HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 1st February, 2013

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 1st February, 2013, at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor A Allen, Councillor A Blackmore, Councillor G Lymer and Councillor Mr M Lyons
LINk Representatives (2):	Dr M Eddy and Mr M J Fittock

Webcasting Notice

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item	Timings
1. Introduction/Webcasting	
2. Substitutes	

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 14)

5.	Patient Transport Services (Pages 15 - 30)	10:00 – 10:45
6.	Maidstone Hospital: Current and Future Developments (Pages 31 - 46)	10:45 – 11:30
7.	Cancer Services: Overview (Pages 47 - 126)	11:30 – 12:30

8. Date of next programmed meeting – Friday 8 March 2013 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

24 January 2013

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 4 January 2013.

PRESENT: Mr C P Smith (Vice-Chairman, in the Chair), Mr R E Brookbank, Mr N J Collor, Mr A D Crowther, Mr D S Daley, Mr K A Ferrin, MBE, Mr L B Ridings, MBE, Mr K Smith, Mr R Tolputt, Mr D L Brazier (Substitute for Mr A T Willicombe), Ann Allen, Cllr M Lyons, Cllr G Lymer, Dr M R Eddy and Mr M J Fittock

ALSO PRESENT: Cllr J Cunningham and Cllr R Davison

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Declarations of Interest

Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes
(Item 4)

RESOLVED that the Minutes of the meeting held on 30 November 2012 are correctly recorded and that they be signed by the Chairman.

4. Kent and Medway NHS Joint Overview and Scrutiny Committee: Update
(Item 5)

AGREED that the Committee note the report.

5. East Kent Maternity Services Review: Implementation
(Item 6)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway), Peter Gilmour (Director of Communications, East Kent Hospitals NHS University Foundation Trust), Dr Neil Martin (Medical Director, East Kent Hospitals NHS University Foundation Trust), Dr Sarah Montgomery (Senior Clinical Advisor, NHS Kent and Medway), Dr Brighton Chireka (GP Clinical Lead for Children Services, South Kent Coast CCG), Laura Counter (Commissioning Project Manager - Maternity Services, NHS Kent and Medway), and Abina Browne (Head of Midwifery, East Kent Hospitals NHS University Foundation Trust) were in attendance for this item.

(a) The item was introduced with NHS representatives explaining that the report covered the implementation of the changes to maternity services introduced the previous year which the Committee had looked at in detail. One Member of the Committee commented it had been the best example of a review since the creation of HOSC.

(b) One main area of discussion was how the changes were being publicised. NHS representatives explained that the information booklet *'Your Birth, Your Choice'* had been produced and was available in key languages. Midwives were provided with copies to hand out and it was advertised in the GP Bulletin which went to all practices. This provided a link so that it could be downloaded and/or printed on demand. Members expressed the hope that this information would be actively promoted so that people were actively aware of the current arrangements for maternity services. A copy of the booklet was requested by Members and a hard copy left by NHS representatives for later circulation (see Appendix).

(c) There would also be publicity around the formal opening of the new Margate Alongside Midwife-led Unit. This had been pushed back to 8 February from its original date as it had been possible to arrange for Pam Ferris, star of television programme *Call the Midwife*, to attend and formally open the unit.

(d) A Member of the Committee referred to the meetings of early 2012 when the Committee had been informed of issues around midwife numbers in East Kent and asked for an update on recruitment and retention. It was reported that the recruitment campaign had achieved what it had set out to do and that retention was very high compared to other areas. There was an in-house training programme to allow midwives to develop their skills; this was enhanced by the presence of two Alongside Midwife-led Units in East Kent which helped develop skills and experience.

(e) The question of monitoring and assessing performance of maternity services regarding the experience of patients was also raised. It was reported this was something the NHS was working on. Patient experience was important to assess but was difficult to get from purely quantitative information.

(f) There was extensive discussion around births before the arrival of the midwife (BBA). There was clarification provided that although in the last three months there had been 17 BBA across East Kent, as stated in the report, there had been 52 across the whole of last year. Of the two in the Dover area in the last quarter, one birth had been en route to the hospital and the other was a scheduled home birth when the midwife had not been called in time. There was a discussion around the possible causes of BBA occurrence, including problems with service organisation, social circumstances and education of the mother, and transportation. The clinicians attending among the NHS representatives emphasised that BBA was a physiological event that would happen however the services were arranged. It was also added that BBA can be less traumatic for the mother than a prolonged labour in hospital precisely because labour is over quickly in a BBA. It was reported that Kent was not an outlier nationally on the number of BBA. Members requested additional information on this subject covering – comparative statistics of numbers over

the last four years, including whether these were home births, comparisons with other regions, and information of outcomes of BBA. NHS representatives undertook to provide this information to the Committee.

(g) There was also a discussion clarifying the opening times at the Buckland Hospital in Dover. Members were reminded that Buckland provided ante-natal and post-natal services but did not carry out deliveries. The hospitals carrying out deliveries were open 24/7. The opening hours 8am – 8pm Monday to Friday, including Bank Holidays, shortened to 9am – 5pm on weekends, and it was reported that shorter opening hours on Saturdays and Sundays were consistent with how mothers wish to use services. In addition, there was a 24/7 on-call midwife service.

(h) The Chairman proposed the following recommendation:

- The Committee thanks its guests for their contribution, asks them to take on board the points raised in the meeting and looks forward to updates in the future.

(i) AGREED that the Committee thanks its guests for their contribution, asks them to take on board the points raised in the meeting and looks forward to updates in the future.

6. Audiology
(Item 7)

Helen Buckingham (Deputy Chief Executive and Director of Whole Systems Commissioning, NHS Kent and Medway) and Kallie Heyburn (Associate Partner - Child Health and Maternity, Kent and Medway Commissioning Support) were in attendance for this item.

(a) Members had before them reprints of NHS reports on audiology provided to the Committee in 2009 along with a new report providing updated information. It was explained to Members that given the state of transition in commissioning services, it may be that some questions would need to be taken away by NHS representatives for answers subsequent to the meeting.

(b) NHS representatives explained that in the past the Committee had been informed about long waiting times for audiology services in Kent but that a concerted effort had been made to tackle this problem. All adult patients were now seen within 6 weeks for assessment and 18 weeks for treatment. Anecdotal evidence was given of waits longer than 18 weeks and NHS representatives asked for details of any instances to be given to them so they could look into it.

(c) The 6 week target in paediatric audiology was being met in West Kent. In East Kent, there had been an increase in the number of referrals and length of waiting times at some clinics. A fourth audiologist was being recruited to cope with this issue. Members requested further detail on the breakdown of the length of waiting times for paediatric audiology services in East Kent over the three months listed on p.58 of the Agenda. NHS representatives undertook to do so.

(d) The issue of maintaining hearing aids was discussed. A Member reported that Age Concern provided services in Folkestone and Hythe. The same Member reported that one provider requested hearing aids be sent by post for maintenance, which was not seen by the Member as the safest way to deliver maintenance services. The walk in service provided at Darent Valley Hospital was praised. The response was given that Hi Kent also provided maintenance services and that for a lot of people maintenance services closer to home and not at a hospital was more appropriate. NHS representatives undertook to provide further information on maintenance services.

(e) In response to a question about the quality assurance of services, it was reported that all providers of NHS services would be registered with the Care Quality Commission, and this included those in the independent sector providing NHS services, but information would need to be provided separately about the quality assurance of other providers.

(f) The question of financing was discussed. NHS spend on audiology services was roughly comparable in West and East Kent, at £6.6 million in the former and £6.7 million in the latter. The contracts were a mix of block contracts, service level agreements and cost per case. This meant the number of independent providers with contracts did not mean an increase in overall costs and that this enabled patient choice. Work was continuing on coding which would make it easier to separate the money spent on adult and paediatric audiology in the future. Some Members expressed the view that a single provider would be less fragmentary than numerous providers and provide a more coherent service.

(g) In response to a specific question, it was explained that the definition of hard to reach service users varied on the service under discussion.

(h) Concern was raised by Members about the impact of loud music in clubs and through headphones on people, particularly young people. The question was raised whether any work had been done mapping a potential future increase in the need for audiology services as a result of the damage possibly caused by loud music. The assessment of need was reported as being core to the future commissioning of services and NHS representatives undertook to provide information on the trends identified for audiology services.

(i) It was reported that the Clinical Commissioning Groups (CCGs) in East Kent had recently determined that they would commission audiology services collaboratively in the future and South Kent Coast CCG would lead on this service. This commissioning would include examining issues of accessibility. The offer was made to return to the Committee when these plans had been developed.

(j) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their contribution and the information provided, and looks forward to updates in the future.

(k) AGREED that the Committee thanks its guests for their contribution and the information provided, and looks forward to updates in the future.

7. South East Coast Ambulance Service NHS Foundation Trust: Performance Update
(Item 8)

Geraint Davies (Director of Commercial Services, South East Coast Ambulance Service NHS Foundation Trust), Chris Stamp (Senior Operations Manager, South East Coast Ambulance Service NHS Foundation Trust), Helen Medlock (Associate Director of Urgent Care and Trauma, NHS Kent and Medway) were in attendance for this item.

(a) Representatives from South East Coast Ambulance Service NHS Foundation Trust (SECAmb) apologised for the lateness of the report submitted to the Committee. The main issue which the Trust wished to bring to the attention of the Committee was recent performance against their key performance indicator of responding to all Category A calls within 8 minutes 75% of the time. Across Kent and Medway, only 74% of Category A calls were being reached within 8 minutes. The key challenges to overcome in improving this were twofold.

(b) Firstly, there was the rural nature of the Weald. This was being addressed by strategically looking at demand and ensuring the right resources were available at the right places. An additional 28 paramedics and technicians had been recruited and a further 28 were being sought. There had been an increase in the number of community first responders in the Weald and Single Responder Vehicles (SRVs) were being put in places like the White Rabbit in Maidstone as Maidstone and Tunbridge Wells were areas of higher demand. Carrying these plans out had seen a performance improvement over the first eight weeks. However, the three weeks immediately preceding the meeting has seen an unexpected rise in demand.

(c) The other factor was the time taken for clinical handover at Pembury Hospital. It was stressed that handing over patients with accurate clinical information was the priority but that compared to other acute hospital sites in Kent, there was an issue at Pembury. This was being addressed in part with the presence of a SECAmb manager going into Pembury. Nationally, this was an area which was getting a higher focus. The recent document from the NHS Commissioning Board, *'Everyone Counts'*, set a handover target of 15 minutes with the possibility of fines for failure.

(d) Separately, there was a specific issue with Darent Valley Hospital (DVH). DVH had always received ambulances from SECAmb and the London Ambulance Service (LAS), but the number of ambulances arriving from LAS had increased recently. SECAmb and DVH liaised regularly throughout any given day but the day before the meeting there had been a nearly continual conversation between the Trusts. There was a need to get more information from LAS in a timely fashion. This would prevent four ambulances from both Ambulance Trusts arriving at DVH near-simultaneously. In response to a question it was reported that there was consistency of clinical practice in both Ambulance

Trusts. There was the same training and evidence base used by both. Equipment did vary, but would be used the same way.

(e) Connected to this, the full impact of the Trust Special Administrator's (TSA) report into South London Healthcare NHS Trust was yet to become clear. In response to a specific question, SECAmb representatives present were uncertain whether SECAmb replied formally to the TSA consultation, but would check. What was important was for SECAmb to be aware of and involved in discussions around future commissioning of accident and emergency services by the CCGs in South East London.

(f) Beyond responding to these specific challenges, SECAmb had to balance a variety of different concerns around skill mix and patient demand when planning services. Investment was being made to increase the number of SRVs which was part of their Front Loaded Service Model which meant more paramedics and paramedic practitioners in cars. These SRVs were able to convey patients to minor injuries units. SECAmb did not have any motorbike paramedics as these tended to topple over carrying the appropriate equipment.

(g) Different ways of working were also being considered, such as working with the Fire and Rescue Service as the number of calls to this service was decreasing. A project was underway in Edenbridge where the Fire and Rescue Service would respond first to calls if they were closest. Elsewhere, standby fire fighters were being trained as community first responders.

(h) One Member asked a question about areas of Kent on county borders as there was sometimes the impression given that SECAmb only sent ambulances from within Kent to Kent calls and only took them to hospitals in Kent, when there could be ambulances and hospitals closer in Surrey or Sussex. The response was given that all ambulances across the whole SECAmb area were tagged and mapped so that it would be the nearest appropriate ambulance, wherever it was located, which would respond and the most appropriate hospital to which patients were then transferred if needed. For some areas of Kent, this hospital would indeed be in a different county, such as East Grinstead.

(i) A number of Members provided anecdotal evidence of calls to the ambulance service which had taken an inordinate amount of time, or did not have paramedics on board. SECAmb expressed the willingness to investigate any specific example if provided by Members. More broadly, the Trust responded by explaining how the Trust operated.

(j) To begin with, it was reported as not being necessary for there to be a paramedic on an ambulance. There were four types of worker on an ambulance – emergency support worker, technician, paramedic and paramedic practitioner or critical care paramedic. An ambulance with a technician and an emergency support worker was capable of responding to an emergency call. A technician was the 'older style' of worker, had all the relevant clinical training and still made up a high proportion of the workforce. It was only 3 years ago that SECAmb required all new recruits to be graduates.

SECAmb needed to be registered with the Care Quality Commission and keeping detailed training records was part of the requirements of this.

(k) All calls received at the Emergency Despatch Centres (EDC) by SECAmb were triaged using a system called NHS Pathways. The same questions were asked of all callers, even when the caller was a health professional as 1 in 6 callers were. The outcome of the call and priority given by the EDC depended on the information provided. In times of high demand, this might result in an ambulance being sent across the county to respond to a call if this was the nearest vehicle. All calls were recorded and audited. Staff identified as outliers in performance were provided with the appropriate additional training. Recently, 3 GPs had come to the EDC to help the triage process. The reports on this project after the first 3 months were positive. Information was being gathered on which GP practices most requested ambulances and referred people to accident and emergency, and was being shared with GP practices. This information was not in a form for wider publication at present.

(l) The new 111 system coming in March would use the same triage system so would enable calls to be transferred to the 999 service, and vice versa. The intention of the 111 system was to enable people to be directed to the most appropriate service available at the time of the call. The system was not live yet and NHS commissioners commented that getting the timing of the publicity was a difficult judgment. The biggest challenge was given as effecting a cultural change where calling 999 ceased being the default option for many. One Member commented that it was often difficult for health professionals to know when to call for an ambulance, let alone a member of the public. However, SECAmb also stressed that they did not wish to become a service people avoided calling; the issue was dealing with all calls appropriately. Hoax calls were not a major issue for them and the vast majority of calls on New Years Eve had been appropriate; SECAmb mentioned the 'We are not a taxi' poster which was on the side of some ambulances.

(m) One Member commented on the information contained in the report and SECAmb responded by saying they were always looking to improve reports. Information on performance against the clinical quality indicators was readily available in SECAmb board papers.

(n) In response to a question about the military, SECAmb representatives responded by saying that a number of staff had military backgrounds and this was still an area of active recruitment. SECAmb also trained with the military at Manston.

(o) The air ambulance service was discussed and it was reported that there were three services which could be called on - two charity air ambulances and the police helicopter service. The charity air ambulances were tasked by the SECAmb EDCs and the staffing was changing to replace doctors from the Royal London with local doctors. Both charities were in discussions with the Civil Aviation Authority to allow night flights and a positive outcome was anticipated. The police service could fly at night but was being extended from covering Surrey and Sussex to include Hampshire. With fewer police helicopters, there was going to be a need for better communication between

helicopter services. In extremis, SECAmb was also able to call on the Coastguard.

(p) Members of the Committee were invited to the existing Make Ready Depots in Ashford and Paddock Wood. Sites were also being sought by SECAmb in Thanet and Medway. Members were also invited to see the 111 system in operation.

(q) In response to specific questions it was confirmed that ambulance commissioning would continue to be done collaboratively, with Swale CCG leading on this. There was currently a national currency for ambulance services, which SECAmb adopted early. A national tariff would be complex and had not yet been confirmed.

(r) Finally, one Member asked whether it would be an idea to teach all schoolchildren first aid. NHS representatives responded favourably to the idea and mentioned there were countries were the diffusion of first aid training was much wider. Closer to home, all staff at Gatwick Airport were trained to use defibrillators. The response was given that if HOSC were to request a report on the implications of this suggestion, they would look into it.

(s) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their contribution and the information provided, and looks forward to updates in the future.

(t) AGREED that the Committee thanks its guests for their contribution and the information provided, and looks forward to updates in the future.

8. Date of next programmed meeting – Friday 1 February 2013 @ 10:00 am
(Item 9)

your birth, your choice

Maternity services in east Kent are changing

Congratulations

You're pregnant, congratulations! We're here to support you and your family during this very special stage in your life.

During pregnancy, it's important to consider where you would like to give birth. We've put this booklet together to let you know about the kinds of pregnancy, birth and aftercare services available in east Kent to help you make the best choice for you and your baby.

When you give birth, it's important to feel relaxed. Some women feel safer in hospital and are reassured by having a range of services on hand to help them – or they would like an epidural for pain relief. Others feel that they would prefer to stay at home where they feel relaxed and in control.

You can choose from a midwife-led unit, a hospital birth, or home birth (even if this is your first baby).

For some women, their choice may be limited by existing medical conditions (for example, diabetes), or by problems arising during pregnancy (for example, high blood pressure) or by problems occurring in a previous pregnancy (for example, caesarean section). In these cases your midwife or GP will be able to advise you about your options.

Remember, you don't need to make a decision immediately, and you can decide at any stage of your pregnancy where you want to give birth. Discuss any concerns you have with your midwife.

We look forward to caring for you and to welcoming your baby into the world.

Lindsey Stevens,
Head of Midwifery at East Kent Hospitals University NHS Foundation Trust

Giving birth naturally

Choosing a natural childbirth, without the use of drugs or surgery, is choosing to trust your body and knowing that you already possess all the tools you need to give birth.

Giving birth naturally is better for you and for your baby as you will feel more in control of your body and more aware of the experience.

Babies who arrive naturally are generally more active and alert, which makes those first few hours of bonding easier, and these infants tend to take to breastfeeding more easily too.

Having a natural birth doesn't have to mean choosing pain – there are a wide variety of natural comfort measures and women often find the experience empowering. Talk to your midwife about what's right for you.

For example, some women find that birthing pools help them to manage their labour more comfortably and for many women help with pain relief. Pools are available at midwife-led units. If you choose to give birth at home you can hire a birthing pool.

Discuss your decision with your midwife.

The choices

Hospital (consultant-led unit)

Available at:

William Harvey Hospital (WHH), Ashford

Queen Elizabeth the Queen Mother Hospital (QEQM), Margate

Advantages

- ✓ You can choose any type of pain relief including an epidural
- ✓ Doctors, specialist equipment and staff support are available at all times
- ✓ If there are any complications, you won't have to move
- ✓ At William Harvey there is a Neo-natal Intensive Care Unit (NICU) which looks after premature ba-bies from 24 weeks of pregnancy
- ✓ At QEQM, there is a Special Care Unit (SCU) for babies born after 28 weeks of pregnancy
- ✓ Your partner/ supporter is now able to visit for 24 hours on the postnatal ward at QEQM but we hope to roll the scheme out at the WHH on 24 September

Disadvantages

- ✗ You may require more pain relief during labour
- ✗ You are more likely to have an intravenous drip and electronic monitoring of the baby's heart-beat, which may restrict your movement during labour
- ✗ You are more likely to be cared for by a midwife you have not met before
- ✗ There are restrictions on visiting times
- ✗ You can't use a birthing pool

Midwife-led units

Available at:

Singleton MLU at the William Harvey Hospital, Ashford

St Peter's MLU at the QEQM Hospital, Margate

Our MLUs are located alongside traditional hospital labour wards. The facilities and care given during labour are provided by midwives only. You should have had a normal pregnancy and be fit and healthy to have your baby here.

Advantages

- ✓ The environment is less clinical than in hospital
- ✓ Birth pools are available
- ✓ Emergency transfers to the labour ward is quick and easy
- ✓ You can move around more during labour
- ✓ Partners / supporters are able to stay overnight

Disadvantages

- ✗ You must be fit and healthy and have had a normal pregnancy
- ✗ You can only remain in the unit for 24 hours
- ✗ You cannot have an epidural
- ✗ You are more likely to be cared for by a midwife you have not met before

Home birth

Advantages

- ✓ Women who have had both a home birth and a hospital birth say they much prefer a home birth
- ✓ You may feel more relaxed and in control when you are in comfortable and familiar surroundings
- ✓ A midwife is able to provide one-to-one care
- ✓ You are more likely to be cared for by a midwife you know
- ✓ You can eat and drink as you wish
- ✓ You can sleep in your own bed and use your own bathroom
- ✓ You are more likely to have a normal birth and need less drugs for pain relief
- ✓ You can move around more during labour

Disadvantages

- ✗ You cannot have an epidural
- ✗ There are no doctors immediately available
- ✗ If complications occur during labour or after the birth, you may have to transfer to hospital

If you are considering a home birth, discuss this with your partner and family, your midwife, and any parent support groups in the area. as usual for day services, which include antenatal and postnatal checks.

