2.1.2 Summary of Compliance for MDT Measures

Royal Berkshire MDTs

| Code | Team | Peer Reviewed | Externally Verified | Internally Validated | Link to Report |
|---------|-------------------------|---------------|---------------------|----------------------|--|
| 08-2B-1 | Breast MDT | | Green | 94% | Breast Report |
| 08-2C-1 | Lung MDT | | Green | 84% | Lung Report |
| 08-2E-1 | Local Gynae MDT | 61% | | | Local Gynae Report |
| 08-2F-2 | Specialist Upper GI MDT | | | 76% | Specialist Upper GI Report |
| 08-2G-1 | Local Urology MDT | 91% | | | Local Urology Report |
| 08-2J-1 | Local Skin MDT | 74% | | | 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 Berks West 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%.

4.3 Mid & South Bucks Locality

4.3.1 BUCKINGHAMSHIRE HOSPITALS NHS TRUST

4.3.1.1 Trust Report

Contextual Information

Buckinghamshire Hospitals NHS Trust provides a range of acute hospital services to a population of over 500,000 located across Buckinghamshire, Thame (Oxfordshire), Tring (Hertfordshire), and Leighton Buzzard (Bedfordshire). Services operate from three hospital sites in Amersham, Stoke Mandeville and Wycombe. A range of specialist services is provided to a much larger population, 1.5 million for burns and plastic services and 14 million for spinal injuries.

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

External Peer Review Visits:

Local skin and upper gastro-intestinal cancer MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The local MDTs for gynaecological and urology cancers were subject to internal validation only.

Trust Executive Summary

The local teams selected for review were visited on the 23rd June 2009.

The local skin MDT is well established and provides a good service to its local population. There are strong links with the two specialist MDTs across the network as the MDT is part of the specialist team hosted by Heatherwood and Wexham Park Hospitals NHS Foundation Trust in the east, and the clinical oncologist core member of the team attends specialist meetings at the Oxford Radcliffe Hospitals NHS Trust in the west. A number of good practices were noted. The permanent patient record includes a clear illustration of the patient's skin lesion which is helpful for patients and is also used as a method of communication to the referring GP. There was cohesive team working with plastic surgery colleagues, with parallel clinics and surgery lists running at the same time to offer patients speedy access to treatment.

There were no immediate risks or serious concerns identified. However, there were concerns regarding the treatment of some skin cancer patients in the community setting. The MDT was encouraged to work with the local PCT to develop mechanisms to monitor inappropriate skin cancer excisions and confirmed cancer cases to ensure all patients benefited from local MDT discussion.

The review of the local upper gastro-intestinal MDT found that significant work had been undertaken to improve the effectiveness of the MDT and joint working since the last review in 2006. Much of this was achieved through the dedication and commitment of the CNS who was the lead clinician for the MDT. For example, the CNS attends some clinics at the specialist centre to ensure consistency in communication to patients and this was considered good practice. Other achievements included the appointment of a dedicated dietician to the MDT; a clearly explained, well illustrated record of patient consultations to provide better understanding for patients; and good attendance at the Advanced Communication Skills training.

However, it was clear from the review that despite a joint management meeting twice a year to discuss operational policies, the MDT still functions as two separate teams with weekly MDT meetings taking place on separate days. There is variable commitment from some consultant members to move towards a single MDT and this was raised as a serious concern, as a single MDT would enhance the MDT discussion bringing increased benefit to both patients and core team members.

The Trust submitted an action plan to address the serious concerns with the intent to progress towards an integrated MDT by December 2009.

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 for both was unconfirmed and rated "Red". Serious concerns were identified by the zonal team for both MDTs which affected the rating. They related to a lack of a full complement of core team members, with patients potentially not benefiting from a comprehensive discussion of treatment options. As a result, these teams will be visited in the 2010/2011 annual peer review programme.

IV Process

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

- Executive Lead;
- Lead Cancer Clinician;
- Lead Cancer Nurse;
- Cancer Manager;
- Patient Representative;
- PCT Commissioner;
- Network Director;
- PCT Public Health Consultant.

The internal validation report was drafted and approved through the Trust's governance processes before final sign off by the Chief Executive. The process is well integrated into the Trust's overall governance mechanisms which is to be commended.

