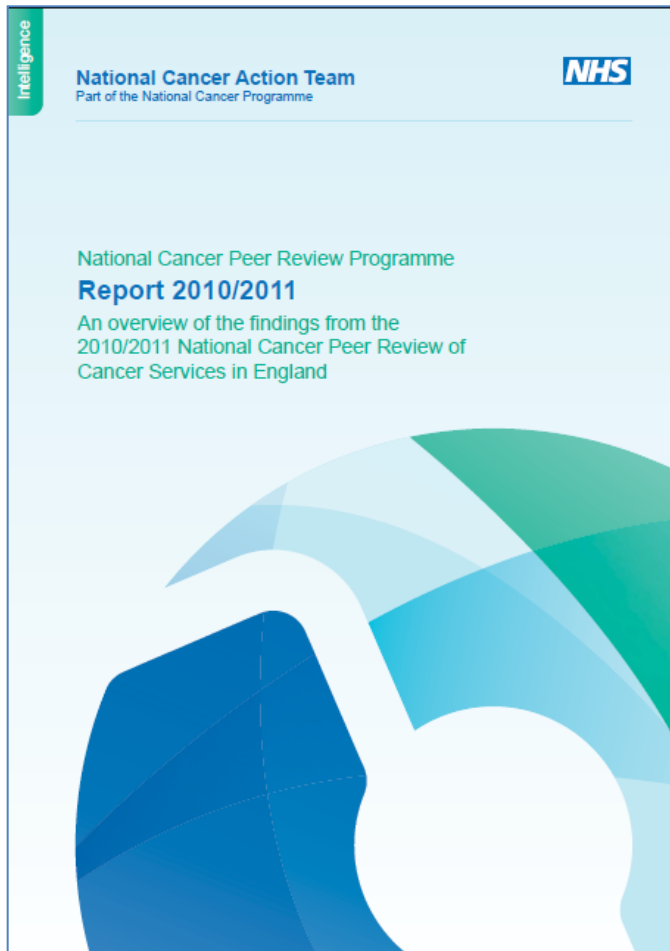# Is Peer Review enough?

Quality Measures in Children's, Teenager and Young Adult Cancer Services

Louise Wilson / Mike Stevens

Cancer Network CTYA Workshop
31st October 2012

2008 – Review of National Cancer Peer Review Programme concluded that there should be a stronger focus on clinical issues

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme
Report 2010/2011
An overview of the findings from the 2010/2011 National Cancer Peer Review of Cancer Services in England

*"The introduction of **Clinical Lines of Enquiry**, as a pilot for Breast and Lung services, is a first step to peer review becoming focused on clinical outcomes.*

An evaluation of this pilot …… has been received well and is already being rolled out to other tumour sites in the 2011/2012 programme….."

CLE and Peer Review (1)

Clinical indicators are being developed by NCPR and NCIN for all tumour types:

- to ensure a much stronger focus on clinical issues;

- ensure reviews are clinically relevant;

- to sustain the continued support and involvement of clinical staff.

Clinical Lines of Enquiry are a consistent way of discussing the data in relation to each of the clinical indicators.

CLE and Peer Review (2)

The introduction of Clinical Lines of Enquiry is important in order to align Peer Review with developments which have emerged since the publication of the agreed peer review measures.

For example :

- use of an increasing range of possible diagnostic and treatment interventions

- addressing subsequent guidance issued by NICE

- supporting the overall aims of evolving national policy about cancer services

Evaluation of pilot experience with CLE in breast and lung cancer

Question	Yes	No
Do the clinical lines of enquiry add value to the cancer peer review process?	77.4%	22.6%
Were the clinical lines of enquiry useful to the MDT/network in stimulating reflection on clinical outcomes and data collection?	77.2%	27.8%
Were any changes in practice of data collection introduced as a result of this process?	43.25	56.8%
Do you agree that the metrics reflected the key clinical priorities within your disease type?	70.3%	29.7%

75% respondents were MDT / NSSG members

Breast Cancer CLEs

Metric	Data source
Percentage of women offered access to immediate reconstructive surgery by MDT or onward referral to another team and rate of uptake	National Mastectomy & Breast Reconstruction Audit report
Ratio of mastectomy to breast conserving surgery	NATCANSAT
Each surgeon managing at least 30 cases per year	NATCANSAT
Average length of stay for breast cancer with any surgical procedure	NATCANSAT
One, two and five year survival rates	NCIN e-atlas / Registry
Local Data	
Proportion of women tested for HER2 prior to commencing drug treatment	Local data
Availability of screening and estimated impact on work load	Local data
Availability of digital mammography	Local data