Useful numbers

- **Canterbury Maternity Unit** – 01227 783105
- **Dover Maternity Unit** – 01304 222523
- **QEQM Hospital, Margate** – 01843 292494
- **William Harvey Hospital, Ashford** – 01233 616124
- **Singleton MLU, Ashford** – 01233 651868
- **St Peter's MLU, Margate** – 01843 235100

For more information

East Kent Hospitals NHS Foundation Trust www.ekhuft.nhs.uk (click on pregnancy and childbirth)

National Childbirth Trust www.nct.org.uk or ring the helpline **0300 330 0700**

La Leche League for breastfeeding support www.laleche.org.uk

Infant feeding in east Kent www.ekbaby.nhs.uk

Remember if you have any questions or concerns speak to your GP or your midwife.

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Item 5: Patient Transport Services.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 1 February 2013

Subject: Patient Transport Services.

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1. Background

(a) The Committee last discussed this item at its meeting of 9 March 2012 when the Committee determined to return to the subject at an appropriate time in the future. A written update was also received at its meeting of 30 November 2012.

(b) On 9 January 2013, Members were forwarded information provided by NHS Kent and Medway. This informed them that following a procurement process, NSL Care Services had been chosen as the preferred provider of non-emergency Patient Transport Services.

2. Recommendation

That the Committee consider and note the report.

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By: Tristan Godfrey, Research officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee, 1 February 2013

Subject: Patient Transport Services

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1. Introduction[1]

(a) The Department of Health defines Patient Transport Services (PTS) in the following way:

- *Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs*.

2. Eligibility

(a) PTS is there to enable eligible patients to access care in hospital, community or primary care settings *"in a reasonable time and in reasonable comfort, without detriment to their medical condition. Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition."* The precise definition of "reasonable" will vary according to different local circumstances.

(b) The Department of Health has set out the following broad principles for eligibility:

- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.

- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.

- Recognised as a parent or guardian where children are being conveyed.

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[1] This Note summarises and takes excerpts from: Department of Health, *Eligibility Criteria for Patient Transport Services (PTS)*, 23 August 2007, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_078372.pdf

(c) It is for the local Primary Care Trust (PCT) to determine the exact details around eligibility locally.

(d) PTS could also be provided for a patients' carer or escort where appropriate.

(e) PTS eligibility does not include those with a 'social need' rather than a 'medical need.' Charges can be levied 'for the provision of transport to patients with a social need' with the following provisos:

- *The scheme must be profitable as it is unacceptable for it to be subsidised from NHS funds;*
- *The profit must be used for improving the health services; and*
- *Income Generation schemes must not in any way interfere with the provision of NHS services to patients*.

(f) PTS providers may be from the NHS sector, independent sector, or a combination.

NHS
Kent and Medway

This report updates HOSC Members about the status of the Kent and Medway Patient Transport PTS project (PTS) and outlines the bid evaluation for provision of the service.

Procurement and evaluation process
The Evaluation Team used an initial stage to select a shortlist of bidders based on responses to a Pre-Qualification Questionnaire (PQQ). 14 initial bids were received in response to the PQQ and 6 bidders were taken through to the final stage through an Invitation to Tender (ITT). Of those, five chose to submit a final bid for both lots (i.e., a contact centre and the provision of the journey service)

The final bids were then evaluated using detailed weighted criteria on the basis of 60% for quality and 40% for price. The analysis of bids was completed by numerous subject matter experts, project team members, patients and stakeholders. Following evaluation, scores were moderated, validated and then reviewed by the project sponsor, Head of Procurement and an acute Trust Executive Director.

The NHS Kent and Medway Cluster Board subsequently approved the recommendation for NSL Care Services as the preferred bidder for both lots, subject to satisfactory completion of due diligence, site visits and references. Site visits in early January were attended by the Project Manager, local Commissioner and two hospital managers.

With site visits, due diligence and references all having been completed, official announcement of the preferred bidder was made on 8th January 2013 and mobilisation started shortly thereafter.

Mobilisation
Although mobilisation has just commenced, there are key stages to the mobilisation that will be worked through with NSL (see attached report from NSL), including:

- Property (location of estates for vehicles and staff but in liaison with local care and incumbent PTS providers)
- Vehicles (vehicle analysis and ordering of appropriate vehicles/equipment)
- Communications (public education, local care providers and communications to GPs, clinicians and their staff)
- HR/TUPE (this work stream shall involve staff, unions as well as a universal email for staff questions and a monthly newsletter)
- IT/IG (expansion of the current system to meet Kent and Medway requirements and also local care provider integration)
- Telephone and equipment (once estates have been located and identified)
- Training (working with local care providers and incumbent providers to ensure staff meet Kent specifications and NSL's standards)
- Constant liaison with the current care and incumbent providers to assure the Project objectives are met in conjunction with their local operations
- Continued liaison and participation with patients to help develop service

Eligibility Criteria
NSL will be responsible for meeting all of the requirements of the contract including applying the existing eligibility criteria. While all local care providers are currently working together to consistently apply the eligibility criteria, NSL will be required to continue that application and record any non-eligible requests.

It is important to note that as previously advised, there has never been an intention to change the Eligibility Criteria (a copy of which is attached) but to consistently apply it for all patients fairly and appropriately across Kent and Medway. The previously agreed Eligibility Criteria was agreed throughout the entire South East Coast several years ago and is based on 2007 guidance issued by the Department of Health.

That guidance defines patient transport as: "*Non-emergency patient transport services, known as PTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs*."

The Department of Health also states that PTS "*could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator.*"

The South East Coast Eligibility Criteria is based on this guidance and outlines the principle for the entitlement to non-emergency PTS as:

- The patient having a medical condition such that they require the skills of ambulance staff or appropriately skilled personnel on, or for the journey *(And/Or)*

- Following a documented clinical decision, it has been determined that the medical condition of the patient is such that it would be detrimental to the patient's condition or recovery if they were to travel by any other means

- Where the entitlement to PTS is clear the patient will be offered PTS regardless of distance and circumstances.

- An agreed assessment tool will be used to determine the patient's entitlement to PTS services and the type of PTS services that are available for patients to travel in, to and from their place of treatment

Ineligible patients
Patients that apply for transport but are not eligible will be referred to numerous alternative methods of transport including public transport, volunteer car and other voluntary organisations, hospital travel schemes and other modes of transport. The Project Team is compiling a current list of the volunteer organisations within Kent and Medway alongside local care and PTS providers. NSL will liaise with volunteer organisations to learn what services they provide and will maintain a current referral list to help those ineligible patients. The Project Team feels that it is crucial that ineligible patients are not abandoned but are assisted to locate alternative transport methods.

One of the first questions that will be asked when transport is requested is how a patient is normally able to get around (i.e., their own car, etc.) to help determine eligibility.

Recent examples of ineligible patients have been a patient (who had been receiving transport in the past) whose only medical condition was dyslexia or a patient who had been receiving hydrotherapy with transport in the past was but is now mobile and can get into her own vehicle.

Whereas an example of eligible patients may be someone with advanced multiple sclerosis that cannot self-support or a patient with recent knee replacement surgery. This condition, however, may change over a period of time, thereby changing eligibility. Another example would be a recent inpatient episode for a deaf patient having procedures on both of his eyes or an elderly lady attending Medway hospital for major surgery. She cannot put shoes on her enlarged feet currently as she has diabetes and gangrene. Once she has recovered, she may be able to use her mobility car.

Future Commissioning

West Kent will be leading on the contract for all Kent and Medway CCGs. The service will be managed by Kent and Medway Commissioning Services (KMCS) once the restructure has taken place after 1st April 2013. Both the Project Manager and the Associate Director in charge of the project are expected to continue to manage this Project through mobilisation and implementation during the early phases. Once the service has been established, contract management will be led by a KMCS contract manager in conjunction with a West Kent CCG lead.

Conclusion

The Project Team will provide another update to HOSC after the mobilisation stage of this project and request that HOSC continue to support this project.

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Patient Transport Service – Eligibility Criteria

1. Introduction

A non emergency patient is defined as a patient who, whilst requiring treatment, does not need the skills of an ambulance paramedic or technician, but may require trained personnel to undertake a journey to or from a health facility.

The NHS expects patients to make their own way to and from outpatient and inpatient appointments unless there is a clearly defined medical reason why they can not use conventional transport options including:

- walking
- cycling
- public transport including bus, train, community transport schemes, voluntary transport schemes, taxi
- private transport including lifts by friends, carers, neighbours, relatives, or the patient's normal network of support
- Or a combination of the above.

The revised process and protocols for the eligibility criteria will be rolled out from April 2010 on all new and existing contracts across the South East Coast Strategic Health Authority to provide non emergency transport only to those patients who have a medical need.

Patient Transport Services (PTS) will continue to offer ambulances and care vehicles for eligible patients and will continue to provide appropriate transport where the medical need and entitlement criteria are applicable.

2. Principles

Not all patients attending a health facility will be entitled to non emergency PTS.

The Principle for the entitlement to non emergency PTS is defined as:

- The patient having a medical condition such that they require the skills of ambulance staff or appropriately skilled personnel on, or for the journey

And/or

- Following a documented clinical decision, it has been determined that the medical condition of the patient is such that it would be detrimental to the patient's condition or recovery if they were to travel by any other means

- Where the entitlement to PTS is clear the patient will be offered PTS regardless of distance and circumstances.

- An agreed assessment tool will be used to determine the patient's entitlement to PTS services and the type of PTS services that are available for patients to travel in, to and from their place of treatment

3. Patients who are entitled to Patient Transport Services (PTS)

- For mental health and learning disability patients -

    1. All community patients and some in-patients (*identified below) should exercise all means available to them to reduce reliance upon health provided transport. This will include, walking, cycling, driving, utilising public transport, lifts from care home staff/partner/carer/family/friends or using a public taxi where affordable to access healthcare services and appointments.

    2. If none of the above means of transport are available/accessible/appropriate on health grounds, people will be eligible to access health provided transport for the duration of their treatment if it is assessed as being required by an individual's care co-coordinator/care manager and it forms part of a care plan subject to regular review. This may be a car or ambulance type vehicle dependant upon assessed need.

    3. For people receiving treatment for mental ill health/learning disability as an in-patient, health funded transport (this may be in the form of a vehicle retained at the hospital for patient transport) will be available for people detained under the mental health act 1983 (revised 2008) who will be escorted by at least one staff member for the duration of the journey.

    4. *People receiving in-patient treatment on a voluntary basis and needing to access alternative healthcare services or appointments where transport is necessary if for whatever reason 2 above is not appropriate then 3 above shall apply.

- Patients with an intravenous infusion that requires medical supervision

- Patients requiring oxygen.

- Patients with a chest drain or morphine pump.

- Patients attending renal dialysis sessions two or more times per week (for the duration of treatment).

- Patients attending radiotherapy/chemotherapy sessions two or more times per week (for the duration of treatment).

- Patients where independent travel presents a clinical risk such as low immunity patients or patients with a reasonable possibility of an event occurring during transport that requires skilled assistance i.e. Epilepsy

- Patients who have a clear need to travel in a wheelchair (providing they do not have a specially adapted vehicle, a mobility allowance or are unable to use public transport)

- Patients who cannot walk without continual physical support (not including the use of aids such as walking sticks or Zimmer frames)

- Patients who cannot use public transport (bus, train, community transport schemes, voluntary transport schemes, taxi) because they:
    - Have a medical condition that would compromise their dignity or cause public concern.
    - Have severe communication difficulties which routinely prevent them using public transport.

- Patients who are Blind, profoundly deaf or have speech (not language) difficulties which mean they are unable to travel alone.

4. Assessment criteria

The following assessment criterion has been developed to ensure PTS is provided to patients who are entitled to it and to determine the type of vehicle they need.

A series of questions is proposed to enable those assessing a patient's entitlement to make a clear decision and to be able to give those asking for patients transport an understanding why they are not entitled to receive PTS and what alternatives exist.

Stage 1 Assessing entitlement

FULFILLING ANY OF THE ETITLEMENT CRITERIA IN SECTION 3 WILL MAKE THE PATIENT ELIGIBLE TO PATIENT TRANSPORT SERVICES

If the MEDICAL reason is not detailed in the entitlement criteria the assessment team will use the next series of questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least monthly) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Patient Transport Services will be provided if after answering any combination of the above the patient achieves the assessment weighting of +5 as assessed by the assessment team

If patients do not have a medical reason listed or are assessed as not eligible for booking Patient transport Service the following advice should be offered.

- **Patients should be reminded that Hospital transport is only provided for those people with a medical need.**
- **Advise Patients of alternatives i.e. Volunteer Car Bureau (48 hours notice required, charges apply, approximately half price of Taxi cost)**
- **Train and bus time tables along with maps and routes to hospitals can be found at (input local information websites)**
- **Patient may be able to get Travel Expenses (HTCS) reimbursed if eligible.**
- **HCI forms for future help or HC5 form for refunds are available from Finance or from www.nhsbsa.nhs.uk**
- **Helpline 0845 8501166**

Stage 2: Assessing the type of patient transport

Does the Patient need to travel lying down on a stretcher?	For Patients up to 18 stone in weight, book as a Normal Stretcher (NS) Mobility Note: - HCT address assessment required For Patients over 18 stone in weight, book as a Bariatric Stretcher (BS) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6) Note: - HCT address assessment required
Does the Patient need to use a wheelchair or more than one assistant to walk? (Please specify if essential that wheelchair travels with patient and/or an electric wheelchair is being used)	For Patients able to transfer to a seat for transit? Book as Wheelchair Assist (WA) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen required) For Patients unable to transfer to a seat for transit, book as a Wheelchair In-situ (WI) Mobility (State number of Assistants required to transfer 1, 2, 3 or 4 and if oxygen and / or hosting equipment required) For Patients over 18 stone in weight, book as a Wheelchair Bariatric (WB) Mobility (State number of Assistants required to transfer, 2, 3, 4, 5 or 6 and if over 25 stone) Note: - HCT address assessment required
Can the Patient travel seated in a vehicle, can they walk and climb steps either independently or with the help of one person?	Book as a Walking Patient (WP) Mobility (State if oxygen required)

Patients and Carers

ESCORTS AND CARER'S WILL BE PROVIDED OR ALLOWED

- **When transferring a patient to/from a secure area (i.e. under Mental Health Section).**
- **For all persons under 16 years of age.**

If a patient requests an escort or carer to assist them, and they do not fit into the categories above the following information will be sought to ensure a carer/escort is only considered in the appropriate cases:

- **The patient's condition is such that they require constant attention or support, as confirmed by clinical assessment.**
- **The patient has severe communication difficulties for example, Blind, profound deafness or speech (not language) difficulties, and therefore is routinely unable to travel alone.**
- **The patient has a mental health condition that makes it unsuitable / unsafe for them to travel unaccompanied.**

Proposed assessment weighting linked to questions

Part 1

- What medical condition does the patient have that requires skilled assistance to transfer to and from a vehicle?
- What disability or condition does the patient have that makes it impossible or medically undesirable to travel by Public transport?
- What medical condition does the patient have that means there is a likelihood that an event could occur during transit that would require skilled assistance?
- What medical condition or disability does the patient have that may result in a risk to themselves or others?

Part 2

- How would the patient usually travel to see their GP?
- Does the patient routinely (at least once a week) get into a normal car by themselves and travel as a passenger?
- Does the patient use public transport (at least once a week)?

Assessment score for entitlement +5

Part 1

- Medical Condition/Disability is such that further assessment is not needed + 5
- Medical Condition/Disability is such that further assessment is needed + 3

Part 2

- Patient uses public transport, taxi, own car or walks to see GP - 3
- Patient only receives home visits from GP + 2
- Patient routinely travels in a car as a passenger - 3
- Patient routinely uses public transport - 3

NHS KENT AND MEDWAY PATIENT TRANSPORT SERVICE

INTRODUCTION

NSL is a public sector outsourcing specialist working for the NHS, Local Authorities and Central Government. We employ over 5,000 staff and are an Investors in People Gold organisation and an Investors in People Champion. We are a large, experienced PTS provider working with 15 NHS trust across the UK, delivering over 900,000 patient journeys per annum.

SERVICE OVERVIEW

The service was tendered in 2 Lots and NSL have been selected to deliver both:

- Lot 1 Patient Transport Service Centre (PTSC)
- Lot 2 Patient Transport Journey Provision Service

Lot 1 – Patient Transport Service Centre

The Lot 1 PTSC will be the first point of contact for patients accessing PTS in Kent. All patients who are Kent residents will access the service through a single dedicated number which will be chargeable at local rate from a landline telephone.

The PTSC will be co-located with an existing patient booking service at our centre in Shrewsbury, driving economies of scale. The staff at the PTSC will focus on ensuring that patients can access the service quickly, with minimum waiting time and that patient bookings are entered accurately. The PTSC represents the 'first impressions' of the NHS and we are focussed on ensuring that we get it right first time at the beginning of the process. The call takers at the PTSC will apply the NHS Kent and Medway Eligibility Criteria consistently to all callers to ensure that only those who meet the criteria access the service. Where a caller does not meet the eligibility criteria, we will offer advice and assistance to help identify an alternative transport solution for them. This will include signposting them to the voluntary sector, if appropriate. In this way, we will ensure that the limited resources available are directed towards those truly in need. Within the Lot 1 Service, NSL will provide a liaison officer to work with each healthcare organisation in Kent to facilitate adequate, effective operational management for patient transport and patient discharges. This Liaison Officer will be based in Kent and will also provide the link between the PTSC and the PTS service itself.

Lot 2 - Patient Transport Journey Provision Service

Within this service, the following will be provided:

- A routine service between the hours of 7.00 – 21.00, 7 days a week, 365 days a year, with reduced activity at weekends.
- Services for same-day and short-notice requests to provide a 2 hour and/or planned time slot service on a 24/7 basis. This will include facilitating same day discharges and inter-hospital transfers.
- A time slot where packages of care are being organised or where bed swaps are being organised at a specific time. Examples of timed responses are for the day hospitals, rehabilitation units and diagnostic scan appointments where arrival and return times for each session are critical to ensure patients receive maximum benefit from their attendance.
- A tailored service for patients receiving intensive treatment e.g.: Renal dialysis, Radiotherapy, etc.

It is our intention to operate the PTS service in Kent from 5 bases. This is shown in the map below and the lay down is broadly: Dartford, Medway/Maidstone, Tunbridge Wells, Ashford and Canterbury. The operating base locations have been selected to ensure that the majority of locations in Kent are within 45 minutes of a base.

Our proposal includes a fleet of 90 new vehicles covering the full spectrum of mobility types and includes 43 ambulances (multi-seat, stretcher, bariatric and HD).

Car - Operational	29
Wheelchair	18
Ambulance - Multi Seat	28
Ambulance - Stretcher	8
Ambulance - Bariatric	5
Ambulance - High Dependency	2
	90

To increase efficiency and control, all vehicles will have vehicle tracking and mobile data devices for real time despatch and control. Patient journeys will be allocated to drivers/crews by locally based planners and controllers using the Meridian Booking system. In addition to directly employed staff, we will use voluntary drivers and qualified bank staff where appropriate. We use volunteer drivers successfully in our other operations and we believe this using correctly vetted local volunteers adds flexibility and commitment to the overall service.

A key value added part of our proposal is the introduction of floorwalkers at the major acute hospitals. In our experience, correctly managing the discharge process is a vital part of a successful service. The floor walker's role is to liaise directly with hospital staff in the discharge lounges and on the wards themselves. They will attend bed meetings and will be the NSL point of contact at the hospital for PTS matters. This will give us early visibility of peaks in activity and enable informed planning for on the day discharges.

As with Lot 1, there will be a strong focus on performance and efficiency to ensure that we deliver a high quality, cost effective service. To ensure this, there are a range of Key Performance Indicators in the contract and measures that are yet to be formally agreed but which will be predominantly patient focussed. The NSL management structure will mirror that of NHS Kent and Medway to ensure that we provide escalation and scope for discussion at the tactical, operational and strategic levels. We see ourselves as a partner rather than a contractor and will ensure that the service delivery develops over time in line with the requirements of the CCGs.