4.3.1.2 Summary of Compliance for MDT Measures

Bucks Hospitals MDTs

| Code | Team | Peer Reviewed | Externally Verified | Internally Validated | Link to Report |
|---------|--------------------|---------------|---------------------|----------------------|---------------------------------------|
| 08-2B-1 | Breast MDT | | Red | 77% | Breast Report |
| 08-2C-1 | Lung MDT | | Red | 97% | Lung Report |
| 08-2E-1 | Local Gynae MDT | | Green | 91% | Local Gynae Report |
| 08-2F-1 | Local Upper GI MDT | 71% | | | Local Upper GI Report |
| 08-2G-1 | Local Urology MDT | | Green | 89% | Local Urology Report |
| 08-2J-1 | Local Skin MDT | 56% | | | Local Skin Report |

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

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

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

4.3.2 Summary of Compliance for Mid & South Bucks 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%.

4.4 Milton Keynes General Locality

4.4.1 MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST

4.4.1.1 Trust Report

Contextual Information

Milton Keynes Hospital NHS Foundation Trust has approximately 500 beds and provides a broad range of medical and surgical services, in addition to more specialised services such as cancer, to over 300,000 people living in Milton Keynes and the surrounding areas.

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

External Peer Review Visits:

Local skin and urology cancer MDTs.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The local MDTs for gynaecological and upper gastro-intestinal cancers were subject to internal validation only.

Trust Executive Summary

The local teams selected for review were visited on the 29th June 2009.

The local skin MDT is committed to providing a flexible service to its local population, demonstrated by the provision of an extended hours service to offer patients the option of attending clinics outside working hours. The clinics run until 8.00pm and this was considered good practice. Also worthy of note was the good level of histopathology support to the MDT which was enhanced by the use of a computerised minimum data set.

A number of serious concerns were raised regarding the constitution of the local MDT and treatment of patients with level 5 or 6 disease. At the time of the review there was no CNS and oncology input to the MDT which impacted on the level of support patients received and it was found that some patients with level 5 or 6 disease were being treated without being discussed at the specialist MDT, potentially limiting their treatment options. The infrequency of clinics for immuno-compromised patients was also a serious concern.

The Trust took action to resolve these serious concerns. Interim arrangements were put in place, pending the appointment of a CNS, to ensure all patients were discussed at the MDT, had a key worker, and that their care and treatment was well coordinated. A lead oncologist was identified to attend the MDT on a regular basis from August 2009. The MDT lead clinician and oncologist were nominated to attend the specialist MDTs by video link to ensure all patients requiring surgery and treatment benefited from full, specialist discussion and there were plans to confirm this in the MDT operational policy. Three dedicated clinic slots per month were scheduled to ensure the needs of immuno - compromised patients were met.

The local urology MDT works well together to provide patient centred care. A number of developments were commended, in particular the one stop clinics for haematuria, prostate, and testicular cancer which are well supported by the radiologists. The use of digital dictation enables fast turnaround times for urgent correspondence which facilitates timely access and treatment for patients. There are also effective links between the MDT and local patient groups.

The patient pathways for specialist urology cancer treatment are complex and cross the boundaries of a number of networks and the review found that not all patients with localised prostate cancer were being discussed at the specialist MDT which was raised as a serious concern. The Trust intended to ensure that the lead oncologist would

take responsibility for presenting patients to the relevant specialist MDT which would be confirmed in the MDT operational policy.

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 for the breast MDT was confirmed and given a "Green" rating. The lung MDT was confirmed with exceptions and rated "Amber". The reason for this was a greater than 20% but less than 30% discrepancy between the compliance found at internal validation and external verification. The lung MDT was also only marginally above the minimum compliance threshold of 50%. There were no immediate risks or serious concerns identified, however, the lung MDT will be visited in the 2010/2011 annual peer review programme.

IV Process

The Trust undertook an internal validation process which involved a panel review of the MDTs' self assessments of compliance with the measures and supporting evidence. The panel involved the following members:

Network Clinical Groups Project Lead;
Patient Representative;
Lead Cancer Nurse / Executive Lead;
PCT Cancer Lead.

The review meeting was conducted with all the core members of the MDT. The final internal validation report was signed off by the Chief Executive.

4.4.1.2 Summary of Compliance for MDT Measures

Milton Keynes General 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 | 81% | Lung Report |
| 08-2E-1 | Local Gynae MDT | | | 76% | Local Gynae Report |
| 08-2F-1 | Local Upper GI MDT | | | 91% | Local Upper GI Report |
| 08-2G-1 | Local Urology MDT | 67% | | | Local Urology Report |
| 08-2J-1 | Local Skin MDT | 15% | | | 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.

