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National Cancer Peer Review Programme

Cancer Network Brain and CNS TSSG Clinical Leads Workshop 11th March 2010

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National Cancer Peer Review

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National Institute for Health and Clinical Excellence

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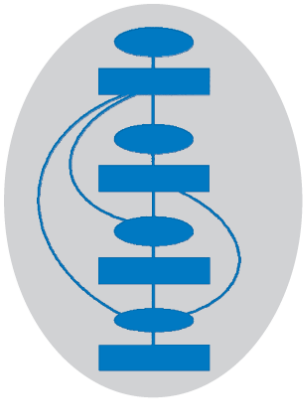
Guidance on Cancer Services

Improving Outcomes for People with Brain and Other CNS Tumours

The Manual



June 2006

Developed by the National Collaborating Centre for Cancer

Note:
Full Implementation of the IOG is expected by 2010/2011

Neuroscience brain and CNS MDT

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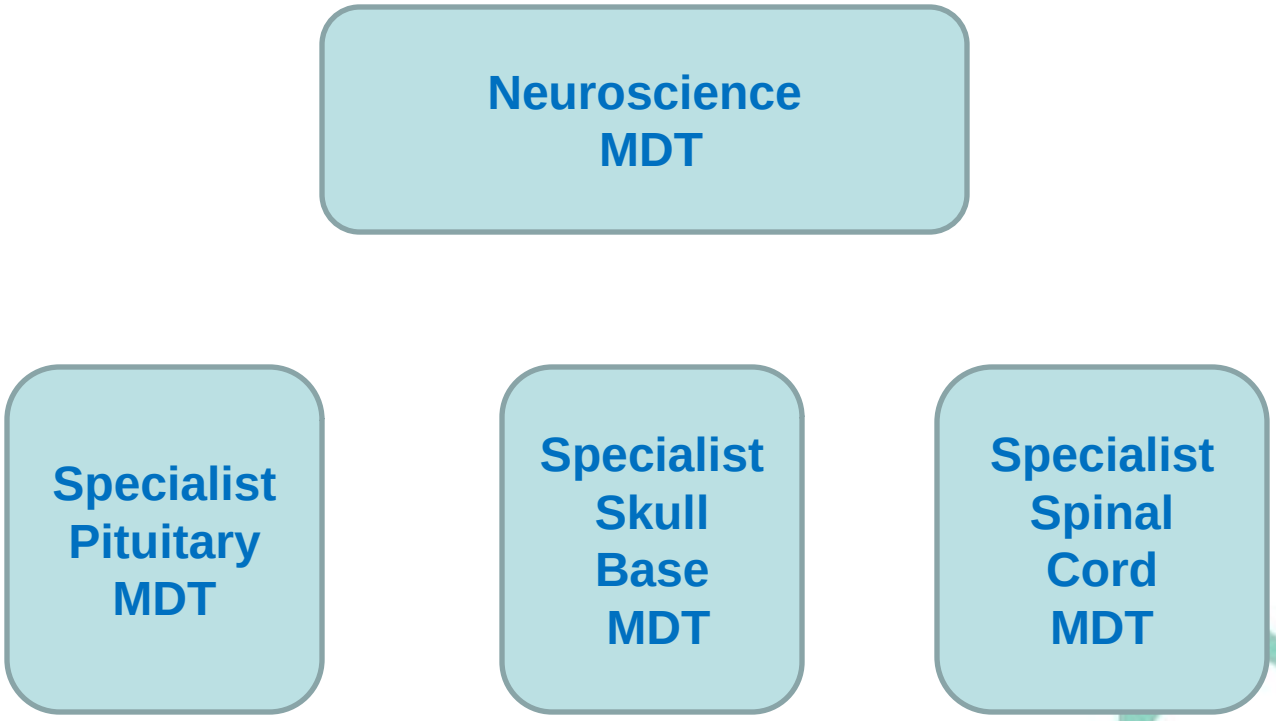
A neurosciences centre may have various models of MDTs which are acceptable to the IOG.



Implications for MDTs

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- The IOG indicates that not all Neuro-science centres should have:
  - a neuro-science specialist Spinal Cord MDT
  - a neuro-science specialist Skull Based MDT
- How do we decide who can and who can't!
- Insufficient Data available to make evidenced based decisions

Configuration of Specialist Spinal Cord and Skull based MDTs

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- Not all neurosciences centers will have a specialist spinal cord or skull based MDT.

- Neuroscience centers that have existing spinal cord and skull based teams will be able to continue but these specialist MDTs should collect **data** on all their patients. SCGs should review the numbers to consider if it is appropriate to continue this work.

- No new specialist spinal cord or skull based MDTs should be established.