Essential services within Lot 2 include:

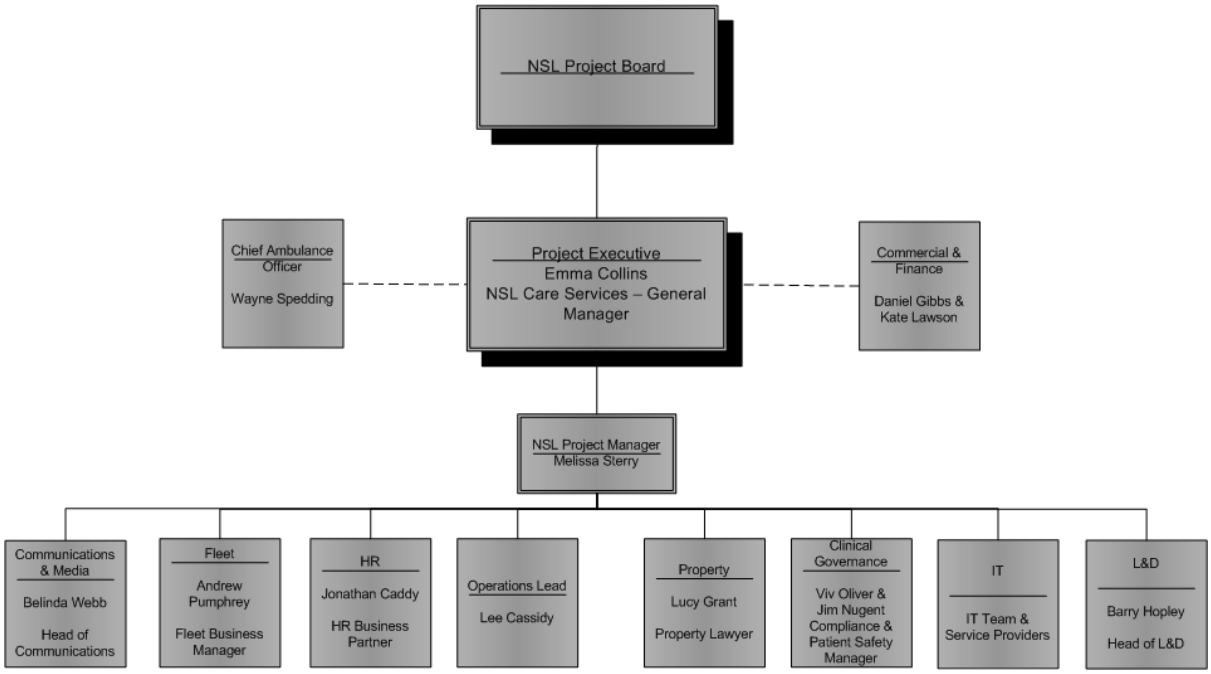
- All high dependency transfers
- Services for renal dialysis and oncology
- Urgent discharges and transfers to support system management where covered by this contract
- End of life transfers to home/hospice for critically ill patients

These services must continue and must not be suspended for any reason, including during periods of major incidents, adverse weather, staff shortages, industrial action, fuel disputes or other emergencies.

IMPLEMENTATION

NSL has a track record of successful implementations and has mobilised over 60 new contracts in the last 10 years, including 9 PTS contracts. We have wide experience of TUPE transfer and more than 60% of our workforce has transferred into NSL from other organisations (both public and private).

We have identified our project implementation team and these individuals are already working with NHS colleagues in Kent, attending meetings and starting the implementation process. The following organisation chart shows the levels of support that NSL will be applying to the mobilisation of the PTS service in Kent.



Our intention is to provide a largely seamless transition from the existing providers to NSL. This will involve extensive communications and stakeholder engagement to ensure that those impacted by the change are fully informed of the process. This includes liaising closely with local print and news media (in conjunction with the NHS Communications and Media Team) to ensure accurate and positive reporting of the transition.

On Day 1 of the new contract the only change we would expect our patients to notice is new vehicles and blue uniforms.

Alastair J Cooper
Managing Director - NSL Care Services

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 1 February 2013

Subject: Maidstone Hospital: Current and Future Developments.

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1. Background

(a) On 19 October 2012, the Chairman of the Committee was sent a letter by Glenn Douglas, Chief Executive of Maidstone and Tunbridge Wells NHS Trust. This provided information about the new Urgent Medical and Ambulatory Unit along with information on other work planned for 2013.

(b) This letter was circulated to HOSC Members and Glenn Douglas' offer to explain these changes in more detail accepted.

(c) Representatives of Maidstone and Tunbridge Wells NHS Trust last attended a meeting of the Committee on 12 October 2012 when it considered the item, *The Tunbridge Wells Hospital: One Year On.*[1]

2. Recommendation

That the Committee consider and note the report.

[1] https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

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Background

Maidstone and Tunbridge Wells NHS Trust wrote to Kent County Council Health Overview and Scrutiny Committee in October 2012 to inform HOSC members about current and future improvements in patient care at Maidstone Hospital.

This paper provides further information on the hospital's clinically-led plans and opening of its new Urgent Medical and Ambulatory Unit (UMAU).

1. Summary

1.1 Clinical leads at Maidstone and Tunbridge Wells NHS Trust (MTW) are developing and beginning to implement, with Board-level support, a new long-term Clinical Strategy to further enhance the patient experience at Maidstone Hospital.

1.2 The evolving strategy has already delivered its first improvements in patient care in the second half of 2012 with the opening of a new Urgent Medical and Ambulatory Unit (UMAU), specialist cardiac service and an intermediate care facility for patients.

1.3 This has started to reduce unnecessary hospital admissions, brought another specialist London-based treatment to Kent and promoted further collaboration within the local health community to the benefit of patients requiring acute, community and social care support.

1.4 MTW has doubled the number of clinicians directly involved in the Trust's management. Nine clinicians now sit on a new Trust Management Executive, providing greater clinical input and leadership at MTW.

1.5 Other clinically-led developments to improve the patient experience and clinical outcomes will continue at regular intervals until 2018. This includes a major ward modernisation programme spread over six years, to develop dedicated specialist medical wards with modern facilities.

1.6 The evolving Strategy, in its current outline form, builds on previous developments at the hospital, strengthening its position as an integrated provider of tertiary (highly specialist/niche) services, acute emergency and ambulatory healthcare for patients in Kent and Medway and the South East.

1.7 Central to all developments within the Strategy is the long-term and continuing provision of high quality and safe care for patients. This is provided in a sustainable and cost-effective way, transforming services, the ward environment and the overall patient experience to reflect local and national changes in healthcare provision.

2. Facilitating change

2.1 MTW's planned health service developments proactively respond to growing changes in national best practice, local GP commissioning intentions, and an ever greater focus on the public health agenda, as an opportunity and enabler to improve the experience of patients who use MTW services.

2.2 GP Clinical Commissioning Groups, and the NHS as a whole, are moving towards the provision of greater levels of ambulatory (day case) acute hospital care, primary care (GP) and community care (community hospital/people's own homes) to help reduce unnecessary hospitalisation. This is recognised in Kent County Council health strategy and supported by growing community and public health spending over the coming years to help people stay healthier for longer and better manage illness in their own homes, with support.

2.3 The Trust uses these changes to improve the patient experience in line with its own Vision to:

- Put patients first and deliver services which improve the quality of their lives
- Support MTW's aim to become an integrated care organisation, providing seamless patient care pathways both in and out of hospital
- Better enable MTW's clinicians to use their skills in the development of healthcare for the communities they serve
- Support possible future collaboration, and/or competition with other care providers to the benefit of patients

2.4 The Strategy will result in a total capital investment of over £20 million in Maidstone Hospital health services over the next six years. Future schemes include the redevelopment and modernisation of 14 of the hospital's 30-year-old wards to enhance patient privacy and dignity and clinical outcomes.

3. Timescales

3.1 MTW's Strategy deliberately runs until 2018 to ensure these ambitious improvements are paced to run alongside the achievement of higher levels of ambulatory care, community care, and ultimately fewer hospital admissions through better management of people's health.

3.2 These are key enablers that, alongside other factors (financial and physical), help determine the percentage of, and pace at which, ward modernisation can occur at Maidstone Hospital, as the number and nature of acute hospital beds changes over time to meet patient needs. The new modern ward layout will contain 66 fewer beds by 2018, than now, as more space is given over to other patient facilities that transform their privacy, dignity and care.

3.3 The lengthy timescales involved also provide these schemes with greater financial viability, spreading the large capital costs involved in transforming services over six years.

3.4 For practical reasons, no more than two wards can be taken out of operation and modernised, during any one year. This necessitates a longer overall period of time to complete all of the modernisation works.

3.5 The timescales involved also provide the Strategy with a level of flexibility. Changes can occur within the Strategy should new clinical practices yet to emerge offer even better patient outcomes in the future.

3.6 For that reason, the Strategy cannot exclude other developments from occurring in the future, if there is good clinical reason to do so that has yet to be recognised. It can, however, facilitate these.

3.7 An example of other services where potential further enhancement and improvement could occur to the benefit of patients in the future includes stroke and cardiac services.

3.8 Ultimately, the Strategy continues to deliver MTW's public pledge to develop both of its hospital sites, to a high standard and in good time, to the benefit of thousands of patients throughout West Kent and the north of East Sussex now and in the future.

4. Clinical excellence

4.1 MTW will improve the patient experience (focusing on efficient and effective treatment with higher levels of privacy and dignity), by providing fit for purpose medical facilities and treatment areas at Maidstone Hospital this decade. These will be capable of supporting the delivery of higher standards of care and patient safety in a modern-day environment.

4.2 Key clinical developments and other patient-experience enhancing changes within the Maidstone Strategy include:

- Development of a new £2.9 million Urgent Medical and Ambulatory Unit
- Ward modernisation and development of specialist medical wards
- New units for urology and endoscopy services, providing emergency, day case, and inpatient care
- Electrophysiological treatment and ablation service
- New admissions and discharge lounges
- Integrated "Community Care" project pilot
- Increase in car parking space

Development	Summary	Status
Development of a new £2.9 million Urgent Medical and Ambulatory Unit (UMAU)	Patients with urgent medical problems now benefit from faster diagnosis and treatment, reducing avoidable hospital admissions. UMAU aims to reduce medical admissions by up to 40% by providing patients with fast-track test results, earlier senior clinical input and care plans. Patients seen in UMAU are more speedily assessed by a consultant physician. The development includes the appointment of two new consultant physicians who will be available to see patients for longer each day, helping reduce unnecessary waits. This development supports Maidstone A&E department and will help enhance the management of patients requiring the most urgent and emergency care. GPs can also directly refer patients to be seen and treated in UMAU (see Appendix 1)	Completed. New facility opened in November 2012
Outcomes	Prior to UMAU opening on 12th November, around 80% of patients arriving in A&E with medical care concerns were admitted to hospital. Many patients were admitted unnecessarily overnight or longer waiting for tests, senior clinical input and discharge home with a treatment plan. Just over 20% of patients were seen, treated and able to go home the same day. By this time next year we hope up to 40% of patients will be able to go home the same day.	

Development	Summary	Status
Ward modernisation and development of specialist medical wards.	Currently medical patients are spread throughout Maidstone Hospital on general medical wards. Adjoining general medical wards in the hospital will be merged to create large specialist medical wards with central nursing stations. The change will enable patients to start the specialist care they need sooner reducing delays that can prolong recovery. The new-look wards will also enable patients to be treated in contemporary surroundings. The large-scale refurbishment, which will take six years to complete, increases the number of single rooms in the hospital and replaces former six-bedded bays with modern four-bedded bays, enhancing privacy and dignity. Each four-bedded bay will have its own bathroom. The single rooms will all be en-suite. Up to 13 patients on a typical ward, which are now 30-years-old, can share a single bathroom. The space between patient beds will also meet latest standards with up to an extra metre of space between each bed (see Appendix 2and 3)	2012-13 to 20-17/18
Outcomes	Work is due to start later this year on the modernisation of Jonathan Saunders and John Day Wards. These medical wards will specialise in respiratory care.	

Development	Summary	Status
Ambulatory day care unit for urology and endoscopy services	These enhanced facilities will enable the endoscopy service at Maidstone Hospital to achieve JAG accreditation, the kitemark for excellence in endoscopic procedures. The endoscopy development will enable the hospital to undertake more endoscopic therapeutic treatments, with new dedicated facilities, and extend the provision of sigmoidoscopies, as part of Kent's bowel cancer screening programme. The new expanded urology investigation unit will provide patients with a purpose-designed unit giving greater privacy and dignity than it is possible to achieve in its current location near the hospital's out-patient department. The two departments (urology and endoscopy) will be based on the ground floor of the former ISTC building. A new short stay surgery unit has now opened on the top floor of the ISTC for patients who do not need to stay for more than 24 hours.	Work underway shortly. New units In use by July 2013

Development	Summary	Status
EPS cardiac service	Cardiac patients with abnormal heart rhythms in Kent can now be treated at Maidstone Hospital. MTW has employed two new consultant cardiologists to provide the EPS (Electrophysiological Studies and Ablation) Service in the hospital's Cardiac Catheter Laboratory. EPS patients are treated with electric pulses to reset the heart's rhythm. In the past people needing this kind of treatment would have been referred to St Thomas's or King's College Hospitals in London. For many patients and their families this would have been logistically difficult and stressful. The Maidstone-based service is the first of its kind in Kent.	Completed. New service started in November 2012
Outcomes	The new service now provides cardiology patients with treatment that is more convenient for them and much closer to home. Most patients are seen as day cases with no need for them to be admitted into hospital overnight. Patients who were previously managing their conditions through medication leave hospital able to live normal lives.	

4.3 Other developments:

- Pilot project to develop a community ward inside Maidstone Hospital. Romney Ward began use as a community ward in December 2012 for patients who have completed the acute phase of their care and are medically fit, but still require a period of multidisciplinary assessment and support. The four-month trial is part of a collaboration between Kent County Council, Kent Community Health Trust and MTW.

  By mid January, a total of 62 patients had been admitted to the ward. The average length of stay was 7 to 8 days, which compares favourably with other community facilities. Early feedback from MTW's key performance indicators show patients receive good care, and are satisfied with their environment. There is growing evidence too that this new integrated pathway of care enables support mechanisms to be put in place sooner for

patients to return to their own homes. Fewer patients have required residential or nursing home placements as a result.

- The development of a new discharge lounge and upgrade of the hospital's admissions lounge, which it has now outgrown. The Trust plans to significantly improve both facilities for patients during 2013/14

- 120 extra car parking spaces on the Maidstone Hospital (subject to planning permission from Maidstone Borough Council) site for patients and staff in 2013/14. This recognises the future of Maidstone Hospital as a full and vibrant centre for the ongoing delivery of modern healthcare.

5. Ongoing Clinical Engagement

5.1 MTW's improvement plans for Maidstone Hospital are being progressed by the organisation's Clinical Directors and other clinical leads.

5.2 The outline Strategy has been shared with MTW's local Clinical Commissioning Group/Primary Care Trust and Strategic Health Authority.

5.3 MTW will work collaboratively with West Kent Clinical Commissioning Group, and other health partners, as new organisational structures within the NHS go live from April 2013, to ensure these improvements continue to be endorsed by, and reflect, the totality of local health thinking.

5.4 MTW is keeping local GPs and the Maidstone Branch of the British Medical Association informed and involved in the implementation of the earliest phases of the Strategy. All GP practices served by MTW in West Kent have been contacted about the UMAU development.

6. Stakeholder engagement

6.1 MTW has sought widespread publicity to promote the early stages of its improvement plans for Maidstone Hospital.

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6.2 It has used press releases, letters, and newsletters to promote these initial developments, via both on and offline means, to audiences including:

- The local media
- MPs
- Kent HOSC
- Kent LINk
- Local council
- Patients
- Hospital staff
- Campaigners

6.3 MTW has liaised with local health campaign group MASH to ensure their early and ongoing involvement in the future development of Maidstone Hospital.

6.4 The Trust has also publicised these developments on its website and via social media (Facebook facebook/mtwhospitals and Twitter @MTWnhs).

6.5 Information about the Strategy will also be included in MTW's public consultation this year to become a Foundation Trust.

7. Conclusion

7.1 MTW is embarking upon the development and implementation of schemes that will help transform the patient experience at Maidstone Hospital over the next five to 10 years.

7.2 These strategic developments are deliberately aligned to changes in the NHS, which will lead to a significant reduction in the number of medical inpatients requiring hospital admission and help reduce the length of stay for those that do.

7.3 The Strategy uses these changes as an opportunity to transform and enhance services at Maidstone, supporting the long-term provision of high quality and safe care for patients, in the most sustainable and cost-effective way.

7.4 The Strategy develops and modernises both acute emergency, planned inpatient and ambulatory day care services at Maidstone. This proactively enables MTW to positively respond to the national shift in provision of medical care from acute inpatient to ambulatory day care, and primary/community settings. It also supports MTW's aim to provide more integrated healthcare through the development of new partnerships and practices.

7.5 The Strategy includes the further repatriation of local patients currently seen and treated in London teaching hospitals, through greater specialisation.

7.6 Ultimately, the strategic developments ensure Maidstone continues to be a modern healthcare facility that patients wish to be treated in and GP clinical groups want to commission services from.

7.7 Audit of the hospital estate shows over 50% of the Maidstone site is in either immediate or growing need of attention to support the delivery of healthcare services in a safe and effective environment.

7.8 It would cost MTW in excess of £20 million to address backlog maintenance, on a like for like basis, on the Maidstone site. This would maintain outdated wards and service areas that are no longer fit for purpose. The strategic developments outlined in this report will bring about a step change in patient care, in line with latest national and local thinking, at a similar cost, while making effective use of scarce NHS resources by providing a good financial return for taxpayers measured in clinical gains for patients over many years.

Appendix 1 - Urgent Medical and Ambulatory Unit Maidstone Hospital

The new Urgent Medical and Ambulatory Unit (UMAU) opened to patients at Maidstone Hospital on Monday, 12th November, 2012.

What is its purpose?

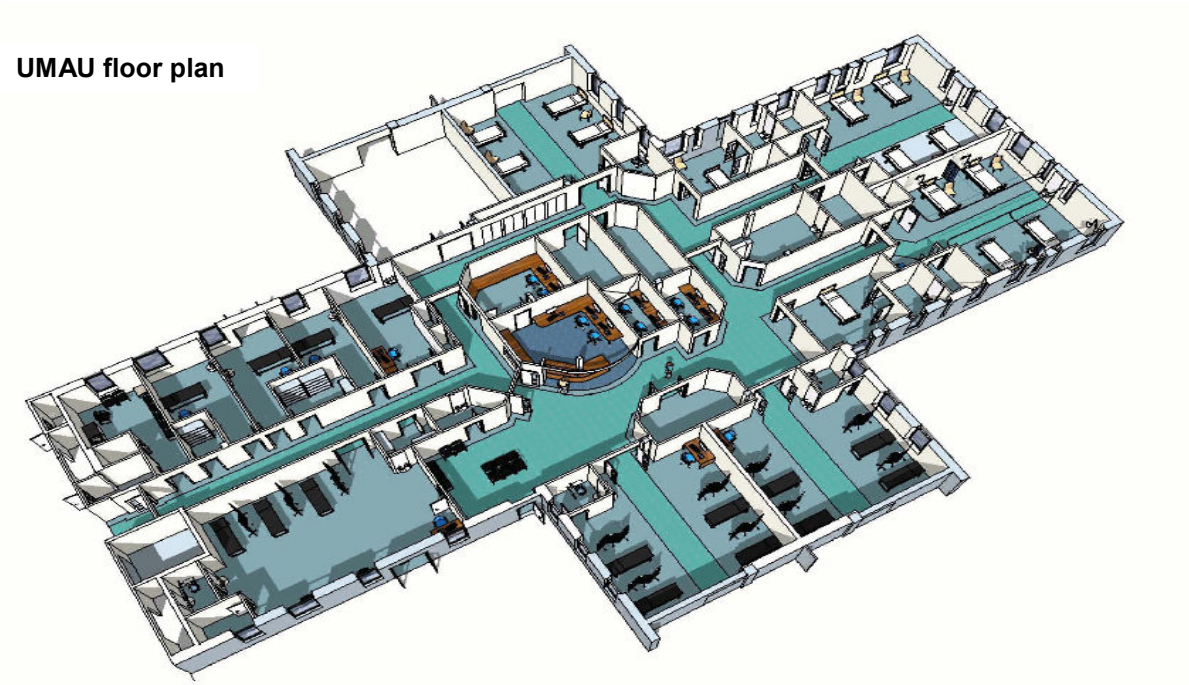
UMAU is a new Consultant-led unit for patients requiring urgent medical treatment. Its philosophy is simple – to provide same-day diagnosis, treatment and discharge for patients with urgent medical conditions, reducing avoidable hospital admissions. UMAU is working alongside the A&E Department at Maidstone Hospital. It is an additional emergency medical service for patients, not a replacement for A&E.

How does it work?

With the exception of GP referrals, patients will continue to be triaged in A&E as they are now. Patients with medical conditions who need to be seen by a physician will be treated in the new unit. In future GP medical referrals will go straight to UMAU because they have already been triaged/assessed by their GP.

Patients will be seen quickly in UMAU by a dedicated medical team including a senior physician, helping speed-up diagnosis and treatment times for patients. UMAU includes a rapid assessment clinic, procedure room, treatment suite (for planned patients with appointments for ongoing care) and 14 beds.

UMAU floor plan



What are the main changes for ambulance crews?

Patients taken by ambulance to Maidstone Hospital A&E Department will continue to be triaged in the same way as they are now. The ambulance crew will be directed to UMAU, following triage, if that is the appropriate place for the patient's care. Ambulance crews with GP referrals will be directed to UMAU when appropriate.

Where is UMAU based?

UMAU is based in the main hospital, on the ground floor, directly behind the A&E Department. It takes up the whole of what used to be Monckton Ward. Ambulance crews will be directed through the A&E Department to UMAU when necessary.

What are its opening times?

UMAU is essentially a 24/7 unit, providing round the clock care for patients 365 days of the year. A senior physician will be available to provide ambulatory care for patients from 8am to 10pm each day, with the last patients being booked in for treatment at 8pm. A member of the hospital's on-call medical team will see medical patients, in A&E, between 10pm and 8am.

UMAU's team of nursing staff will provide round the clock and overnight care for medical patients who stay on the unit for a maximum of 24 hours, before being discharged home or admitted on to a specialist medical ward.

Why have we opened UMAU?