4.4.2 Summary of Compliance for Milton Keynes General 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 Oxford Radcliffe Locality

4.5.1 OXFORD RADCLIFFE HOSPITALS NHS TRUST

4.5.1.1 Trust Report

Contextual Information

The Oxford Radcliffe Hospitals NHS Trust is one of the largest NHS teaching hospitals in the UK. It consists of three hospital sites: The John Radcliffe Hospital and Churchill hospitals in Oxford and the Horton General Hospital in Banbury. The Trust provides a wide range of acute hospital services for people in Oxfordshire and neighbouring counties, and specialist services, including cancer on a regional and national basis. A new £109 million Cancer Centre opened at the Churchill Hospital in March 2009 enabling patients to receive all their care in a dedicated purpose built Centre.

The 2009/2010 annual peer review programme for the Oxford Radcliffe Hospitals NHS Trust is outlined below:

External Peer Review Visits:

Local and specialist skin MDTs and specialist gynaecology MDT.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

The specialist MDTs for upper gastro-intestinal, pancreatic, urology and testicular cancers were subject to internal validation only.

Trust Executive Summary

The local teams selected for review were visited on the 1st July 2009.

Both the local and specialist skin cancer MDTs were reviewed at the Oxford Radcliffe Hospitals NHS Trust. The local skin cancer MDT was fully constituted and benefited from good histopathology support with three team members sub specialising in skin cancers. The team is committed to providing responsive, timely services for patients. For example, the one stop, joint clinics for patients that involve the plastics team, oncologists and the CNS. The comprehensive, local patient information produced such as the melanoma card was considered good practice, as was the MDT inviting GPs to attend meetings on an educational basis when their patients were being discussed.

There were no immediate risks or serious concerns identified, however, further work was required to develop a robust reporting and monitoring system with the PCT to manage inappropriate excisions of skin cancer by GPs.

At the time of the review, the specialist skin cancer MDT was still in the early stages of development and had not yet met as a joint, specialist team. It comprises membership from the three local MDTs in the west of the network involving the Royal Berkshire NHS Foundation Trust and the Great Western Hospitals NHS Foundation Trust. The progress made in moving towards the implementation of a specialist skin service, with commitment and agreement from all parties is a significant achievement. However, there was serious concern at the lack of radiologist input as a core member of the specialist MDT. The Trust took immediate action to resolve this and identified a consultant radiologist to attend all specialist MDT meetings effective from 1st August 2009 and included this responsibility in the consultant's job plan.

Good progress had been made in reconfiguring specialist gynaecology cancer services and the team had worked hard to establish effective links with the local MDTs across the network. The review highlighted a number of good practices. Nurse led clinics and low level psychosexual counselling are in place to support patients. A patient information checklist ensures patients receive relevant information and patients have good access to clinical trials.

There were no immediate risks or serious concerns raised for the specialist MDT. Although the anticipated increase in workload and the additional capacity and support that would be required as a result, need to be considered in the future.

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.

IV Process

The Trust undertook an internal validation process which involved a panel review of the MDTs' self assessments of compliance with the measures and supporting evidence. This was followed by a review meeting with the MDTs. The panel included the following members:

Lead Clinician;
Cancer Directorate Manager;
Lead Cancer Nurse;
Director of Operations;
Patient Representatives;
Network Nurse Director;
Cancer Commissioner.

A draft internal validation report was submitted to the panel and the relevant MDT chair before the final report was presented and approved through the Trust's governance structure and Executive Board. This process is well integrated into the Trust's overall governance mechanisms which is to be commended.

4.5.1.2 Summary of Compliance for MDT Measures

Oxford Radcliffe MDTs

| Code | Team | Peer Reviewed | Externally Verified | Internally Validated | Link to Report |
|---------|---------------------------|---------------|---------------------|----------------------|--|
| 08-2B-1 | Breast MDT | | Green | 94% | Breast Report |
| 08-2C-1 | Lung MDT | | Green | 90% | Lung Report |
| 08-2E-2 | Specialist Gynae MDT | 85% | | | Specialist Gynae Report |
| 08-2F-2 | Specialist Upper GI MDT | | | 84% | Specialist Upper GI Report |
| 08-2F-3 | Specialist Pancreatic MDT | | | 81% | Specialist Pancreatic Report |
| 08-2G-2 | Specialist Urology MDT | | | 94% | Specialist Urology Report |
| 08-2G-3 | Testicular MDT | | | 90% | Testicular Report |
| 08-2J-1 | Local Skin MDT | 58% | | | Local Skin Report |
| 08-2J-2 | Spec Skin MDT | 30% | | | 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.