What's a Specialist

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A "Core" member of site specific MDT √
A regular attendance (weekly) at an MDT √
A regular specialist clinic with CNS and or oncologist √
(diagnosis and follow-up)
>50% theatre time in specialist area √
CPD >50% related to National or International meetings in area
Audited contribution to NCRN trials √
Contribution to Cancer Network development
Commitment to record Cancer DataSet √
Training requirements?

All Brain and CNS tumour patients must be seen by specialist
All Brain and CNS tumour patients must be considered by MDT
All specialists caring for Brain and CNS tumours must attend MDT

The cancer network brain and CNS MDT

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- The IOG group confirmed that each network should normally have **only one** cancer network brain and CNS MDT.

- It is accepted that the IOG allows a model where a neurosciences brain and CNS MDT and a cancer network brain and CNS MDT can be combined.

- The key role of the cancer network MDT is the coordinating of non-surgical management of adult patients with brain and CNS tumours including the coordination of rehabilitation and supportive care.

The cancer network brain and CNS MDT - Responsibilities

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The cancer network MDT coordinates patient care across the network. This requires the cancer network MDT to work with local hospitals, general practitioners and community teams to:

- Agree who is responsible for implementing the next stage of the management plan
- Ensure that there are systems in place for the continuous assessment of the needs of patients, their relatives and carers, and provide or ensure provision of appropriate support
- Inform the local referring hospital and general practitioner of the current management plans

The cancer network brain and CNS MDT - Responsibilities

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- Involve the local referring hospital or community services in continuing, palliative and supportive care where appropriate, and provide specialist advice to local healthcare professionals when needed

- Re-refer patients to the neuroscience MDT where appropriate, as defined in local protocols

- Act as an educational resource for local service providers

Combined neuroscience and cancer network MDT

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It is essential that appropriate time is given to ensure the role of the cancer network MDT is fulfilled for all patients.

- Patients from within the cancer network
- Patients referred from outside the cancer network.

For patients outside the cancer network, it will be necessary for communication to take place with the cancer network brain and CNS MDT from which the patient is referred.

This is to ensure their care is picked up locally once they leave the care of the neurosciences brain and CNS MDT.

Combined neuroscience and cancer network MDT

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Where a neurosciences centre has more than one neuroscience MDT, it is **not** permitted to have a combined neurosciences and cancer network brain and CNS MDT.

IOG compliant models

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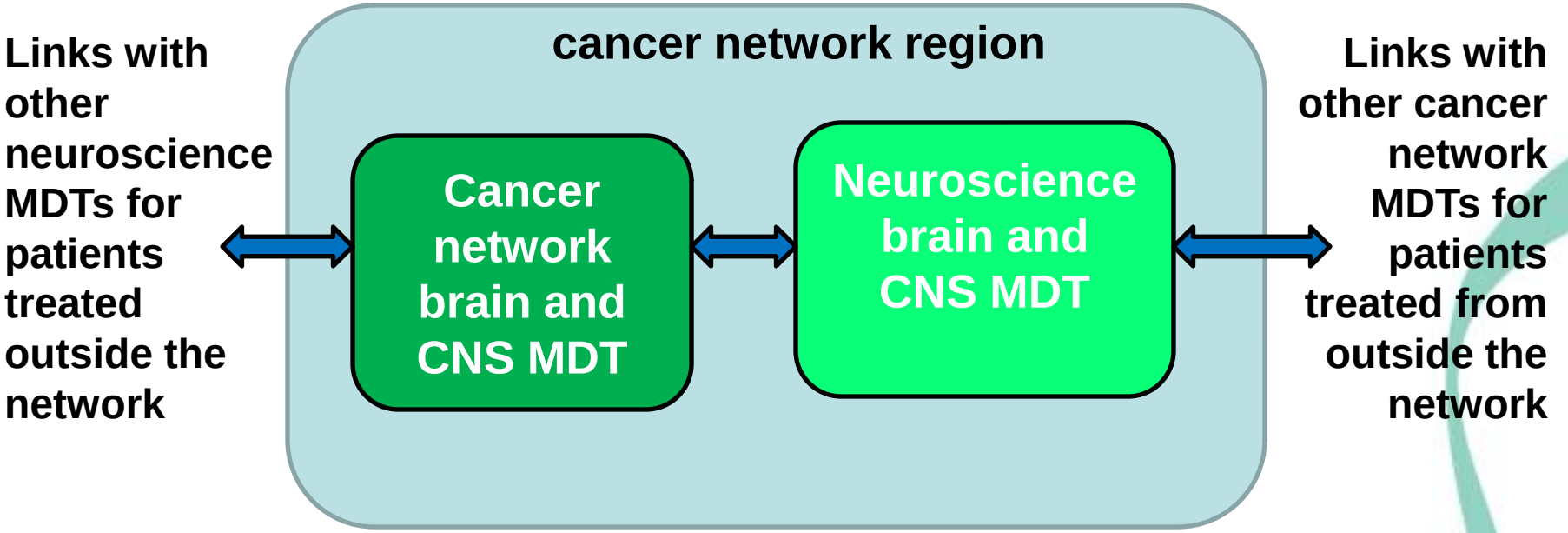
A separate cancer network brain and CNS MDT and neuroscience brain and CNS MDT.