Previously, the hospital's medical on-call team was called to A&E if a patient arrived in the emergency department with a medical condition. The patient may have been admitted on to a ward for diagnostic tests, senior clinical opinion, and a treatment plan before being discharged home. In some instances this could take 24 to 48 hours to complete. UMAU provides all of this care on the same day, enhancing the patient experience.

Appendix 2 - Current patient environment

Early thinking behind plans to improve the patient environment at Maidstone Hospital could see up to 14 neighbouring wards merge to create seven dedicated specialist wards, leading to greater privacy and care improvements for patients.

Standard ward – A standard ward at Maidstone Hospital can contain up to 28 beds consisting of up to four six-bedded bays and/or up to four single rooms.

Bed space - The current distance between the beds on a six-bedded bay is 2.4 to 2.8 metres from bed centre to bed centre. Beds on modern wards have more space between them for greater privacy, dignity and improved infection control.

Toilets and bathrooms per standard ward - A standard ward of four six-bedded bays (24 patients) has two bathrooms (each with a toilet), plus two separate toilets. Only two of the four single rooms on wards have en-suites. These facilities are normally located in a main corridor on the ward which is a thoroughfare for doctors, nurses, visitors, patients and other service providers using the ward such as porters, domestic and catering staff. At present, up to 26 patients can share four toilets and two bathrooms on a ward, the equivalent of 6.5 patients per toilet and 13 patients per bathroom.

The 14 wards identified for complete modernisation currently contain 260 beds. Maidstone Hospital has a total of 357 beds, which covers all clinical areas including small specialist areas such as Intensive Care.

Future patient environment

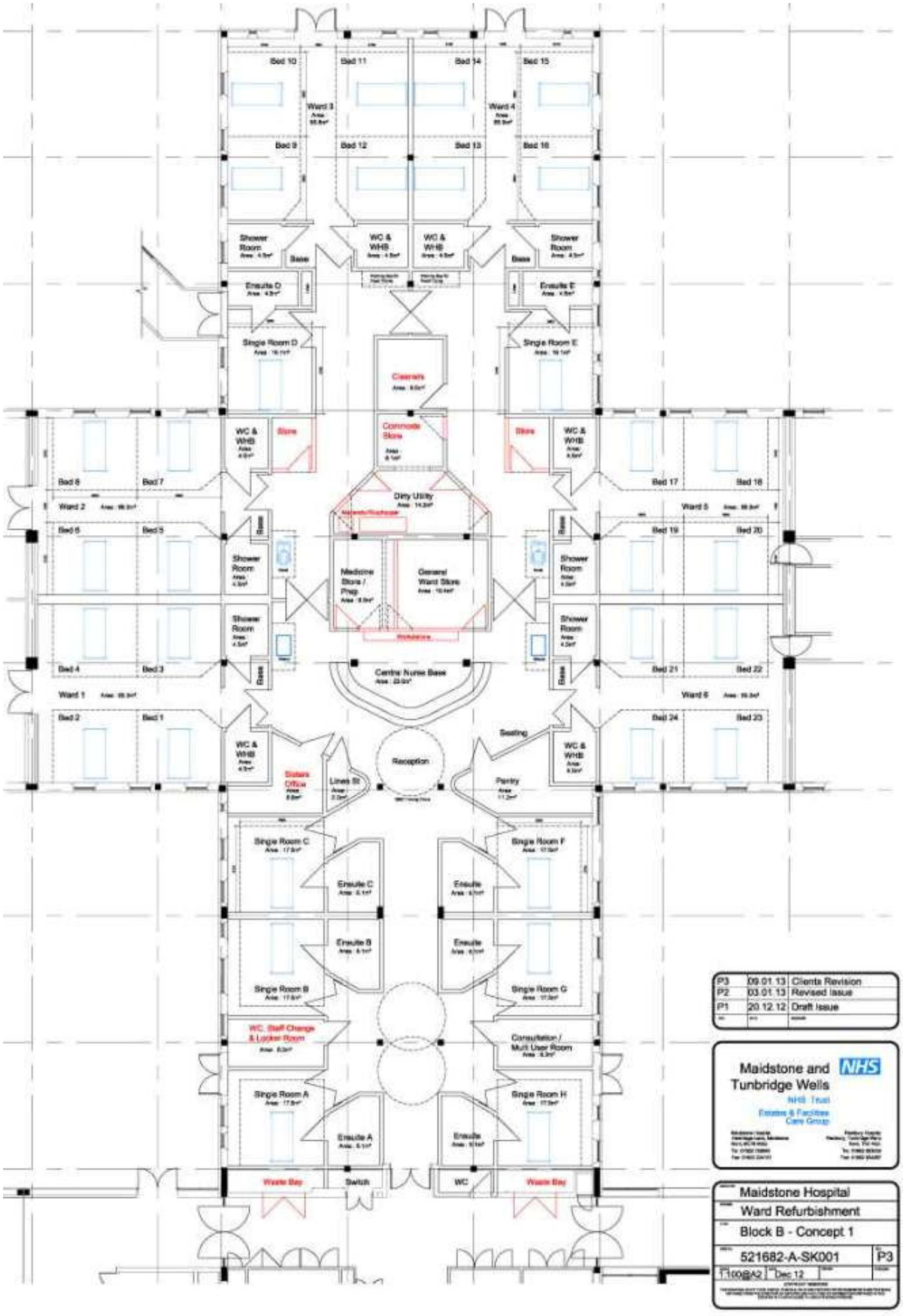
Specialist wards – Outline plans for the new specialist wards are at an early stage of development. It is likely that each specialist ward will have 32 beds. This includes 6 x 4 bedded bays and eight single rooms, improving the patient experience in key areas of privacy and dignity.

Bed space - In future, the distance between hospital beds will be 3.6 metres from bed centre to bed centre, giving patients an extra 1.2 metres of personal space in line with latest national health building guidelines for modern hospital wards.

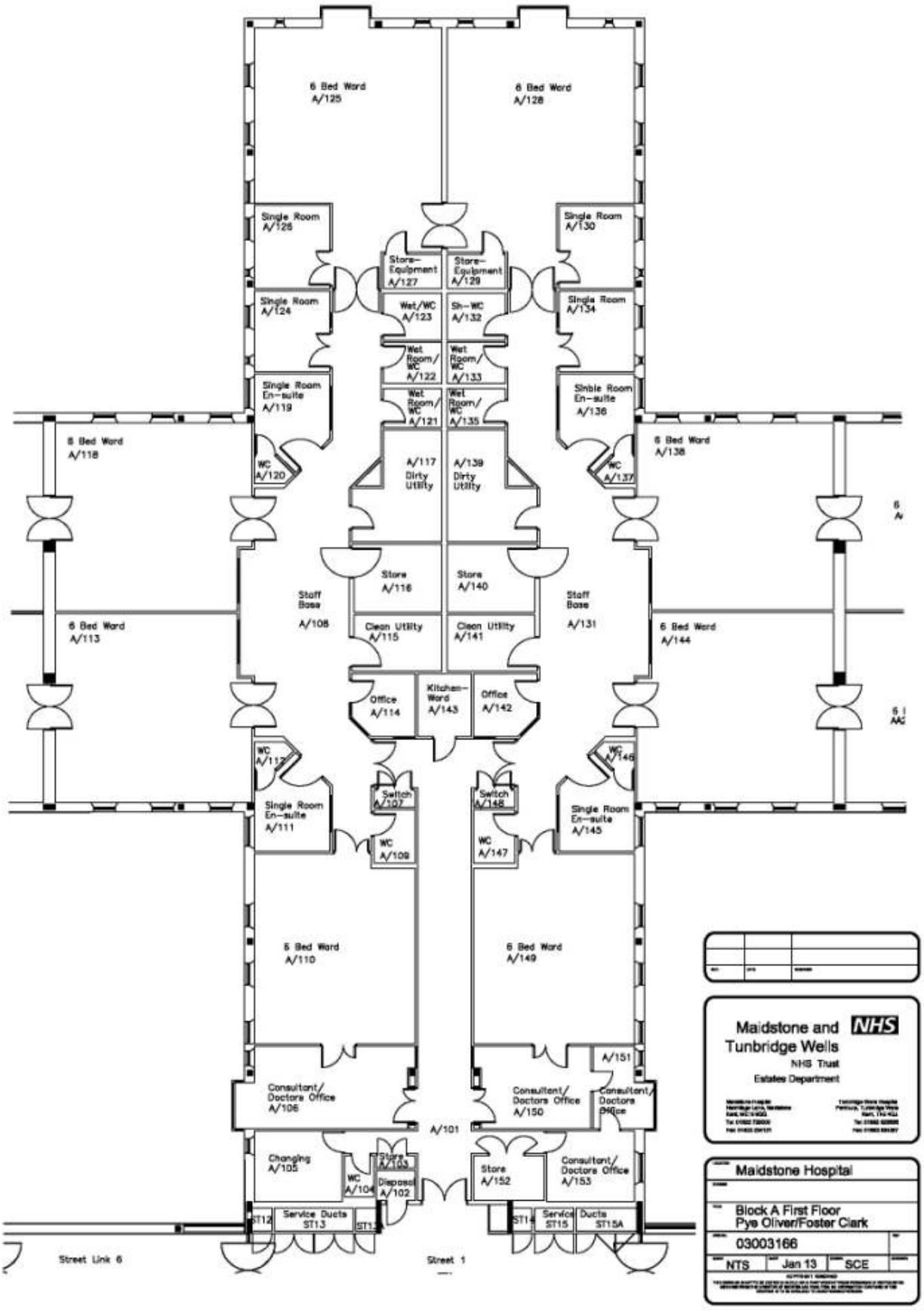
Toilets and bathrooms per specialist ward – The aim is for every four-bedded bay to have its own en-suite bathroom and toilet plus a separate toilet. All single rooms will be en-suite. This equates to four patients sharing a bathroom – compared to 13 currently - and two patients per toilet – compared to 6.5 currently. Importantly, patients will no longer have to walk through busy corridors to use these facilities, as they will all be en-suite either in their single rooms or on their bay.

The specialist medical wards will improve clinical care for patients and help speed up recovery times, as described earlier. Improving privacy and dignity with additional bathroom and toilet facilities for patients, and increased personal space between beds in line with modern standards, will reduce the total number of beds on the 14 wards, over the next six years, to 194. This is a total reduction of 66 beds.

Appendix 3 - Specialist ward floor plan (one large combined ward)



Appendix 4 – Current ward floor plan (two smaller separate wards)



By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 1 February 2013

Subject: Cancer Services: Overview.

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1. Background

(a) The term 'Cancer services' includes a broad field of NHS activity and cannot be fully covered within one meeting; however, with the publication in 2011 of *Improving Outcomes: A Strategy for Cancer* and the broader changes forthcoming to the NHS, the Committee has determined it would be useful to receive a snapshot of the services currently offered in Kent.

(b) The following questions were asked in advance of the meeting:

1. The 2011 cancer strategy contained a list of information which would prove useful to members of the public as well as providers and commissioners. The Committee therefore requests an overview of cancer services in Kent and Medway based on these key sets of information:

    a. the range of cancer services provided by each Trust;
    b. whether each team has core members from all the relevant disciplines;
    c. whether the team has a clinical nurse specialist;
    d. how many patients by equality characteristic were diagnosed/treated in the previous year;
    e. compliance with waiting time standards;
    f. compliance with peer review measures;
    g. major resection rates; and
    h. mortality rates within 30 days of treatment.

2. In addition, we would like to know:

    a. Whether any assessment has been made of how the 2011 cancer strategy is being implemented in Kent?

    b. What the future of the Kent and Medway Cancer Network will be after 1 April 2013?

2. Recommendation

That the Committee consider and note the report.

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By: Tristan Godfrey, Research officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee

Subject: Improving Outcomes: A Strategy for Cancer

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1. Introduction

(a) *Improving Outcomes: A Strategy for Cancer* was published by the Department of Health in January 2011. The aim of the outcomes strategy was to save 5,000 lives each year by 2014/15 along with reducing the inequalities gap. The following is a summary of some of the main features in the document.[1]

2. Improving Outcomes: A Strategy for Cancer

(a) Key facts:[2]

- More than 250,000 people in England are diagnosed with cancer each year; 130,000 die of the disease. 1.8 million are living either with or beyond cancer.
- Cancer survival rates at the European average would save 5,000 lives/year. Cancer survival rates at the European best would save 10,000 lives/year.
- The estimated cost of cancer services in 2008/09 was more than £5.1 billion (perhaps as much as £6.3 billion) and the cost to the economy as a whole, £18.3 billion.

(b) Lifestyle and Occupation[3]

- Changes to lifestyle behaviours could cut the number of cancers in half. Lifestyle changes can also prevent recurrence.
- Smoking is the major preventable risk of cancer. Those who are overweight or obese are more likely to develop cancer and more likely to die from it.
- According to the Health and Safety Executive, 8,000 cancer deaths in Britain each year are due to occupational exposure.

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[1] Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf Page numbers in references to this document unless stated. Supporting documents to the cancer strategy available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

[2] Pp.7-8

[3] Pp.36-7

(c) Patient Choice[4]

- Assisted by accessible and relevant information, in cancer services the following areas of choice are given as relevant in cancer services:

    - when to have treatment;
    - where to have treatment (some treatments can be given in hospital or in the community);
    - which organisation delivers treatment and care;
    - which team delivers the treatment; and
    - what form of clinically appropriate treatment to have.

(d) Outcomes Frameworks[5]

- The high level set of national outcomes against which the NHS Commissioning Board will be held to account is structured around five domains. A number of the indicators relate directly to, or include reference to, cancer. For reference, a summary of the 2012/13 NHS Outcomes Framework is appended to this Note.[6]
- The Social Care Outcomes Framework also contains a range of measures relevant for patients with cancer and their carers.[7]
- Similarly, the Public Health Outcomes Framework contains a number of indicators directly related to cancer.[8] The two high-level outcomes for the public health framework are:

    1. Increased healthy life expectancy.
    2. Reduced differences in life expectancy and healthy life expectancy between communities.[9]

(e) Waiting Times[10]

- In summer 2010 National Cancer Director was asked to review cancer waiting time standards. The review concluded that the standards should remain.
- The review considered the following waiting time standards introduced by the NHS Cancer Plan (2000) and Cancer Reform Strategy (2007): [11]

[4] Pp.21-3
[5] Pp.26-33
[6] Taken from: Department of Health, The NHS Outcomes Framework 2012/13 At a Glance, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131724.pdf
[7] For the full Social Care Outcomes Framework see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133334
[8] For the full Public Health Outcomes Framework see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
[9] Ibid., p.5.
[10] P.31

- Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP;
- Maximum one month wait from urgent GP referral to treatment for acute leukaemia and children's and testicular cancers;
- Maximum one month wait from date of decision to treat to first treatment for breast cancer;
- Maximum two month wait from urgent GP referral to first treatment breast cancer;
- Maximum one month wait from date of decision to treat to first treatment for all cancers;
- Maximum two month wait from urgent GP referral to first treatment for cancer.
- Maximum 31-day wait for subsequent treatment where the treatment is surgery;
- Maximum 31-day wait for subsequent treatment where the treatment is an anticancer drug regimen;
- Maximum 62-day wait from a consultant's decision to upgrade a patient's priority to first treatment for all cancers;
- Maximum 62-day wait from a referral from an NHS screening service to first treatment for all cancers; and
- Maximum two-week wait for first outpatient appointment for patients referred with breast symptoms, where cancer was not initially suspected.

(f) Screening.[12]

- The UK National Screening Committee will continue to provide advice to Ministers. PHE will set screening policy and the NCB will commission services on its behalf.
- 5% of cancers are currently diagnosed via screening, with the number set to rise as screening expands. One-third of breast cancers are diagnosed via screening.
- The national HPV immunisation campaign began in 2008. 80% of 12-13 year old girls received three doses of the vaccine in 2008/09.
- There are three nationally coordinated cancer screening programmes in England:
  - NHS Breast Cancer Screening Programme;
  - NHS Cervical Screening Programme;
  - NHS Bowel Screening Programme.[13]

- Prostate cancer screening was reviewed in 2009/10 with a decision not to introduce a programme. This decision will be reviewed in the

[11] Department of Health, *Review of Cancer Waiting Times Standards*, January 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123395.pdf
[12] Pp.38-42.
[13] NHS Cancer Screening Programmes, http://cancerscreening.nhs.uk/

future. An informed choice programme, Prostate cancer Risk Management, has been introduced.[14]

(g) Early Diagnosis[15]

- Nearly a quarter of all cancers are diagnosed through an emergency route.
- The DH began a £10.75m "signs and symptoms" campaign consisting of 59 local campaigns targeting awareness of the three cancers accounting for the greatest number of deaths.[16]
- A GP will on average see 8-9 new patients with cancer each year.
- The DH believes GPs should be able to directly refer to the following diagnostics (where the two week urgent referral pathway is not appropriate): Chest x-ray; non-obstetric ultrasound; flexible sigmoidoscopy/colonoscopy; Magnetic Resonance Imaging (MRI). Guidance was published in April 2012.[17]
- Work is ongoing about raising awareness of rarer cancers.

(h) Living with cancer, survivors and carers[18]

- By 2030 it is estimated that 3 million people will be living with or beyond cancer. Nearly two-thirds of cancer survivors are over 65 years old.
- A number of different actions to improve the quality of life of survivors and carers are given in the strategy.
- A national survey of cancer survivors is being piloted in 2011 to help improve services.
- 28% of all deaths are due to cancer. Reference is made to the End of Life Care Strategy of 2008. [19]

(i) Improving treatment[20]

- Three measures are listed to improve access to high quality surgery.
    1. promote the uptake of the latest surgical techniques, ensuring that the existing surgical workforce receives appropriate training to do this;
    2. reduce regional variation in access to surgery; and

[14] Ibid.
[15] Pp.43-6
[16] An evaluation of the 2010/11 pilots as published by the Department of Health on 26 June 2012, http://www.dh.gov.uk/health/2012/06/evaluation-cancer-pilot/
[17] Department of Health, *Direct access to diagnostic tests for cancer: best practice referral pathways for general practitioners*, 12 April 2012, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133510
[18] Pp.47-54
[19] Department of Health, *End of life care strategy*, 16 July 2008, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277
[20] Pp.55-63.

3. improve intervention rates for older people who could benefit, ensuring that age alone is never a barrier to the most appropriate treatment.

- Modelling suggests 52% of cancer patients should receive radiotherapy. In 2007, only 37% did.
- Additional investment is being made in radiotherapy. Options for developing Proton Beam Therapy are being explored. The Strategic Outline Case for the National Proton Beam Therapy Service Development Programme was published by the Department of Health on 12 October 2012. Proton Beam Therapy is not currently available in the country and patients travel overseas for treatment. The Strategic Outline Case sets out plans for the first one to be operational in 2017.[21]
- Value based pricing for drugs, including cancer drugs, will be introduced in 2014. In the interim, the Cancer Drugs Fund has been introduced.
- The average length of stay for cancer inpatient admissions varied from 5.1 to 10.1 days between PCTs.

(j) Commissioning and Cancer Networks[22]

- Cancer networks, like other clinical networks, bring together clinicians from different sectors to improve pathways of care and integration.
- In the future a number of cancer services will be classed as specialised commissioning and commissioned by the NCB.
- A large amount of cancer care needs commissioning for populations of 1.5-2 million.
- The cancer strategy discusses the role of cancer networks in the future. One of the first four strategic clinical networks which will be established by the NHS Commissioning Board will focus on cancer.[23]
- In 2012/13 cancer networks are funded by the Department of Health. From April 2013, the funding of clinical networks will be through the NHS Commissioning Board.
- £42 million has been allocated by the NHS Commissioning Board to support Strategic Clinical Networks and Clinical Senates in 2013/14. 12 support teams will be hosted the NHS Commissioning Board Local Area Teams.
- A range of tariffs will be developed to incentivise quality treatment.

[21] Department of Health, *Developing a national proton beam therapy service,* 12 October 2012, http://www.dh.gov.uk/health/2012/10/proton-beam-therapy/
[22] Pp. 19, 71-74.
[23] NHS Commissioning Board, *The Way Forward: Strategic Clinical Networks,* 26 July 2012, http://www.commissioningboard.nhs.uk/files/2012/07/way-forward-scn.pdf

3. Annual assessment of the cancer strategy

(a) The first annual report into *Improving Outcomes: A Strategy for Cancer* was published in December 2011.[24] The achievements are given as including:

- improved data collection and analysis,
- expansion of the cancer screening programmes,
- campaigns to improve the public's awareness of cancer symptoms and to encourage them to present promptly to the doctor,
- surgical training programmes, and
- reducing inpatient bed days.

(b) The following were highlighted as challenges for the subsequent year:

- moving forward on piloting flexible sigmoidoscopy bowel screening,
- a national awareness campaign on bowel cancer,
- improving diagnostic capacity and productivity,
- the needs of survivors in different post-treatment phases,
- providing information to commissioners and providers about patients' experience of care, and
- giving support to tackle issues such as information provision and better communication.[25]

(c) The second annual report was published on 11 December 2012. This states that the data to assess whether the goal of saving an additional 5,000 lives will be met is not yet available, but that there have been improvements in survival rates. The further work to be done includes:[26]

- Raising awareness of the role lifestyle changes can have on preventing cancer.
- Improving cancer survival rtes through, for example, extending breast and bowel screening programmes, and introducing flexible sigmoidoscopy bowel screening.
- Improving the quality of life for cancer survivors.[27]
- Improving patient experience.