Lung Cancer CLEs

Metric	Data source
% of expected cases on whom data is recorded	National Lung Cancer Audit
% histological confirmation rate	National Lung Cancer Audit
% patients having active treatment	National Lung Cancer Audit
% patients undergoing surgical resection (excluding mesothelioma)	National Lung Cancer Audit
% patients with small cell lung cancer receiving chemotherapy	National Lung Cancer Audit

Responses to Lung Cancer CLEs

- MDTs taking greater ownership of data collection & data collection systems

- Recognition of variation between units triggered investigation of reasons for this – e.g. accuracy and collection of data; problems with referral pathways to oncologists and surgeons including lack of oncological or surgical presence at MDTs

- 40% of responders to an on line survey about introduction of CLE indicated that this had led to changes in clinical practice

What are we trying to measure and why?

- Are there important differences in patient outcome between PTCs / PTC-POSCU networks?

- Are there important differences in patient experience between PTCs / PTC-POSCU networks?

- Are there some simple indicators which might discriminate what a 'good' service looks like – how can we separate the 'good' from the merely satisfactory and will this drive up standards?

Work done at a previous CTYA workshop

Identify 3 things that would tell you that a service was 'good'

Answer as if you were :

     a) A patient or parent using the service

     b) A health professional working in the service

     c) A commissioner buying the service

Can you justify your choices ?

Are they readily measurable ?

Are these different for Children and TYA ?

PERSPECTIVE (Pt/parent; health professional; commissioner)	DESCRIPTION – What should be measured?	How is it justified?	Is it measurable and how?	Is it Different between Children and TYA
Pt/parent	Ease of access into service. Are relevant people being offered access to C TYA service	To monitor equitable service	Yes – count by age etc	No
PT/parent	Offered access to age appropriate facilities and skills – peers, internet, etc, playroom	Users say it matters!	Yes eg Education of workers	Yes
Pt/parent	Key worker known and relevant to role	Adult survey shows valued by users	Yes	No
Pt/parent	Reasonable volume of patients seen – size of centre, throughput	Proxy for expertise etc	Yes, needs to relate to average size. Varies by disease type.	No
Pt/parent	Effective systems for communication between team members	Yes	Yes – score – ask teams, pts if feel adequately informed	No
Pt/parent	Rapid access to appropriate service at all stages of pathway	Delays matter to patients. Not just prior to diagnosis but also to other services	Yes, but need standards to measure against	No
Pt/parent	Effective systems for information. Good information service, 24 hour access	Pt experience. Appropriate advice	Yes. Existence, use of service	No
Pt/parent	Expertise within the Multi Disciplinary Team and broad range of membership, eg holistic aspects	Yes	Yes. Roles of team members	Yes

Ease of **access** into service. Equity of access to CTYA services	**Transition** between services – effective integration across services, eg child to adult, types of service, locality
Offered access to **age appropriate** facilities and skills	Clear **defined pathway** into service and between units and centre
Key worker known and relevant to role	Good **MDT working**: appropriate, good quality data; efficient processes
Reasonable volume of patients seen – **size of centre**, throughput	**Seamless** service: from diagnosis to treatment
Effective systems for **communication** between team members	Professional development: education, training and support
Rapid **access** to appropriate service at all stages of pathway, including diagnostics	**Critical mass** of patients coming through MDT
Effective systems for **information**. Good information, 24 hour access	**Patient satisfaction**
Expertise within the Multi Disciplinary Team and broad range of membership, eg holistic aspects	**Safe practice**: nurse patient ratio, caseload size, skills mix
Possibility of access to local treatment and support – **shared care**	**Value for money**: length of stay, readmission rates, efficiency
Survival outcomes	**Quality** of service
Access to the **best possible treatment** – in accordance with guidelines	Access to **data**
Patient experience- of service	Meeting **national targets**: emergency admission rates
Outcomes other than survival:, rate of infection, acute morbidity measures, medical complications	**Sharing expertise/good practice** with other disease groups:
Effective **communication** between teams	

Themes:
Access – Timeliness – Information – Outcomes (Survival, Complications) – Resources & Skills – Local Services –Clear Pathways - Efficiency – Patient Experience

Table Work

- Review the list of possible indicators provided on the worksheets

- What theme(s) do these represent?

- Are they clinically relevant?

- Are they measurable? If so how?

- Would you value the collection and reporting of these data?

- Can you decide on a 'top 4' ?

- Have you got ideas for other possible indicators?