4.5.2 Summary of Compliance for Oxford Radcliffe 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%.

4.6 Swindon & Marlborough Locality

4.6.1 GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

4.6.1.1 Trust Report

Contextual Information

The Great Western Hospitals NHS Foundation Trust (formerly the Swindon and Marlborough NHS Trust) provides acute hospital services from two main sites - the Great Western Hospital in Swindon and Savernake Hospital in Marlborough. The Trust achieved foundation status and became the Great Western Hospitals NHS Foundation Trust in December 2008. It provides cancer services to a population of approximately 300,000 people.

The 2009/2010 annual peer review programme for the Great Western Hospitals NHS Trust is outlined below:

External Peer Review Visits:

Local skin cancer MDT.

External Verification of Internally Validated Self Assessments:

Breast and lung MDTs.

Internal Validation:

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

Trust Executive Summary

The local skin cancer MDT selected for review was visited on the 22nd June 2009.

The team had made good progress in developing its service, benefited from a full complement of core team members and had moved to weekly MDT meetings which was considered good practice. Effective working relationships had been established with the PCT and GP colleagues. For example, there is a robust system in place to manage inappropriate excisions of skin cancer by GPs, which involves the GPs concerned and the primary care governance team. The CNS team also provides GPs with further details on treatment options when their patients have been discussed at the MDT, ensuring there is not total reliance on faxing of this communication.

The MDT is part of the newly developed joint specialist MDT hosted by the Oxford Radcliffe Hospitals NHS Trust and also involving the local skin MDT at the Royal Berkshire NHS Foundation Trust. At the time of the review, the specialist skin cancer MDT was still in the early stages of development and had not yet met as a joint, specialist team. This was not reflected in the MDT's operational policy, and it was unclear how specialist opinion had been obtained prior to this point.

No immediate risks or serious concerns were highlighted by the review. CNS capacity was an issue raised in relation to the level of commitment dedicated to rarer cancers in addition to skin cancer, and it was felt the MDT's policies should reflect actual practice regarding referral and working arrangements with the specialist MDT.

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.

IV Process

The Trust undertook a robust internal validation process which involved a "desk top" review by the cancer management team of the MDTs' self assessments of compliance and the supporting evidence. This was then followed by a panel review meeting with the Lead Clinician, CNS and MDT coordinator representatives from the MDTs.

The internal validation panels consisted of the following members:

Executive Lead for Cancer;

Cancer Clinical Lead;
Lead Cancer Nurse;
Cancer Manager;
Patient Representative;
Director of Commissioning (PCT representative);
Network Clinical Groups Project Lead.

The internal validation report was drafted following the panel review meeting and signed off by the Chief Executive.

4.6.1.2 Summary of Compliance for MDT Measures

Great Western Hospitals MDTs

| Code | Team | Peer Reviewed | Externally Verified | Internally Validated | Link to Report |
|---------|--------------------|---------------|---------------------|----------------------|---------------------------------------|
| 08-2B-1 | Breast MDT | | Green | 83% | Breast Report |
| 08-2C-1 | Lung MDT | | Green | 74% | Lung Report |
| 08-2E-1 | Local Gynae MDT | | | 79% | Local Gynae Report |
| 08-2F-1 | Local Upper GI MDT | | | 83% | Local Upper GI Report |
| 08-2G-1 | Local Urology MDT | | | 87% | Local Urology Report |
| 08-2J-1 | Local Skin MDT | 63% | | | 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 Swindon & Marlborough 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%.

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 |
|---------------------|-------------|--|
| Berkshire East PCT | 0% | Berkshire East PCT Report |
| Berkshire West PCT | 100% | Berkshire West PCT Report |
| Buckinghamshire PCT | 0% | Buckinghamshire PCT Report |
| Milton Keynes PCT | 50% | Milton Keynes PCT Report |
| Oxfordshire PCT | 0% | Oxfordshire PCT Report |
| Swindon PCT | 100% | Swindon 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 | |
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| 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 | |
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| 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 | |
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| 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 | |
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| 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 | |
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| 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
Thames Valley Cancer Network

South Zone Peer Review Team

July 2010