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[24] Department of Health, *Improving Outcomes: A Strategy for Cancer - First Annual Report 2011*, 13 December 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131690

[25] Department of Health, *Assessment of strategy for improving cancer outcomes published*, 13 December 2011, http://www.dh.gov.uk/health/2011/12/cancer-annual-report/

[26] Department of Health, *Improving Outcomes: A Strategy for Cancer Second Annual Report 2012*, 11 December 2012, pp.7-8, https://www.wp.dh.gov.uk/publications/files/2012/12/cancer.pdf

[27] For further information on this point see: Department of Health, *Cancer survivors give their views in pilot survey*, 11 December 2012, http://www.dh.gov.uk/health/2012/12/cancer-proms/

The NHS Outcomes Framework 2012/13

At a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

*Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.

** A complementary indicator is included in the Adult Social Care Outcomes Framework

***Indicator replicated in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Kent and Medway Cancer Network

Overview of Cancer Services in Kent and Medway

The 2011 Cancer strategy contained a list of information which would prove useful to members of the public as well as providers and commissioners.

The following report sets out an overview of Cancer Services in Kent and Medway as requested by the Committee and specifically addresses the questions raised under section 1.

Question 2a is addressed in the accompanying document Cancer Peer Review Report 2011 - 2012

Kent & Medway Cancer Network South Zone Peer Review Team June 2012.

This report contains:

- An overall summary diagram of the structure of the Network and compliances
- A national benchmarking summary of MDT and Network measures
- An overall Network Report which contains:
- Contextual information about the Network
- An Executive Summary
- Progress against Improving Outcomes Guidance
- A summary of compliance of MDT measures per Trust

Question 2b is addressed in the attached document: KMCN Closure letter 2013 01

Section 1

1. **A) The range of cancer services provided by each Trust.**

An overview of Unit, Centre and Supranetwork Cancer Services in place for Kent & Medway

Provider (s) →	East Kent			West Kent & Medway			Centre/Supranetwork Providers							
Cancer Type & Process ↓	East Kent Ashford	East Kent Canterbury	East Kent Margate	Maidstone & Tunbridge Wells Maidstone & Pembury *MTW have now merged all of their Disease Sire Specific MDTs*	Dartford	Medway	Guy's	King's College Hospital	Royal Marsden	St Georges	University College Hospital	RNOH	Charring Cross	East Grinstead
Breast														
Unit level MDT	✓	✓	✓	✓	✓	✓								
Routine surgery	✓		✓	✓	✓	✓								
Limited reconstruction				✓		✓								
Reconstruction *Whole of K&M*														✓
Liver resection *Whole of K&M*								✓						
Brain & Central Nervous System														
Centre level MDT & surgery								✓						
Unit level MDT and surveillance *Whole of K&M*				✓										
Colorectal														
Unit level MDT	✓		✓	✓	✓	✓								
Routine surgery	✓	✓	✓	✓	✓	✓								
Routine surgery linked to Ashford +/- Margate MDTs		✓												
Anal cancer MDT *Whole of K&M*				✓										
Salvage surgery for anal cancer *Whole of K&M*				✓										
Trans-anal microsurgery for rectal cancer *Whole of K&M*				✓				✓						
Liver resection *Whole of K&M*								✓						
Gynaecology														
Unit level MDT			✓	✓	✓	✓								
Centre level MDT & surgery			✓	✓										
Germ cell MDT and treatment *Whole of K&M*													✓	
H&N														
Centre level MDT	✓			✓										
Centre level surgery for EK	✓													
Centre level Surgery for WK														✓

Provider (s) →	East Kent			West Kent & Medway			Specialist Centre/Supranetwork Providers								
Cancer Type & Process ↓	East Kent Ashford	East Kent Canterbury	East Kent Margate	Maidstone & Tunbridge Wells Maidstone & Pembury *MTW have now merged all of their Disease Sire Specific MDTs*	Dartford	Medway	Guy's	King's College Hospital	Royal Marsden	St Georges	University College Hospital	RNOH	Charring Cross	East Grinstead	St John's (GKT)
Haematology															
Unit level MDT and treatments		✓		✓	✓	✓		✓							
Centre level MDT & treatments (e.g. Bone Marrow Transplant) *Whole of K&M*								✓							
Sarcoma *															
Bone MDT, surgery & chemotherapy *Whole of KM*									✓		✓	✓			
Soft tissue surgery & chemotherapy *Whole of K&M*									✓		✓				
Skin															
Centre level MDTs & treatments		✓				✓									
Specialist level treatments							✓								✓
Unit level treatment	✓	✓	✓	✓		✓*								✓*	
Thyroid															
Unit level MDT		✓		✓											
Surgery		✓		✓		✓									
Upper GI															
Unit level MDT	✓ *(linked)*			✓	✓	✓									
Centre level MDT for oesophago-gastric *Whole of K&M*				✓											
Oesophago-gastric surgery *Whole of K&M*				✓											
Centre level MDT for pancreas *Whole of K&M*								✓							
Pancreatic surgery *Whole of K&M*								✓							
Urology															
Unit level MDT and routine surgery		✓		✓	✓ *Linked*										
Penile cancer MDT & surgery										✓					
Testicular cancer MDT									✓						
Centre level MDT		✓				✓									
Radical prostatectomy		✓				✓									
Total cystectomy		✓				✓									
Complex nephrectomy							✓								

(*These Skin MDTs function as a "single" MDT, QVH relies of MFT for joint Unit/Centre status)

1. b) Whether each team has core members from all the relevant disciplines -

1. c) Whether the team has a Clinical Nurse Specialist

All team except those detailed in the following table have core members from all the relevant disciplines and include a Clinical Nurse Specialist

Kent & Medway MDT Core Membership by disease group

EAST KENT BREAST MDT	**2012/2013 Peer Review Cycle Information**
Kent & Canterbury Hospital	Not a complete team:- No named Histopathologist, only one Radiologist attends the MDT, Oncologist has limited cover
Queen Elizabeth The Queen Mother Hospital	Not a complete team:- No 2nd Histopathologist, 2nd Radiologist
Brain and Central Nervous system MDT	
Maidstone Hospital	Not a complete team:- No Occupational Therapist, Speech & Language Therapist Specialist Palliative Care representation, Physiotherapist, Keyworker. No formal CNS cover (just informal). does not meet attendance requirements, limited Oncologist cover, Research nurse needs to attend the MDT.

1 d) The number of patients by equality characteristic diagnosed/treated in the previous year

New cancers diagnosed – Jan to Dec 2011: 11,372

Male	6009
Female	5363
Age	
<= 18	15
19 – 40	328
41 – 60	2252
61 – 80	6361
80+	2187
Unknown	229

1 e) compliance with waiting times standards - Cancer Waiting Times Dashboard - Kent and Medway 2011 summary

Percentages	Operational Standard	Tolerance	January 2011	February 2011	March 2011	April 2011	May 2011	June 2011
14 Days	**93**	**+2%**	94.7	**97.1**	**96.3**	**95.7**	94.8	94.4
14 Days Breast Symptoms	**93**	**+2%**	95.2	95.1	94.8	94.1	93.6	94.0
31 Days First Treatment by Tumour	**96**	**+1%**	97.9	96.0	98.2	97.8	97.5	99.2
31 Days Subsequent Treatment by Tumour	**98**	**+1%**	98.7	99.1	98.6	**97.8**	98.9	98.1
31 Days Subsequent Drug Treament	**98**	**+1%**	100.0	100.0	99.4	98.6	100.0	**97.9**
31 Days Subsequent Radiotherapy	**-**	**-**	98.0	100.0	98.9	98.2	99.3	99.7
31 Days Subsequent Surgery	**94**	**+1%**	98.6	96.4	96.7	95.9	97.6	94.5
62 Days Standard	**85**	**+3%**	85.6	**84.3**	89.1	90.2	86.3	88.9
62 Days Screening	**-**	**-**	95.3	91.9	92.1	100.0	97.1	95.6
62 Days Upgrade	**-**	**-**	100.0	81.2	82.6	71.4	90.5	90.9

Percentages	Operational Standard	Tolerance	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011
14 Days	**93**	**+2%**	95.9	95.7	95.3	96.0	97.0	97.4
14 Days Breast Symptoms	**93**	**+2%**	94.8	95.1	94.1	94.9	94.2	94.2
31 Days First Treatment by Tumour	**96**	**+1%**	98.7	98.7	98.5	98.4	98.3	98.7
31 Days Subsequent Treatment by Tumour	**98**	**+1%**	99.8	99.2	99.5	99.4	99.7	99.7
31 Days Subsequent Drug Treament	**98**	**+1%**	99.3	100.0	99.3	100.0	100.0	100.0
31 Days Subsequent Radiotherapy	**-**	**-**	100.0	99.7	100.0	100.0	100.0	100.0
31 Days Subsequent Surgery	**94**	**+1%**	100.0	97.0	98.6	98.2	98.7	98.6
62 Days Standard	**85**	**+3%**	88.9	89.8	88.3	85.8	87.3	90.3
62 Days Screening	**-**	**-**	88.6	96.7	97.8	91.4	100.0	89.4
62 Days Upgrade	**-**	**-**	100.0	83.3	100.0	82.4	85.7	81.0

Dark grey	Above Target
Light grey	Within Tolerance of Target
White on grey	Below Target

1 f) Compliance with peer review measures.

Please see attached document Cancer Peer Review Report 2011 – 2012

1 g) major resection rates –

I am unable to supply this data – the provider organisations will submit this data in April for national upload. Once the quality of the data has been reviewed these figures will be made available.

However the numbers of Patients with surgery as their first definitive treatment:

7562 patients have a first definitive treatment recorded

4232 have surgery as first definitive treatment = 55.96%

1 h) Mortality within 30 days of treatment

I am unable to supply this data at this point in time – This data is beginning to be collected by the provider organisations – they are not mandated to submit against this until 2014 and at this time remains incomplete.

2 a) is addressed in the accompanying document Cancer Peer Review Report 2011 – 2012

2 b) is addressed in the attached document: KMCN Closure letter 2013 01

Kent and Medway Cancer Network
50 Pembroke Court
Chatham Maritime
Chatham
ME4 4UF

16th January 2013

Our Ref: SD/NG/ivbnct

For the attention of: All Stakeholders within Kent & Medway

(sent via email to avoid delay)

Dear Colleagues

RE: Kent and Medway Cancer Network

The Kent & Medway Cancer Network (KMCN), which was established in 1999 following the Calman Hine Report, will cease to exist in its current format after the 31st March 2013 as a result of the NHS reforms.

The plans are to replace the current Networks with Strategic Clinical Networks (SCNs) which will cover a larger geography in line with the new Clinical Senate of Kent, Surrey and Sussex. The new SCNs will have a generic approach covering not just cancer, but also cardiac and stroke, maternity and child health, mental health, dementia and neurological conditions. These new organisations will have fewer support staff than are currently available and will be focused on improving quality and outcomes in line with the NHS Outcomes Framework. We are advised that the SCNs will build on the legacy of the existing configuration of Networks and will have clinical, patient and public engagement at their heart.

We have attached a copy of the "The Way Forward: Strategic Clinical Networks" which outlines the vision for the SCNs in the new NHS. The specific details of the SCN work programme are still being finalised and Deborah Tomalin has now been appointed as the Associate Director of the SCNs/Senate for Kent, Surrey and Sussex to support that process.

As yet we are still awaiting more details on what this means for KMCN led groups, such as the Clinical Advisory Team (CAT), Disease Orientated Groups (DOGs), and their various sub groups (i.e. Non-surgical Oncology Sub Groups (NOGs), Research and Trials Groups (RATs)), Cross Cutting Advisory Groups (CCAGs) and the User/Patient Partnership Groups. We will let you know as soon as more information becomes available.

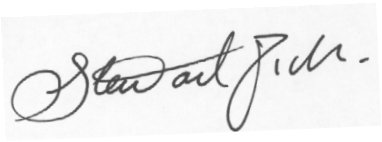
Hospital Trusts will still be required to have Network-wide clinical guidelines, agreed configurations and a collective review of audit, all of which we will be supporting the Trusts over the next couple of months on how these can be achieved alongside the emerging Operational Delivery Networks.

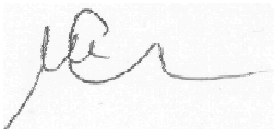
Meetings are currently being held between the Network, commissioner and provider organisations to assess the risks and implications associated with the closure of the KMCN in its current format and how these risks might be mitigated.

We can confirm that it has been announced by the National Peer Review Team that any assessment against the Network Group and Network Board measures are suspended for 2013/14. However, the Trust level measures will still fall into the assessment cycle.

We would like to thank you for your continued support and input to the Network over the years, we have jointly achieved a great deal to improve services for people with cancer and been an innovative and forward thinking Network which will leave a lasting legacy across Kent & Medway.

With kind regards





Stewart Dicker
Clinical Director, Quality & Care
Kent & Medway Cancer Network

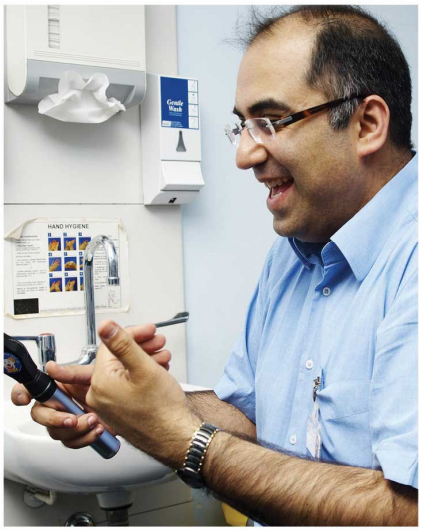
Nic Goodger
Medical Director, Secondary Care
Kent & Medway Cancer Network

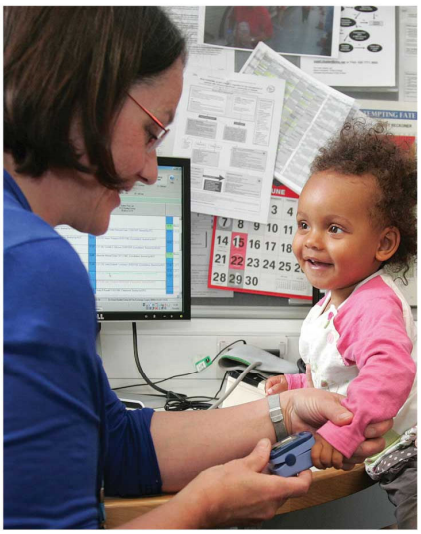
Enc.

NHS
Commissioning Board
A special health authority

The Way Forward:

Strategic clinical networks





THE NHS CONSTITUTION
the NHS belongs to us all

The Way Forward

Strategic clinical networks

First published: 26 July 2012

Prepared by

NHS Commissioning Board, a special health authority

Contents

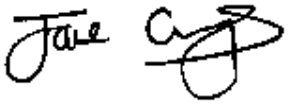
Foreword

Clinical networks are an NHS success story. Combining the experience of clinicians, the input of patients and the organisational vision of NHS staff they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care. For example, stroke networks have enabled transformation in the way services are delivered in many parts of the country leading to measurable improvements in both outcomes and experience for patients. Cancer networks have raised standards, supported easier and faster access to services and encouraged the spread of best practice.

We want to build on the success of networks and ensure that the NHS Commissioning Board and clinical commissioning groups have access to a broad range of expert clinical input to support and inform their decisions about the way care for local populations is planned and delivered.

Over the past year, we have worked with colleagues across the NHS to develop and enhance clinical networks. There has been extensive discussion and engagement about how we can improve this part of the new system, with an extraordinary and welcome level of interest from within the NHS, from patients and from specialist interest groups. We want to thank everyone for their contributions, which have been vital in the way we have shaped our proposals.

We know there are currently many different types of clinical networks. We want this to continue in the future because networks perform varied and valuable roles. This document focuses specifically on strategic clinical networks, which will be established and hosted by the NHS Commissioning Board.



Professor Sir Bruce Keogh

Medical Director

NHS Commissioning Board Authority

Jane Cummings

Chief Nursing Officer

NHS Commissioning Board Authority

Introduction

Continuously improving the quality of care we give our patients and the outcomes of their treatment is the core purpose of the new NHS commissioning system. Clinical commissioning groups (CCGs) and the NHS Commissioning Board (NHS CB) will use the interactions they have with providers (such as hospitals) and the clinical expertise offered by new organisations in the system to drive these improvements.

In the current system, clinical networks have been responsible for some significant improvements. Groups of health professionals, hospitals and other providers and commissioners have collaborated to make improvements in their local area, in a particular pathway or for a particular group of patients. This approach has led to real change and sustained improvement over the past decade. The NHS CB is committed to ensuring that, in the new system, we maintain this way of working and delivering services.

Existing networks in the NHS have varied in their formality, function and funding structures. Informal clinical networks have often been created by professional groups as a way of diffusing knowledge, learning and best practice, supporting professional development and to drive implementation of new ways of working.

Elsewhere, formal clinical networks have been established to bring improvements to clinical pathways or areas where many professional groups and organisations are involved in the development and delivery of care. This may be for a specific condition or patient group and is often across a defined geographical area. They have typically had formal leadership and governance structures and have operated with a mandate from commissioners and providers to work on their behalf and ensure that the quality of care for all patients is consistently high.

In the new system, we want to ensure that the benefits of clinical networks, whether formal or informal, continue. For instance, some networks are currently hosted by primary care trusts but after 2013 these organisations will not longer exist. In the new system, the NHS CB will act as a host, including providing financial support, for a number of these more formal clinical networks. These networks will work across the boundaries of commissioning and provision, acting as engines for change in the modernised NHS.

We will introduce a new type of network called strategic clinical networks. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities.

For some services such as burns care, critical care, neonatal and trauma care operational delivery networks have brought providers and commissioners together to coordinate patient pathways over a wide geographic area to ensure access to specialist resources and expertise. The NHS Commissioning Board Authority (NHS CBA) recognises the vital importance of these delivery focussed networks and will soon announce how they will be maintained in the new system.

The NHS CB wants to encourage CCGs and local health economies to develop or continue their own networks for clinical pathways or for patient groups which would benefit from this kind of focus. Where professionals and organisations see value in working as a network to improve care, they should do so. The support teams for strategic clinical networks will be able to offer support and learning to help the development of local networks.

This document sets out the NHS CBA's work in setting the criteria for deciding on the strategic clinical networks that it will host, and identifies the areas where

we will continue to do more work in advance of the new system coming into effect on 1 April 2013.

Strategic clinical networks will develop key relationships with other networks and organisations, such as clinical senates, academic health science networks (AHSNs), local education and training boards (LETBs) and clinical research networks, and this document also explains how those interactions should operate.

Clinical networks in the new health system

Networks in the NHS have focussed clinical advice and leadership on specific conditions and patient groups. This has led to improvements in the quality of services, in significant changes in the delivery of some services and a reduction in unacceptable variations of care.

The new commissioning system will encourage a range of networks performing different functions. These will include:

- a small number of strategic clinical networks that are established and supported by the NHS CB to advise commissioners, support change projects and improve outcomes;

- operational delivery networks that are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources, such as critical care beds or burns units;

- local professional networks developed by the NHS CB to advise on the commissioning of a specific service such as dental, pharmacy and optometry services;

- local networks decided on and resourced by CCGs to support the achievement of local priorities and ways of working; and

- networks established and maintained by a group of providers to enable the joint delivery of a service.

CCGs and the NHS CB will be able to establish and retain clinical networks, for specific conditions or patient groups to assist them in achieving their core purpose of quality improvement.

It is expected that CCGs may choose to deploy clinical networks to support them with local priorities and ways of working. The NHS CB will be able to use networks where it has a direct involvement in the commissioning of a service; where a national steer is needed to support implementation and where national network coverage is needed.

Strategic clinical networks will work on the guiding principle of engaging patients and the public in all their work, whether it is developing quality improvement bodies or providing an oversight of the network's activities. The NHS CB is developing a universal approach to ensure that public and patient involvement is meaningful and effective. Other organisations, particularly those from social care and the voluntary sector, will also be important partners in strategic clinical networks.

CCGs, the local area teams of the NHS CB and the providers of NHS services within the geographical area will be key stakeholders. CCGs will be able to use

networks as a source of clinical advice and support in driving their quality improvement programmes locally.

Strategic clinical networks will assist commissioners in ensuring best value for money in addition to improving the quality of care and outcomes for patients.

Establishing strategic clinical networks

The new commissioning system is designed to give clinicians the best opportunities to plan and pay for the most appropriate and effective health services for their local populations. This local focus, supported by an NHS structure that has clinicians at every level, aims to improve the health outcomes that matter most to patients.

A small number of strategic clinical networks will help drive improvements in key areas.

- when a large scale change is required across very complex pathways of care involving many professional groups and organisations and is the best approach to planning and delivery of services; and

- where a co-ordinated, combined improvement approach is needed to overcome certain healthcare challenges, which have not responded previously to other improvement efforts.

Strategic clinical networks will focus on the main health issues identified by the NHS CB against a set of criteria. The decision to establish a strategic clinical network will be based on achieving significant and lasting change.
We have used the following criteria to identify the first strategic clinical networks.