A combined cancer network and neuroscience brain and CNS MDT.

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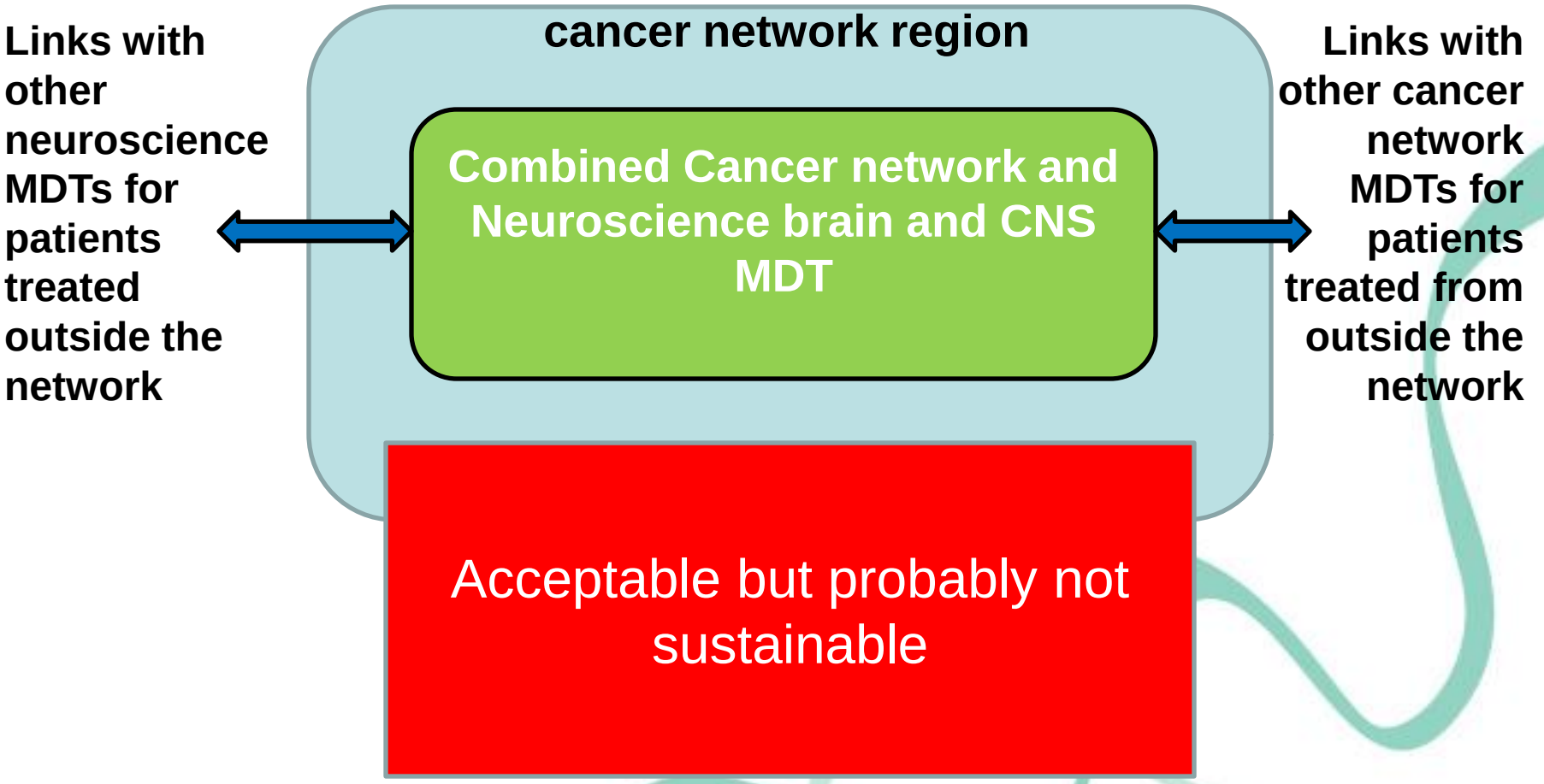

A separate cancer network brain and CNS MDT and a neuroscience brain and CNS MDT plus specialist MDT/s