- there is a strong case for a measurable improvement in quality of care, due to poor outcomes in relation to international comparators and / or there are significant variations across the country;
- there are significant benefits that can be achieved for patients, professionals and partner organisations;
- a wide range of professionals and organisations are already involved in the delivery of care;
- a network approach is the best way to plan and deliver a specific care pathway due to the scale and volume of the condition it addresses;
- there are demonstrable links to NICE guidance;
- there is good evidence and / or rationale for why the desired quality improvement could not be achieved by other means such as by a clinical commissioning group or by using contracts or tariffs;
- there is evidence and /or rationale that the quality improvement required can be achieved through a network model;
- a whole-England approach is the best way to improve services; and
- there is a risk/impact from the absence of a strategic clinical network.

The first strategic clinical networks

The criteria outlined above have been used to identify those overarching conditions and patient groups for which strategic clinical networks will be established and supported from 2013. These are:

- Cancer
- Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease)
- Maternity and children;
- Mental health, dementia and neurological conditions.

The NHS CBA will set out what it expects each strategic clinical network to achieve by way of improvement programmes when they are operational. Strategic clinical networks will be established for up to five years, depending upon the amount of change that is needed in a specific area. As priorities change or when the work of one of the initial strategic clinical networks concludes the NHS CB will identify new conditions or patient groups that would benefit from a strategic clinical network approach.

The NHS Outcomes Framework

The work of the NHS CB is organised around the five domains of the NHS Outcomes Framework:

Domain one	Preventing people from dying prematurely
Domain two	Enhancing quality of life for people with long term conditions
Domain three	Helping people to recover from episodes of ill health or following injury
Domain four	Ensuring that people have a positive experience of care
Domain five	Treating and caring for people in a safe environment and protecting them from avoidable harm.

Individual strategic clinical networks will be organised under one of the domains so there is a tight focus on achieving change in that area.

Improvements to patient experience and patient safety underpin all NHS care and will be similarly embedded in the work of all strategic clinical networks.

Domain	**Strategic clinical network**
Reducing mortality	Cancer Cardiovascular disease
Long term conditions	Mental health, dementia and neurological conditions
Recovery from injury and illness	Maternity and children

Local geography and organisations

The new system is designed to improve local accountability and promote a truly regional approach to delivering high quality NHS care. The NHS CB has divided England into 12 areas, broadly based around major patient flows into specialist or tertiary centres. The footprint of each area maps onto CCG and local authority boundaries.

Each area will contain a number of different bodies including clinical senates, strategic clinical networks and academic health science networks. The work of these bodies will support and encourage the improvement of local health services.

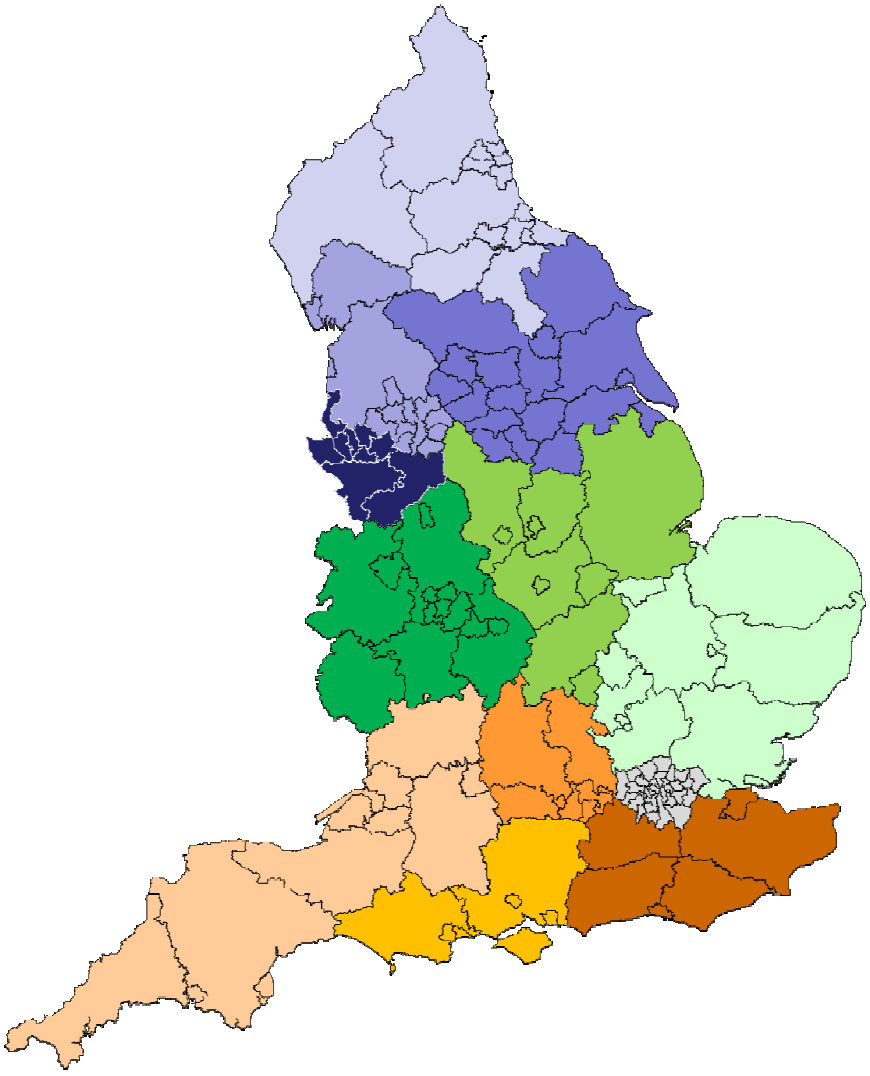
Clinical senates will have a particularly close relationship with strategic clinical networks. Each geographical area will have one clinical senate, taking a broader, strategic view on the totality of healthcare within that patch.

Clinical senates will provide evidence-based advice to help commissioners put the needs of patients above those of organisations or professions. They are likely to play a key role in providing a strategic overview of major service change – for example, on service redesign and reconfiguration. Further information on the detail of how clinical senates will be developed and established will be the subject of a separate publication.

Academic health science networks will bring together academia, NHS commissioners, providers of NHS services and industry. AHSNs will undertake a range of agreed core functions to bring about collaborations between education,

training, research, informatics and healthcare delivery and encourage innovation and the improvement of patient and population health outcomes.

The 12 geographical areas are illustrated in this map



Support teams

Each of the 12 geographical areas will contain a support team to provide clinical and managerial support for the strategic clinical networks and the clinical senates in that area. The support team will be based in one of the local area team offices within the patch and will be funded by the NHS CB.

The support teams will:

- build and oversee coherent and effective network arrangements in their area;
- provide and support leadership;
- help networks to develop an annual programme of quality improvement based on local and national priorities;
- provide robust project and programme management expertise;
- encourage the use of the NHS single model of change to include promoting the adoption of innovation and spreading of best practice; and
- enable quality assurance processes, including clinical audits, and support the assessment of network activity.

The support teams will also help strategic clinical networks access a number of other services including information, audit and expertise in economic appraisals, finances, public health information and analysis.

Each support team will be led by a part-time clinical director and an overall network director. The two directors will decide on the level of clinical input the team will need and arrange this to be supplied from local clinicians and professionals such as doctors, nurses, allied health professionals and scientists. These roles will be mainly part time or session based.

The first stage in establishing the support team will be the appointment of the clinical and network directors.

The next stage is to appoint a core team which spans the breadth of generic and more specialist skills needed in each support team. The NHS CB is working to core values and behaviours, including matrix working, and this approach will ensure the new way of working is successful.

Accountability and governance

Strategic clinical networks are non-statutory bodies, this means they do not have a legal duty to commission health services. In the new commissioning system, only CCGs and the NHS CB are accountable for commissioning and delivering contracts.

Providers, such as hospital trusts, are accountable for the quality of the service they deliver. We will achieve improved clinical outcomes through better commissioning and service provision.

Strategic clinical networks will have clear terms of reference and an annual accountability agreement with the NHS CB for the programmes of quality improvement they carry out.

The clinical and network directors will be accountable to the local area team which hosts them, and through the local area director to the regional director.

The support teams' clinical and network directors will help co-produce an accountability and governance framework once they are appointed.

New improvement body support

The new improvement body will provide national support for strategic clinical networks when it is fully functioning. The following support is anticipated:

- communication and co-operation,
- sharing and disseminating good, innovative practice,
- knowledge building and trouble shooting, and
- training, development, coaching and support.

The Transformation Directorate of the NHS CB will provide further information on the new improvement body in due course, which will include future arrangements for the National Cancer Action Team (NCAT), NHS Diabetes and Kidney Care together with NHS Improvement, all of which have supported clinical networks in the past.

Timetable

Outlined below is a timetable with the next steps for setting up strategic clinical networks. The Operations Directorate in the NHS CB will lead the workforce changes to implement these proposals and will follow the procedures set out in the NHS CB's people transition policy.

July to September 2012	• Test the new arrangements in a simulation exercise • Confirm funding for each geographical patch • Finalise hosting and support arrangements (such as analytical support) • Appoint clinical directors and network directors • Establish a programme group of clinical directors and network directors to develop the single operating model • Finalise the terms of reference for specific strategic clinical networks
October to December 2012	• Complete recruitment for all the remaining support team posts • Finalise the single operating model
January to March 2013	• Develop individual strategic clinical networks • Finalise quality improvement plans for each strategic clinical network taking account of the terms of reference and local context • Develop links with AHSNs, clinical senates and other local structures

Evaluation

The programme group will set out detailed proposals for evaluating the work of strategic clinical networks. These will include ways of demonstrating evidence of effectiveness and the publication of quality improvement programmes and annual reports.

Future updates

The Way Forward has provided a summary of the proposals for clinical networks with an emphasis on the new strategic clinical networks.

We will publish more information on the development of operational delivery networks on the NHS Commissioning Board Authority website.

We have addressed frequently asked questions and published our responses alongside this document.

First published 26 July 2012
Published to NHS CBA website, in electronic format only.

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Intelligence

National Cancer Action Team

Part of the National Cancer Programme

NHS

Cancer Peer Review Report 2011 - 2012

Kent & Medway Cancer Network

South Zone Peer Review Team

June 2012

DH INFORMATION READER BOX	
Publication Date	June 2012
Target Audience	Chief Executives of NHS Trusts and Primary Care Trusts Network Board Chair Primary Care Cancer Leads National Coordinating Team National Cancer Peer Review Care Quality Commission National Cancer Director Monitor National Cancer Intelligence Network (NCIN) Site Specific Reference Groups (SSCRGs)
Contact Address	National Cancer Peer Review Team 18th Floor Portland House Bressenden Place London SW1E 5RS
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ACKNOWLEDGEMENTS

The NCPR Zonal Team gratefully acknowledge the support of the reviewers, and where relevant, of their employing organisations. Reviewers willingly give their time before, during and after each visit and without them the process could not take place.

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

CONTENTS

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 gynaecology 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 six 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 visit.

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 the peer review programme was supported but changes were recommended in order to meet: the annual requirements of the national regulator Care Quality Commission (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 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.

National Cancer Peer Review Programme 2010

In April 2010 a second round of the new methodology was undertaken. There were only minor changes made from the 2009 programme. These were the introduction of:

- Earned Autonomy

  In recognition that some teams/services have achieved a good standard of internal quality assurance governance, the concept of 'Earned Autonomy' was introduced for the Internal Validation (IV) process during 2010. A team/service who had earned autonomy did not have to be subject to IV.
  A team/service that had an external review, be it a peer review visit or External Verification (EV), in the previous year indicating compliance against the measures at 75% or greater, and had no immediate risks or serious concerns, was eligible for earned autonomy if the self-assessment in 2010 was also above 75% and was no less than that of the previous year.

- Clinical Lines of Enquiry - Pilot for breast and lung services.

  Working with the National Cancer Intelligence Network (NCIN) Site Specific Clinical Reference Groups, a number of key clinical indicators were identified for breast and lung services. National and local benchmarked data against these indicators was identified for each service. As part of the review process, reviewers were asked to discuss the data on the service in relation to the clinical indicators. This discussion is referred to as 'Clinical Lines of Enquiry', and has been included in peer review reports. Clinical Lines of Enquiry are intended to provide greater clinical engagement in the peer review programme.

National Cancer Peer Review Programme 2011

In 2011 the peer review programme introduced further changes to reduce the burden on organisations whilst maintaining an annual review of all cancer services.

- Self-Assessment

  The programme maintained annual SA in order to provide up to date information for commissioners, patients and the public but reduce the burden of providing documentary evidence to support the process. Instead teams/services were accountable for the accuracy and honesty of the SA confirmed by the lead clinician. The documentary evidence is only required every other year.

- Internal Validation

  The Internal Validation (IV) process has been reduced to every other year rather than an annual process. Documentary evidence for SA is only required when Internal Validation or a Peer Review visit is taking place.

- Amnesty

  It was noted that the introduction of further new measures for Acute Oncology, Brain and CNS and Sarcoma negated the reduction in burden in the revised methodology. Therefore, in recognition of this, a one year self-assessment amnesty was agreed whereby high performing teams did not have to complete a self-assessment in 2011.

  To have been eligible for the self-assessment amnesty a team must not have been subject to internal validation or have been identified for a peer review visit during April 2011 and March 2012 and have met the following criteria:
  - Peer review visit 2010/11: Teams with 85% or over with no Immediate Risks (IRs) or Serious Concerns (SCs).
  - IV with EV 2010/11: Teams with IV score of 85% or over with a green overall EV (and therefore by implication no IRs or SCs).
  - IV only 2010/11: Teams with IV score of 85% or over with no IRs or SCs.

- Clinical Lines of Enquiry

  In order to better address outcomes within the peer review programme, the Clinical Lines of Enquiry pilot for breast and lung services was extended to another four cancer sites in 2011-2012; gynaecology, head & neck, upper GI and colorectal.

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 SA, IV 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 EV is to:
  - Check SA has been completed.
  - Ensure that a robust process of IV has taken place.
  - Verify the IV assessment is accurate.
  - Support identification of the teams/services that 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.

- Please see section 1.2 for more details on amendments to the process for 2011-2012 introduced in order to reduce the burden of NCPR on the NHS.

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.

Topics reviewed in 2011-2012

Acute Oncology, Brain and CNS, Sarcoma, Chemotherapy, Teenage and Young Adults (TYA), Psychological Support, and Network Service User Partnership Group Measures were all introduced in the 2011-2012 cycle, making the full list of topics reviewed;

Breast
Lung
Gynaecology
Upper Gastrointestinal (Upper GI)
Urology
Skin
Colorectal
Head & Neck
Children's Services
Radiotherapy
Complementary Therapy
Rehabilitation
Cancer Research Networks.

Acute Oncology

Brain and Central Nervous System (CNS)

Sarcoma

Teenage and Young Adults (TYA)

Psychological Support

Network Service User Partnership Group

Section 2 - ORGANISATION OF THE REPORT

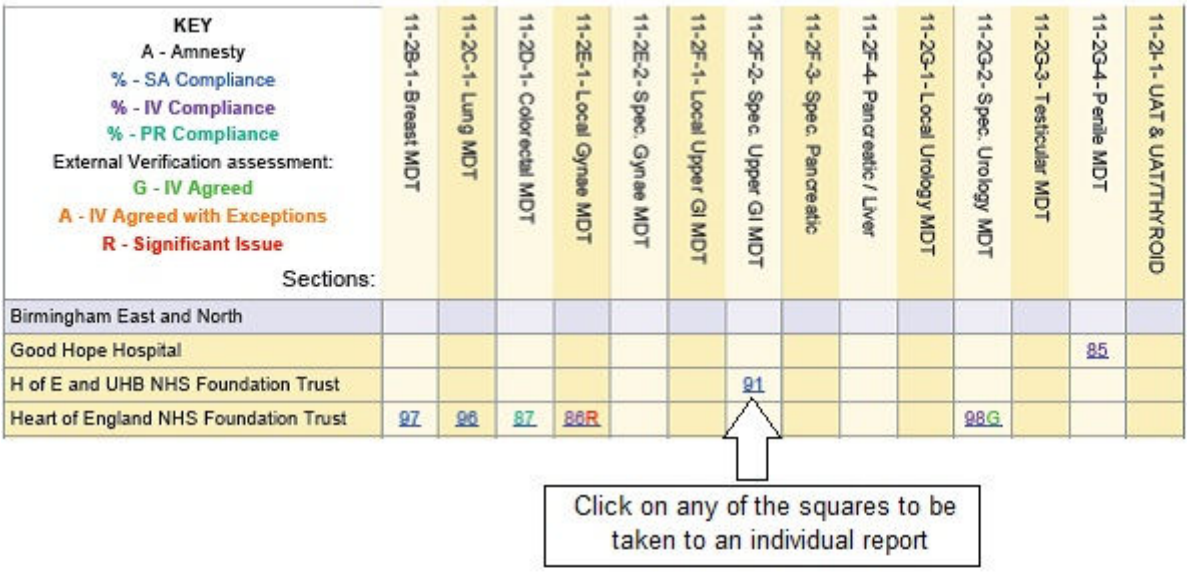
This report contains:

- An overall summary diagram of the structure of the Network and compliances
- A national benchmarking summary of MDT and Network measures
- An over all Network Report which contains:
  - Contextual information about the Network
  - An Executive Summary
  - Progress against Improving Outcomes Guidance

- A summary of compliance of MDT measures per Trust

Reports on individual teams may be accessed by 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 indicated in the diagrams below. This will take you to the report as a word document which can then be downloaded or printed.



KEY A - Amnesty % - SA Compliance % - IV Compliance % - PR Compliance External Verification assessment: G - IV Agreed A - IV Agreed with Exceptions R - Significant Issue Sections:	11-2B-1- Breast MDT	11-2C-1- Lung MDT	11-2D-1- Colorectal MDT	11-2E-1- Local Gynae MDT	11-2E-2- Spec. Gynae MDT	11-2F-1- Local Upper GI MDT	11-2F-2- Spec. Upper GI MDT	11-2F-3- Spec. Pancreatic	11-2F-4- Pancreatic / Liver	11-2G-1- Local Urology MDT	11-2G-2- Spec. Urology MDT	11-2G-3- Testicular MDT	11-2G-4- Penile MDT	11-2I-1- UAT & UAT/THYROID
Birmingham East and North														
Good Hope Hospital													85	
H of E and UHB NHS Foundation Trust							91							
Heart of England NHS Foundation Trust	97	96	87	86R							98G			

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

Code	Team	%	Stage	IR	SC	Link to Report
11-2F-4	Pancreatic / Liver MDT	50	PR		SC	Pancreatic / Liver MDT
11-2G-2	Specialist Urology MDT	93	IV (R)			Specialist Urology MDT

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 services the percentage compliance is shown in dark green. If a service has been internally validated and also externally verified, the IV percentage is shown in purple. 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. For teams on the SA cycle, percentage compliance is shown in blue, and those teams with SA amnesty are shown as a black A.

As referred to in the introduction, 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 is undertaken on a sample of the IVs, for all new measures and for those teams for which a visit is planned. 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 agreed', 'Amber - IV agreed with exceptions' and 'Red - significant issues identified'. The three key documents, SA and IV reports are reviewed and the EV form completed against a check list of key themes. The level of confidence in the IV is established by collating the results from each of the themes and applying the following; All themes agreed = IV Agreed; one theme agreed with exceptions = IV agreed with exceptions; Any significant issue or more than one theme agreed with exceptions = significant issue.

As referred to in the introduction, to have been eligible for the SA amnesty a team must not be subject to internal validation in 2011-2012 or have been identified for a peer review visit during April 2011 and March 2012 and have met the following criteria: Peer review visit 2010/11: Teams with 85% or over with no Immediate Risks (IRs) or Serious Concerns (SCs); IV with EV 2010/11: Teams with IV score of 85% or over with a green overall EV; IV only 2010/11: Teams with IV score of 85% or over with no IRs or SCs.

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

3.1.1 NETWORK LEVEL SUMMARY AND REPORTS

3.1.1.1 Summary of MDT Measures

KEY A - Amnesty % - SA Compliance **% - IV Compliance** **% - PR Compliance** External Verification assessment: **G - IV Agreed** **A - IV Agreed with Exceptions** **R - Significant Issue** Sections:	11-1D-1d- Colorectal Loc Group	11-1D-1e- Gynae LOC Funct.	11-1D-1i- Head Neck Loc Group	11-1D-1j- Skin Locality Msrs	11-1D-1k- Brain CNS Loc Group	11-1D-1l- Sarcoma Loc Group	11-1D-1w- Comp Therapy Loc Gro	11-1D-1z- TYA Hospitals
East Kent								
Kent & Canterbury			-	100	82	100	-	100R
Queen Elizabeth, Queen Mother	100		-					
William Harvey	100		89					
Maidstone - Dartford								
Dartford & Gravesham	100	100	-		100	100	-	
Maidstone Hospital	100		89R	100	82	100	-	0
Tunbridge Wells								
Medway								
Medway NHS Foundation Trust	100	0	100	100	90	63	-	100R

Summary of MDT Measures Cont...

KEY A - Amnesty % - SA Compliance **% - IV Compliance** **% - PR Compliance** External Verification assessment: **G - IV Agreed** **A - IV Agreed with Exceptions** **R - Significant Issue** Sections:	11-2B-1 - Breast MDT	11-2C-1- Lung MDT	11-2D-1- Colorectal MDT	11-2E-2- Spec. Gynae MDT	11-2F-1- Local Upper GI MDT	11-2F-2- Spec. Upper GI MDT	11-2G-1- Local Urology MDT	11-2G-2- Spec. Urology MDT	11-2I-1- UAT & UAT/THYROID	11-2I-2- THYROID ONLY MDT	11-2J-2- Spec Skin MDT	11-2K-1 - Cancer Network MDT
East Kent												
Kent & Canterbury	-	93						91		77R	83	
Queen Elizabeth, Queen Mother	74R		85	97	90A							
William Harvey	87G	93	80						87			
Maidstone - Dartford												
Dartford & Gravesham	97	96	82		97							
Maidstone Hospital	A	100	83	90		82R	69R		89R	A		0
Tunbridge Wells	A											
Medway												
Medway NHS Foundation Trust	97	96	83		97		97	98R			97	

Summary of MDT Measures Cont...

KEY A - Amnesty % - SA Compliance **% - IV Compliance** **% - PR Compliance** External Verification assessment: **G - IV Agreed** **A - IV Agreed with Exceptions** **R - Significant Issue** Sections:	11-3S-1 - Chemo Serv. MDT	11-3S-2- Onc. Pharmacy Serv. MD	11-3S-3- Intra. Chemo ITC MDT	11-3T-1- Rad Generic	11-3T-2- Rad External Beam	11-3T-3- Rad IMRT	11-3T-4- Rad Brach	11-3Y-1- Acute Oncology MDT	11-3Y-3- Gen. Acute Onc. MDT	11-3Y-4- Acute Onc. In-Pat. MDT
East Kent										
Kent & Canterbury	88R	100G						33	33	0
Queen Elizabeth, Queen Mother								33	33	0
William Harvey								33	33	0
Maidstone - Dartford										
Dartford & Gravesham	88R	100A	100G					100	67	100
Maidstone Hospital	83R	100A	100R	75	87	A	A	50	45	0
Tunbridge Wells								17	27	0
Medway										
Medway NHS Foundation Trust	85R	100G	100R					17	56	25

Summary of MDT Measures Cont...

KEY A - Amnesty % - SA Compliance **% - IV Compliance** **% - PR Compliance** External Verification assessment: **G - IV Agreed** **A - IV Agreed with Exceptions** **R - Significant Issue** Sections:	11-6A-1s- Chemotherapy PCT	11-6A-2- Chemo Childrens PCT	11-7C-1- Level 1 Core POSCU	11-7C-4- POSCU MDT
East Kent				
Kent & Canterbury			69	79
Queen Elizabeth, Queen Mother				
William Harvey				
Maidstone - Dartford				
Dartford & Gravesham				
Maidstone Hospital			80	63
Tunbridge Wells				
Medway				
Medway NHS Foundation Trust			69	95
Eastern And Coastal Kent PCT	100G	-		
Medway PCT	100G	-		
West Kent PCT	100G	-		

3.2 Network Report

3.2.1 Contextual Information

Kent and Medway Cancer Network serves a population of approximately 1.7 million people residing in the towns and coastal areas across Kent, including Dartford, Gravesend, Sevenoaks, Maidstone, Margate, Canterbury, Ashford, Folkstone and Dover. Some residents from the eastern side of Sussex flow into Kent for oncological treatments expanding the population to approximately 1.9 million.

Kent and Medway Cancer Network is a part of the South East Coast Strategic Health Authority (SHA) which has now merged with the South Central and South West SHAs to form the NHS South SHA cluster.

The Network and its constituent organisations are subdivided into discrete localities known as Local Implementation Groups (LIGs) which are co-terminus with three primary care trusts (PCTs), namely, NHS Eastern and Coastal Kent; NHS Medway; and NHS West Kent. During 2011/2012, the three PCTs joined a Kent and Medway cluster to support the emerging clinical commissioning groups and are now known as NHS Kent and Medway. Currently, there are nine clinical commissioning groups being established with the support of NHS Kent and Medway and the Network.

The Network comprises the following acute hospital trusts:

Dartford and Gravesham NHS Trust;

East Kent Hospitals University NHS Foundation Trust;

Maidstone and Tunbridge Wells NHS Trust; and

Medway NHS Foundation Trust.

There are plans for Dartford and Gravesham, and Medway NHS Foundation Trust to merge at some point in the near future. Whilst geographically outside the area of Kent and Medway, Queen Victoria NHS Foundation Trust at East Grinstead is linked to the Network.

In summary, the 2011/2012 annual peer review programme for the Network included the following:

External peer review visits were targeted according to the national selection criteria for a visit and included all the colorectal multidisciplinary teams (MDTs) within the Network together with the Colorectal Network Site Specific Group (NSSG). In addition, Children's Paediatric Shared Care Unit (POSCU) Services were subject to an external peer review visit as part of the nationally agreed programme of comprehensive visits.

The external verification programme at Network level focused on the Network Partnership and Chemotherapy Groups and Teenager and Young Adult (TYA) Coordinating Groups where applicable. At trust level, all chemotherapy services and TYA services where designated were included in the external verification programme. A number of MDTs across the Network were subject to risk based external verification to monitor progress on issues identified in 2010/2011. In addition to gynaecology and urology services that had not been peer reviewed or externally verified previously, these included the following:

The Upper Gastrointestinal, Head and Neck and Urology MDTs at Maidstone and Tunbridge Wells NHS Trust;

The Thyroid, Breast and Upper Gastrointestinal MDTs at East Kent University Hospitals NHS Foundation Trust; and

the Specialist Urology MDT for West Kent, hosted by Medway NHS Foundation Trust.

3.2.2 Executive Summary

The Kent and Medway Cancer Network reports to the Kent and Medway Cancer Partnership Board which comprises representatives from all the acute hospital trusts, PCTs and local hospices within the Network. The Partnership Board is supported by a Clinical Advisory Team which includes clinical representation from the trusts, PCTs, NSSGs and other cross cutting groups.

The Network Management Team has remained relatively stable over the last year and is still overseen by the Network Nurse Director who is officially titled as the Clinical Director for Quality and Care. The Network Management Team has recently moved premises and is co-located with the NHS Kent and Medway.

As highlighted previously, all the colorectal MDTs within the Network together with the Colorectal NSSG and Children's POSCU Services were subject to an external peer review visit in 2011/2012. These took place between May and June 2011.

In summary, five colorectal MDTs were peer reviewed, including the two MDTs located on different sites across East Kent University Hospitals NHS Foundation Trust. All MDTs achieved a high level of compliance with the measures ranging between 80 to 85%. It was evident that all MDTs benefited from full core membership and good attendance at meetings with clear patient pathways in place which followed agreed Network guidelines. The exception to this was a lack of clarity regarding the pathway and designated surgeons for anal cancer. Despite there being a Network Anal MDT with all trusts participating, and two surgeons designated, it was apparent from the review that not all clinicians and trusts were signed up to this. However, the Network benefited from a fully constituted NSSG with excellent attendance from all organisations which presented a clear opportunity to resolve this issue. Only one serious concern

was identified across the Network regarding complex colorectal cancer surgery being performed by a single handed, locum consultant surgeon on a Friday operating list with limited cover provided over the weekend. It was considered this potentially could result in patients being at risk of unrecognised complications. However, this was resolved by East Kent University Hospitals NHS Foundation Trust.

At the time of the review, most MDTs were at an early stage of considering and acting on the results from the National Patient Experience Survey. It was suggested that the Network Management team in conjunction with the trust cancer management teams, should consider a more proactive approach in supporting MDTs to address the issues raised.

Significant achievements and good practice were identified for specific colorectal MDTs and at Network level. These included a range of examples such as progress with enhanced recovery programmes, a support care MDT, 48 hour turnaround for biopsies and the availability of laparoscopic surgery, as well as attendance and commitment to NSSG meetings, effective links with supranetwork services and good engagement with commissioners.

The clinical lines of enquiry for colorectal cancer had been considered by both the MDTs and the NSSG, albeit in varying degrees across the trusts. The NSSG planned to regularly review the data as a key part of the NSSG's work-plan over the next 12 months with any specific MDT outliers being followed up as appropriate. The issue of data collection across the Network still required urgent improvement as highlighted in previous annual Network reports. There were plans for the Infoflex system to be implemented during 2011 but it was unclear whether this would meet all data requirements, particularly in terms of clinical outcome data. This will need to be monitored in future reviews to ensure data accuracy and reliability of data can be trusted as an indicator of the quality of services.

Three Children's POSCU services were reviewed at East Kent University Hospitals NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust. All three MDTs provide level one care and are part of the South Thames Children's and Young People's Cancer Network, referring patients to the Royal Marsden Principal Treatment Centre (PTC) and Great Ormond Street for children under one year's of age.

This was the first year of external peer review of children's services and compliance with the measures ranged between 63% to 95%. All three MDTs had full core membership with most achieving good attendance at meetings. It was clear that effective and timely referral pathways were in place with patients benefiting from rapid referral within 24 hours. It was evident the MDTs treated on average between 10 to 15 newly diagnosed patients a year and had effective working relationships with the PTCs.

Some common themes to emerge related to implementing more robust prescribing policies including the checking, verification and signing off of chemotherapy prescriptions. Immediate risks were raised with all three POSCU MDTs regarding the lack of lockable fridges on the ward for storing chemotherapy agents which were resolved immediately. In addition, further work was required on the level one foundation training, which was being progressed at the time of the review.

Although the PTC provides most information to children and their families, the level of local information given appeared to vary across the three MDTs and would benefit from sharing of examples between the trusts. Good progress had been made on getting feedback from children and their families, particularly from patient surveys, although some actions still needed to be implemented by two of the MDTs. The facilities observed during the review were of an acceptable or good standard across the trusts.

A key theme to emerge from the reviews was that the POSCU MDTs had not given much consideration to potential clinical outcome indicators. The view was that it was challenging to identify specific indicators for shared care, as the numbers treated by the POSCUs were low. The one outcome measure identified that the teams did think could be managed locally was febrile neutropenia and most were undertaking an audit of measuring whether patients receive antibiotics within the agreed standard with varying degrees of success due to the small numbers involved.

A number of significant achievements and good practice specific to each MDT were recognised by the review teams. These included examples such as the facilities, effective links between the community nursing and inpatient teams, and parents and children being invited to meet the team before treatment commenced.

A number of significant issues were raised through the external verification process for the specific teams mentioned previously. These were generally related to MDT core membership and attendance and lack of progress in implementing IOG. These teams will be monitored and reviewed through the 2012/2013 peer review programme.

3.2.3 IOG Progress

Good progress has been made on the majority of IOG configurations as is set out below.

The IOG for gynaecology services is fully implemented. The Network configuration of specialist services for gynaecology cancers consists of two specialist MDTs, one for the east on the Queen Elizabeth/Queen Mary site of the East Kent University Hospitals NHS Foundation Trust and one for the west, hosted by Maidstone and Tunbridge Wells NHS Trust including Maidstone, Medway and Dartford and Gravesham NHS Trusts. The diagnostic service is part of the specialist MDT at East Kent and there are two local diagnostic teams for West Kent at Medway and Maidstone, including Dartford.

The IOG for head and neck cancer services is also fully implemented. The Network configuration of head, neck and thyroid cancers comprises four specialist MDTs in total. There are separate MDTs for head and neck and thyroid cancers at East Kent University Hospitals NHS Foundation Trust on two different sites. Thyroid is on the Kent and Canterbury site, with head and neck on the William Harvey site. Then two separate MDTs for head and neck and thyroid at Maidstone Hospital. Diagnostic and local support services are provided at East Kent, Medway and Maidstone, including Dartford. Skull base cancers are referred to Guys and St.Thomas hospital in London.

The Network configuration of urology services comprises a single, joint local and specialist MDT at East Kent University Hospitals NHS Trust, based on the Canterbury site with all specialist, complex surgery undertaken at Canterbury.

There is also a joint specialist MDT comprising Medway, Maidstone and Dartford, with local MDTs at Maidstone and a joint local MDT for Medway and Dartford. All specialist, complex urological surgery should be undertaken at Medway. However, external peer review and external verification of the specialist MDT (West) and local MDTs at Medway and Maidstone during the period covering 2009 to 2011 found that complex surgery was still being performed at all three sites with transfer of surgery delayed. This was raised as an immediate risk with the trusts concerned and the Network and trusts were advised to work with NHS South East Coast to ensure appropriate action was taken to resolve this situation with an implementation date of October 2011. Progress reported to the SHA in November 2011 indicated that all complex urology surgery had been centralised at Medway NHS Foundation Trust and this will be monitored through external peer review in 2012.

Penile cancers are referred to St George's, and Testicular to Royal Marsden in London.

The IOG for upper gastrointestinal services is fully implemented. The Network configuration comprises of three local upper GI MDTs at East Kent, Dartford and Gravesham and Medway, with one designated specialist MDT at Maidstone. All hepatobiliary and pancreatic cancers are referred to Kings College Hospital, London.

The current configuration of skin cancer services comprises two joint local and specialist skin MDTs across the Network. One at East Kent hospitals on the Kent and Canterbury site and one hosted by Medway involving Medway, Dartford and Gravesham, Maidstone and Tunbridge Wells and Queen Victoria Hospital in East Grinstead. Queen Victoria also acts as a specialist tertiary level reconstructive surgery centre and is the named centre for block dissections.

Pathology has been centralised at Maidstone and Tunbridge Wells NHS Trust and the IOG is fully implemented.

The current position for haematology, based on the latest update from the National Cancer Action Team (NCAT) in October 2011, is that there are two haematology MDTs at East Kent, on the Kent and Canterbury hospital site and at the Maidstone hospital site of the Maidstone and Tunbridge Wells NHS Trust.

Currently, TYA services within the Network are not formally designated.

3.3 Summary of Compliance for Network Board / NSSG Measures

Code	Team	%	Stage	IR	SC	Link to Report
11-1A-1l	Sarcoma Network Board	0	IV			FAILED TO COMPLETE REPORT
11-1A-2b	Breast Network Board	100	SA			Breast Network Board
11-1A-2c	Lung Network Board	100	SA			Lung Network Board
11-1A-2d	Colorectal Network Board	86	PR			Colorectal Network Board
11-1A-2e	Gynae Network Board	90	IV			Gynae Network Board
11-1A-2f	Upper GI Network Board	100	SA			Upper GI NSSG
11-1A-2g	Urology Network Board	46	IV			Urology Network Board
11-1A-2i	Head and Neck Network Board	100	SA			Head and Neck NSSG
11-1A-2j	Skin Network Board	92	SA			Skin Network Board
11-1A-2k	Brain and CNS Network Board	50	IV			Brain and CNS Network Board
11-1A-3s	Chemotherapy Network Board	100	IV (A)			Chemotherapy Network Board
11-1A-3t	Radiotherapy Network Board	86	SA			Radiotherapy Network Board
11-1A-3u	Partnership Network Board	0	IV (G)			Partnership Network Board
11-1A-3v	Rehab Network Board	0	SA			Rehab Network Board
11-1A-3w	CompTherapy NET	100	SA			CompTherapy NET
11-1A-3x	Psychological Network Board	100	SA			Psychological Network Board
11-1A-3y	Acute Oncology Network Board	33	IV			Acute Oncology Network Board
11-1C-1b	Breast NSSG	82	SA			Breast NSSG
11-1C-1c	Lung NSSG	90	SA			Lung NSSG
11-1C-1d	Colorectal NSSG	91	PR			Colorectal NSSG
11-1C-1e	Gynae NSSG	75	IV			Gynae NSSG
11-1C-1f	Upper GI NSSG	78	SA			Upper GI NSSG
11-1C-1g	Urology NSSG	67	IV			Urology NSSG
11-1C-1i	Head and Neck NSSG	85	SA			Head and Neck NSSG
11-1C-1j	Skin NSSG	80	SA			Skin NSSG
11-1E-1s	Chemotherapy Network Group	91	IV (A)			Chemotherapy Network Group
11-1E-1t	Radiotherapy Network Group	58	SA			Radiotherapy Network Group
11-1E-1u	Network Partnership Group	9	IV (G)			Network Partnership Group
11-1E-1v	Rehab Network Group	29	SA			Rehab Network Group
11-1E-1x	Psychological Network Group	42	SA			Psychological Network Group
11-1E-1y	Acute Oncology Network Group	58	IV			Acute Oncology Network Group

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. If a service has been on the self-assessment cycle, then the self-assessment compliance is shown.

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

The Immediate Risks and Serious Concerns at Board level for Upper GI and Head & Neck are not able to be displayed due to the potential linkage to more than one NSSG.

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

Section 4 - TRUST REPORTS

4.1 East Kent Locality

4.1.1 EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

4.1.1.1 Summary of Compliance for MDT Measures

Kent & Canterbury

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1i	Head and Neck Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-1D-1j	Skin Locality Measures	100	SA			Skin Locality Measures
11-1D-1k	Brain and CNS Locality Measures	82	IV			Brain and CNS Locality Measures
11-1D-1l	Sarcoma Locality Measures	100	IV			Sarcoma Locality Measures
11-1D-1w	Comp Therapy Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-1D-1z	TYA Hospitals	100	IV (R)			TYA Hospitals
11-2B-1	Breast MDT	0	SA			FAILED TO COMPLETE REPORT
11-2C-1	Lung MDT	93	SA			Lung MDT
11-2G-2	Specialist Urology MDT	91	IV			Specialist Urology MDT
11-2I-2	THYROID ONLY MDT	77	IV (R)			THYROID ONLY MDT
11-2J-2	Spec Skin MDT	83	SA			Spec Skin MDT
11-3S-1	Chemotherapy Serv MDT	88	IV (R)			Chemotherapy Serv MDT
11-3S-2	Oncology Pharmacy Serv MDT	100	IV (G)			Oncology Pharmacy Serv MDT
11-3Y-1	Acute Oncology MDT	33	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	33	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	0	IV			Acute Oncology In-Patient MDT
11-7C-1	Level 1 Core POSCU	69	PR	IR		Level 1 Core POSCU
11-7C-4	POSCU MDT	79	PR	IR		POSCU MDT

Queen Elizabeth, Queen Mother

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1d	Colorectal Locality Measures	100	PR		SC	Colorectal Locality Measures
11-1D-1i	Head and Neck Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-2B-1	Breast MDT	74	IV (R)			Breast MDT
11-2D-1	Colorectal MDT	85	PR		SC	Colorectal MDT
11-2E-2	Specialist Gynae MDT	97	IV			Specialist Gynae MDT
11-2F-1	Local Upper GI MDT	90	IV (A)			Local Upper GI MDT
11-3Y-1	Acute Oncology MDT	33	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	33	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	0	IV			Acute Oncology In-Patient MDT

William Harvey

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1d	Colorectal Locality Measures	100	PR			Colorectal Locality Measures

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1i	Head and Neck Locality Measures	89	SA			Head and Neck Locality Measures
11-2B-1	Breast MDT	87	IV (G)			Breast MDT
11-2C-1	Lung MDT	93	SA			Lung MDT
11-2D-1	Colorectal MDT	80	PR			Colorectal MDT
11-2I-1	UAT & UAT/THYROID MDT	87	SA			UAT & UAT/THYROID MDT
11-3Y-1	Acute Oncology MDT	33	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	33	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	0	IV			Acute Oncology In-Patient MDT

4.2 Maidstone - Dartford Locality

4.2.1 DARTFORD AND GRAVESHAM NHS TRUST

4.2.1.1 Summary of Compliance for MDT Measures

Dartford & Gravesham

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1d	Colorectal Locality Measures	100	PR			Colorectal Locality Measures
11-1D-1e	Gynae Locality Measures	100	IV			Gynae Locality Measures
11-1D-1i	Head and Neck Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-1D-1k	Brain and CNS Locality Measures	100	IV			Brain and CNS Locality Measures
11-1D-1l	Sarcoma Locality Measures	100	IV			Sarcoma Locality Measures
11-1D-1w	Comp Therapy Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-2B-1	Breast MDT	97	SA			Breast MDT
11-2C-1	Lung MDT	96	SA			Lung MDT
11-2D-1	Colorectal MDT	82	PR			Colorectal MDT
11-2F-1	Local Upper GI MDT	97	SA			Local Upper GI MDT
11-3S-1	Chemotherapy Serv MDT	88	IV (R)			Chemotherapy Serv MDT
11-3S-2	Oncology Pharmacy Serv MDT	100	IV (A)			Oncology Pharmacy Serv MDT
11-3S-3	Intrathecal Chemotherapy ITC MDT	100	IV (G)			Intrathecal Chemotherapy ITC MDT
11-3Y-1	Acute Oncology MDT	100	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	67	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	100	IV			Acute Oncology In-Patient MDT

4.2.2 MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

4.2.2.1 Summary of Compliance for MDT Measures

Maidstone Hospital

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1d	Colorectal Locality Measures	100	PR			Colorectal Locality Measures
11-1D-1i	Head and Neck Locality Measures	89	IV			Head and Neck Locality Measures
11-1D-1j	Skin Locality Measures	100	SA			Skin Locality Measures
11-1D-1k	Brain and CNS Locality Measures	82	IV			Brain and CNS Locality Measures
11-1D-1l	Sarcoma Locality Measures	100	IV			Sarcoma Locality Measures
11-1D-1w	Comp Therapy Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-1D-1z	TYA Hospitals	0	IV	IR		FAILED TO COMPLETE IV REPORT TYA Hospitals
11-2B-1	Breast MDT	A	SA			NO REPORT REQUIRED
11-2C-1	Lung MDT	100	SA	IR	SC	Lung MDT
11-2D-1	Colorectal MDT	83	PR			Colorectal MDT
11-2E-2	Specialist Gynae MDT	90	IV			Specialist Gynae MDT
11-2F-2	Specialist Upper GI MDT	82	IV (R)			Specialist Upper GI MDT

Code	Team	%	Stage	IR	SC	Link to Report
11-2G-1	Local Urology MDT	69	IV (R)			Local Urology MDT
11-2I-1	UAT & UAT/THYROID MDT	89	IV (R)			UAT & UAT/THYROID MDT
11-2I-2	THYROID ONLY MDT	A	SA			NO REPORT REQUIRED
11-2K-1	Cancer Network MDT	0	IV			FAILED TO COMPLETE IV REPORT Cancer Network MDT
11-3S-1	Chemotherapy Serv MDT	83	IV (R)			Chemotherapy Serv MDT
11-3S-2	Oncology Pharmacy Serv MDT	100	IV (A)			Oncology Pharmacy Serv MDT
11-3S-3	Intrathecal Chemotherapy ITC MDT	100	IV (R)			FAILED TO COMPLETE REPORT
11-3T-1	Radiotherapy Generic	75	SA			FAILED TO COMPLETE REPORT
11-3T-2	Radiotherapy External Beam	87	SA			FAILED TO COMPLETE REPORT
11-3T-3	Radiotherapy IMRT	A	SA			NO REPORT REQUIRED
11-3T-4	Radiotherapy Brachytherapy	A	SA			NO REPORT REQUIRED
11-3Y-1	Acute Oncology MDT	50	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	45	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	0	IV			Acute Oncology In-Patient MDT
11-7C-1	Level 1 Core POSCU	80	PR	IR		Level 1 Core POSCU
11-7C-4	POSCU MDT	63	PR	IR		POSCU MDT

Tunbridge Wells

Code	Team	%	Stage	IR	SC	Link to Report
11-2B-1	Breast MDT	A	SA			NO REPORT REQUIRED
11-3Y-1	Acute Oncology MDT	17	IV			FAILED TO COMPLETE REPORT
11-3Y-3	General Acute Oncology MDT	27	IV			FAILED TO COMPLETE REPORT
11-3Y-4	Acute Oncology In-Patient MDT	0	IV			FAILED TO COMPLETE REPORT

4.3 Medway Locality

4.3.1 MEDWAY NHS FOUNDATION TRUST

4.3.1.1 Summary of Compliance for MDT Measures

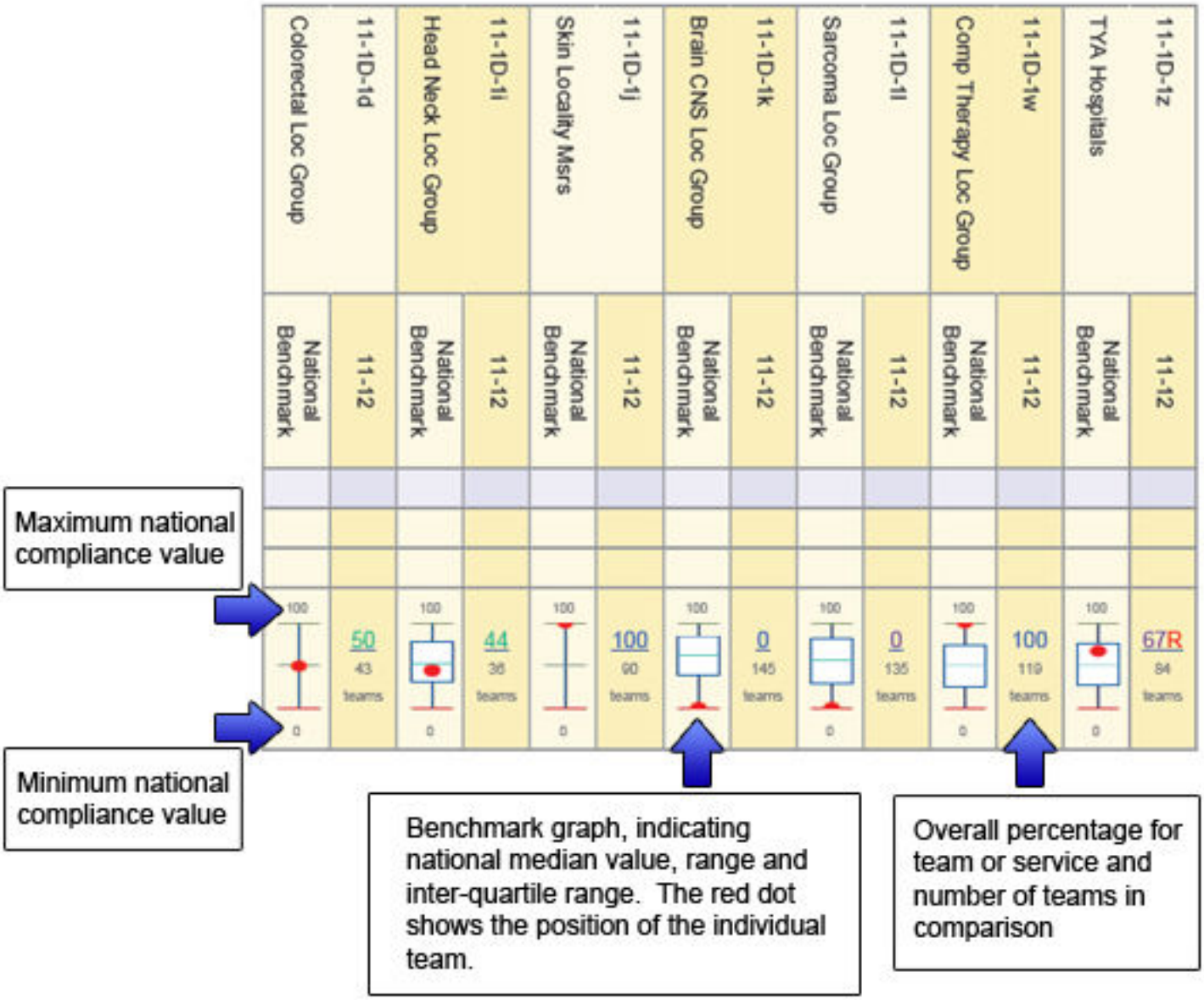
Medway NHS Foundation Trust

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1d	Colorectal Locality Measures	100	PR			Colorectal Locality Measures
11-1D-1e	Gynae Locality Measures	0	IV			FAILED TO COMPLETE IV REPORT Gynae Locality Measures
11-1D-1i	Head and Neck Locality Measures	100	SA			Head and Neck Locality Measures
11-1D-1j	Skin Locality Measures	100	SA			Skin Locality Measures
11-1D-1k	Brain and CNS Locality Measures	90	IV			Brain and CNS Locality Measures
11-1D-1l	Sarcoma Locality Measures	0	IV			FAILED TO COMPLETE REPORT
11-1D-1w	Comp Therapy Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-1D-1z	TYA Hospitals	100	IV (R)			TYA Hospitals
11-2B-1	Breast MDT	97	SA			Breast MDT
11-2C-1	Lung MDT	96	SA			Lung MDT
11-2D-1	Colorectal MDT	83	PR			Colorectal MDT
11-2F-1	Local Upper GI MDT	97	SA			Local Upper GI MDT
11-2G-1	Local Urology MDT	97	IV			Local Urology MDT
11-2G-2	Specialist Urology MDT	98	IV (R)			Specialist Urology MDT
11-2J-2	Spec Skin MDT	97	SA			Spec Skin MDT
11-3S-1	Chemotherapy Serv MDT	85	IV (R)			Chemotherapy Serv MDT
11-3S-2	Oncology Pharmacy Serv MDT	100	IV (G)			Oncology Pharmacy Serv MDT
11-3S-3	Intrathecal Chemotherapy ITC MDT	100	IV (R)			Intrathecal Chemotherapy ITC MDT
11-3Y-1	Acute Oncology MDT	17	IV			Acute Oncology MDT
11-3Y-3	General Acute Oncology MDT	56	IV			General Acute Oncology MDT
11-3Y-4	Acute Oncology In-Patient MDT	25	IV			Acute Oncology In-Patient MDT
11-7C-1	Level 1 Core POSCU	69	PR	IR		Level 1 Core POSCU
11-7C-4	POSCU MDT	95	PR	IR		POSCU MDT

If a team is on the IV cycle, but has failed to complete an IV report, a link is provided to any published SA report, and any Immediate Risks or Serious Concerns identified in that report are indicated in the table.

Section 5 - National Benchmarking Summary of MDT Measures

This section displays the national benchmark position of the team or service, alongside the overall percentage;



5.1 Comparison Summary of MDT Measures

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	Colorectal Loc Group 11-1D-1d		Gynae LOC Funct. 11-1D-1e		Head Neck Loc Group 11-1D-1i		Skin Locality Msrs 11-1D-1j		Brain CNS Loc Group 11-1D-1k		Sarcoma Loc Group 11-1D-1l		Comp Therapy Loc Group 11-1D-1w	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
East Kent														
Kent & Canterbury						-	100 0	100 94 teams	100 0	82 139 teams	100 0	100 139 teams		-
Queen Elizabeth, Queen Mother	100 0	100 44 teams				-								
William Harvey	100 0	100 44 teams			100 0	89 113 teams								
Maidstone - Dartford														
Dartford & Gravesham	100 0	100 44 teams	100 80	100 42 teams		-			100 0	100 139 teams	100 0	100 139 teams		-
Maidstone Hospital	100 0	100 44 teams			100 0	89R 113 teams	100 0	100 94 teams	100 0	82 139 teams	100 0	100 139 teams		-
Tunbridge Wells														
Medway														
Medway NHS Foundation Trust	100 0	100 44 teams	100 80	0 42 teams	100 0	100 113 teams	100 0	100 94 teams	100 0	90 139 teams	100 0	63 139 teams		-

Comparison Summary of MDT Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	TYA Hospitals	11-1D-1z	Breast MDT	11-2B-1	Lung MDT	11-2C-1	Colorectal MDT	11-2D-1	Spec. Gynae MDT	11-2E-2	Local Upper GI MDT	11-2F-1	Spec. Upper GI MDT	11-2F-2
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
East Kent														
Kent & Canterbury	100 0	100R 84 teams		-	100 0	93 130 teams								
Queen Elizabeth, Queen Mother			97 65	74R 24 teams			93 27	85 69 teams	100 66	97 42 teams	97 13	90A 20 teams		
William Harvey			97 65	87G 24 teams	100 0	93 130 teams	93 27	80 69 teams						
Maidstone - Dartford														
Dartford & Gravesham			100 68	97 126 teams	100 0	96 130 teams	93 27	82 69 teams			100 68	97 80 teams		
Maidstone Hospital	100 0	0 84 teams		A	100 0	100 130 teams	93 27	83 69 teams	100 66	90 42 teams			94 79	82R 6 teams
Tunbridge Wells				A										
Medway														
Medway NHS Foundation Trust	100 0	100R 84 teams	100 68	97 126 teams	100 0	96 130 teams	93 27	83 69 teams			100 68	97 80 teams		

Comparison Summary of MDT Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	Local Urology MDT	11-2G-1	Spec. Urology MDT	11-2G-2	UAT & UAT/THYROID	11-2I-1	THYROID ONLY MDT	11-2I-2	Spec Skin MDT	11-2J-2	Cancer Network MDT	11-2K-1	Chemo Serv. MDT	11-3S-1
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
East Kent														
Kent & Canterbury			98 17	91 45 teams			100 55	77R 8 teams	100 66	83 35 teams			100 43	88R 164 teams
Queen Elizabeth, Queen Mother														
William Harvey					100 61	87 49 teams								
Maidstone - Dartford														
Dartford & Gravesham													100 43	88R 164 teams
Maidstone Hospital	98 62	69R 78 teams			90 72	89R 6 teams		A			89 0	0 20 teams	100 43	83R 164 teams
Tunbridge Wells														
Medway														
Medway NHS Foundation Trust	98 62	97 78 teams	98 17	98R 45 teams					100 66	97 35 teams			100 43	85R 164 teams

Comparison Summary of MDT Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	Onc. Pharmacy Serv. MDT		Intra. Chemo ITC MDT		Rad Generic		Rad External Beam		Rad IMRT		Rad Brach		Acute Oncology MDT	
	11-3S-2		11-3S-3		11-3T-1		11-3T-2		11-3T-3		11-3T-4		11-3Y-1	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
East Kent														
Kent & Canterbury	100 72	100G 160 teams											100 0	33 186 teams
Queen Elizabeth, Queen Mother													100 0	33 186 teams
William Harvey													100 0	33 186 teams
Maidstone - Dartford														
Dartford & Gravesham	100 72	100A 160 teams	100 0	100G 157 teams									100 0	100 186 teams
Maidstone Hospital	100 72	100A 160 teams	100 0	100R 157 teams	100 50	75 51 teams	100 77	87 41 teams		A		A	100 0	50 186 teams
Tunbridge Wells													100 0	17 186 teams
Medway														
Medway NHS Foundation Trust	100 72	100G 160 teams	100 0	100R 157 teams									100 0	17 186 teams

Comparison Summary of MDT Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	Gen. Acute Onc. MDT	11-3Y-3	Acute Onc. In-Pat. MDT	11-3Y-4	Chemotherapy PCT	11-6A-1s	Level 1 Core POSCU	11-7C-1	POSCU MDT	11-7C-4
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
East Kent										
Kent & Canterbury	100 / 0	33 194 teams	100 / 0	0 192 teams			96 / 33	69 57 teams	100 / 16	79 82 teams
Queen Elizabeth, Queen Mother	100 / 0	33 194 teams	100 / 0	0 192 teams						
William Harvey	100 / 0	33 194 teams	100 / 0	0 192 teams						
Maidstone - Dartford										
Dartford & Gravesham	100 / 0	67 194 teams	100 / 0	100 192 teams						
Maidstone Hospital	100 / 0	45 194 teams	100 / 0	0 192 teams			96 / 33	80 57 teams	100 / 16	63 82 teams
Tunbridge Wells	100 / 0	27 194 teams	100 / 0	0 192 teams						
Medway										
Medway NHS Foundation Trust	100 / 0	56 194 teams	100 / 0	25 192 teams			96 / 33	69 57 teams	100 / 16	95 82 teams
Eastern And Coastal Kent PCT					100 / 0	100G 103 teams				

Comparison Summary of MDT Measures Cont...

KEY A - Amnesty % - SA Compliance **% - IV Compliance** **% - PR Compliance** External Verification assessment: **G - IV Agreed** **A - IV Agreed with Exceptions** **R - Significant Issue** Sections:	Gen. Acute Onc. MDT	11-3Y-3	Acute Onc. In-Pat. MDT	11-3Y-4	Chemotherapy PCT	11-6A-1s	Level 1 Core POSCU	11-7C-1	POSCU MDT	11-7C-4
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
Medway PCT					100 0	100G 103 teams				
West Kent PCT					100 0	100G 103 teams				

5.2 Comparison of Summary of Network Measures

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	11-1A-1l Sarcoma Net Board		11-1A-2b Breast Net Board		11-1A-2c Lung Net Board		11-1A-2d Colo Net Board		11-1A-2e Gynae Net Board		11-1A-2f Upper GI Net Board		11-1A-2g Urology Net Board	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
KMCN		-	100 100	100 27 teams	100 100	100 20 teams	100 63	86 22 teams	100 60	90 26 teams	100 40	100 21 teams	100 47	46 23 teams
KMCRN														

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	11-1A-2i Head Neck Net Board		11-1A-2j Skin Net Board		11-1A-2k Brain & CNS Net Board		11-1A-3s Chemotherapy Net Board		11-1A-3t Rad Net Board		11-1A-3u Partnership Net Board		11-1A-3v REHAB Net Board	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
KMCN	100 69	100 27 teams	100 77	92 22 teams	100 20	50 27 teams	100 60	100A 28 teams	100 29	86 23 teams	100 0	0G 28 teams	100 0	0 25 teams
KMCRN														

Comparison of Summary of Network Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	11-1A-3w Comp Therapy		11-1A-3x Psychological Net Board		11-1A-3y Acute Oncology Net Board		11-1A-5 Research Net Msrs		11-1C-1b Breast NSSG		11-1C-1c Lung NSSG		11-1C-1d Colorectal NSSG	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
KMCN	100 0	100 20 teams	100 0	100 28 teams	100 0	33 28 teams			100 60	82 27 teams	100 50	90 20 teams	100 57	91 22 teams
KMCRN							100 100	100 20 teams						

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	11-1C-1e Gynae NSSG		11-1C-1f Upper GI NSSG		11-1C-1g Urology NSSG		11-1C-1i Head Neck NSSG		11-1C-1j Skin NSSG		11-1E-1s Chemotherapy Net Group		11-1E-1t Radio Net Group	
	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12	National Benchmark	11-12
KMCN	100 72	75 26 teams	100 67	78 20 teams	100 34	67 23 teams	100 67	85 27 teams	100 70	80 22 teams	100 19	91A 28 teams	100 59	58 24 teams
KMCRN														

Comparison of Summary of Network Measures Cont...

KEY
A - Amnesty
% - SA Compliance
% - IV Compliance
% - PR Compliance
External Verification assessment:
G - IV Agreed
A - IV Agreed with Exceptions
R - Significant Issue

Sections:	Partnership Net Group 11-1E-1u National Benchmark	Partnership Net Group 11-1E-1u 11-12	REHAB Net Group 11-1E-1v National Benchmark	REHAB Net Group 11-1E-1v 11-12	Psychological Net Group 11-1E-1x National Benchmark	Psychological Net Group 11-1E-1x 11-12	Oncology Net Group 11-1E-1y National Benchmark	Oncology Net Group 11-1E-1y 11-12	Research Net Fns. 11-5A-1 National Benchmark	Research Net Fns. 11-5A-1 11-12
KMCN	100 10	9G 28 teams	100 6	29 27 teams	100 0	42 28 teams	100 8	58 28 teams		
KMCRN									100 50	100 16 teams

Section 6 - PCT REPORTS

6.1 Summary of Compliance for PCTs

6.1.1 EASTERN AND COASTAL KENT PCT

Code	Team	%	Stage	IR	SC	Link to Report
11-1D-1j	Skin Locality Measures	0	SA			FAILED TO COMPLETE REPORT
11-6A-1s	Chemotherapy PCT	100	IV (G)			Chemotherapy PCT

6.1.2 MEDWAY PCT

Code	Team	%	Stage	IR	SC	Link to Report
11-6A-1s	Chemotherapy PCT	100	IV (G)			Chemotherapy PCT

6.1.3 WEST KENT PCT

Code	Team	%	Stage	IR	SC	Link to Report
11-6A-1s	Chemotherapy PCT	100	IV (G)			Chemotherapy PCT

Section 7 - 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.

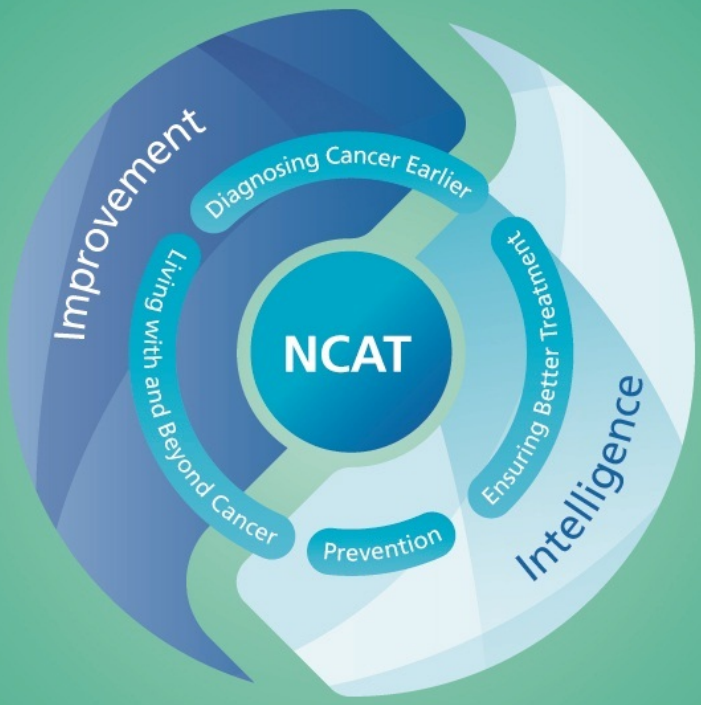
GLOSSARY	
NCAG	National Chemotherapy Advisory Group.
NCEPOD	National Confidential Enquiry into Peri Operative Death - A long running national audit of surgical practice and organisation designed to reduce preventable mortality.
NCIN	National Cancer Intelligence Network.
NCRN	National Cancer Research 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.

GLOSSARY	
SIF	Service Improvement Facilitator.
SIL	Service Improvement Lead, part of the core membership of a cancer network.
SHA	Strategic Health Authority.
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

Kent & Medway Cancer Network

South Zone Peer Review Team



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