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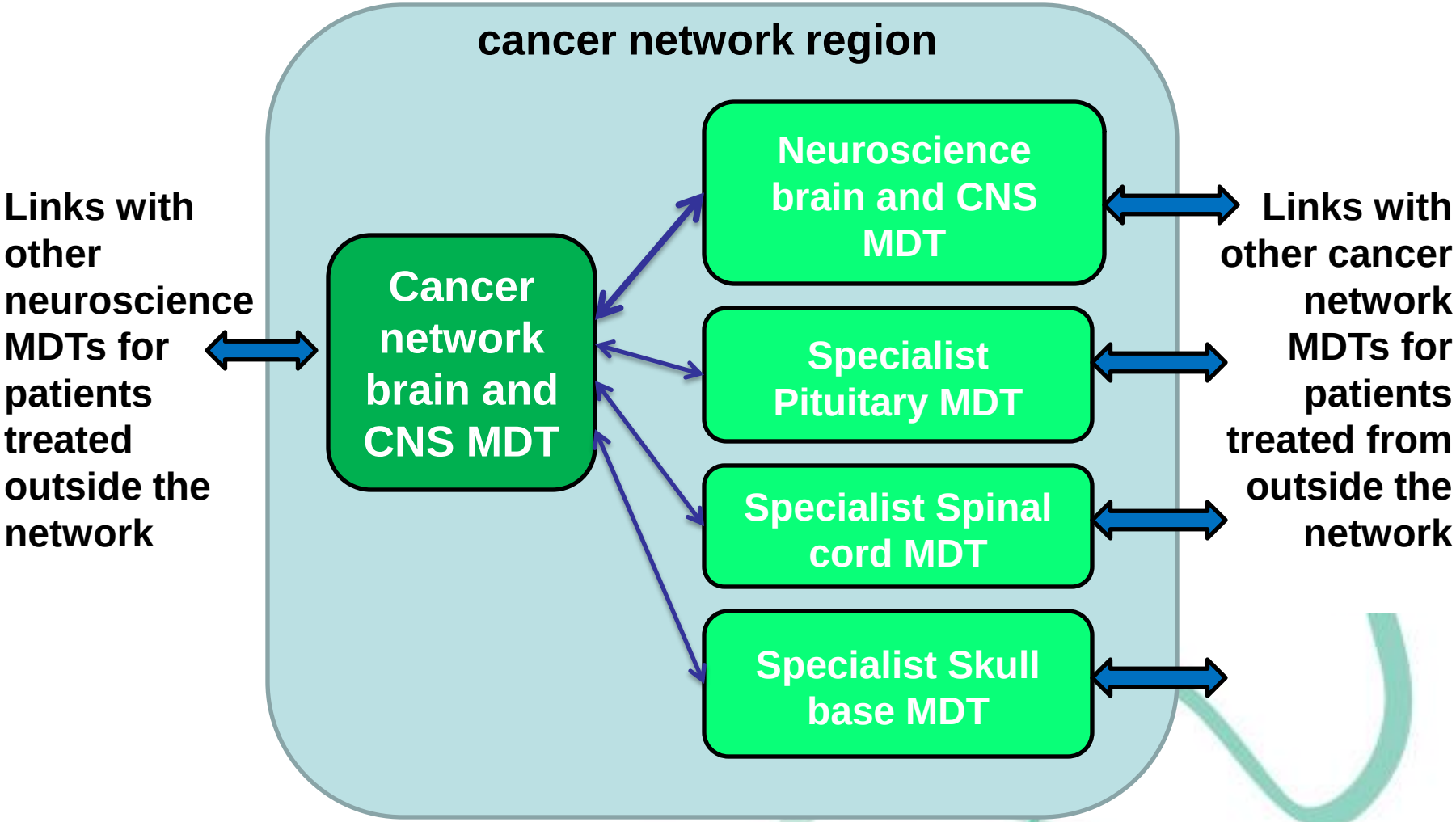

Configuration of Brain and CNS MDTs

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- It is not clear what teams exist, whether they are combined surgical and non surgical teams, or if separate specialist teams exist
- Don’t force specialist teams into combined MDTs to meet the IOG. It is right to specialise if there is sufficient workload.
- Clearly defined referral pathways

Example: A letter from a support group

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- A patient goes to GP and is referred ‘out of Region’ to surgical centre.
- There is no local team dedicated to the coordination of care of these patients currently no local nurse specialist and no ‘site specific’ group in the region.
- Discharge planning is patchy and poorly coordinated and carers’ needs are largely ignored.
- People are often passed from one agency to another when seeking help rather than having one named care coordinator.
- Patients are often discharged home on a Friday leaving the family without planned support over the week-end when service are less accessible

Supra-network site specific groups

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- It is not clear where the site specific group are and who is attending (which MDTs)
- Think about the patient flows outside your region.

Building the managed supra cancer network

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- A designated lead for each acute trust – most plan have done this.
- Communication Framework – Should we have a national list of designated leads and MDTs.
- Training for referral guidelines for suspected cancer as they apply to CNS tumours

Supra network working - the national picture

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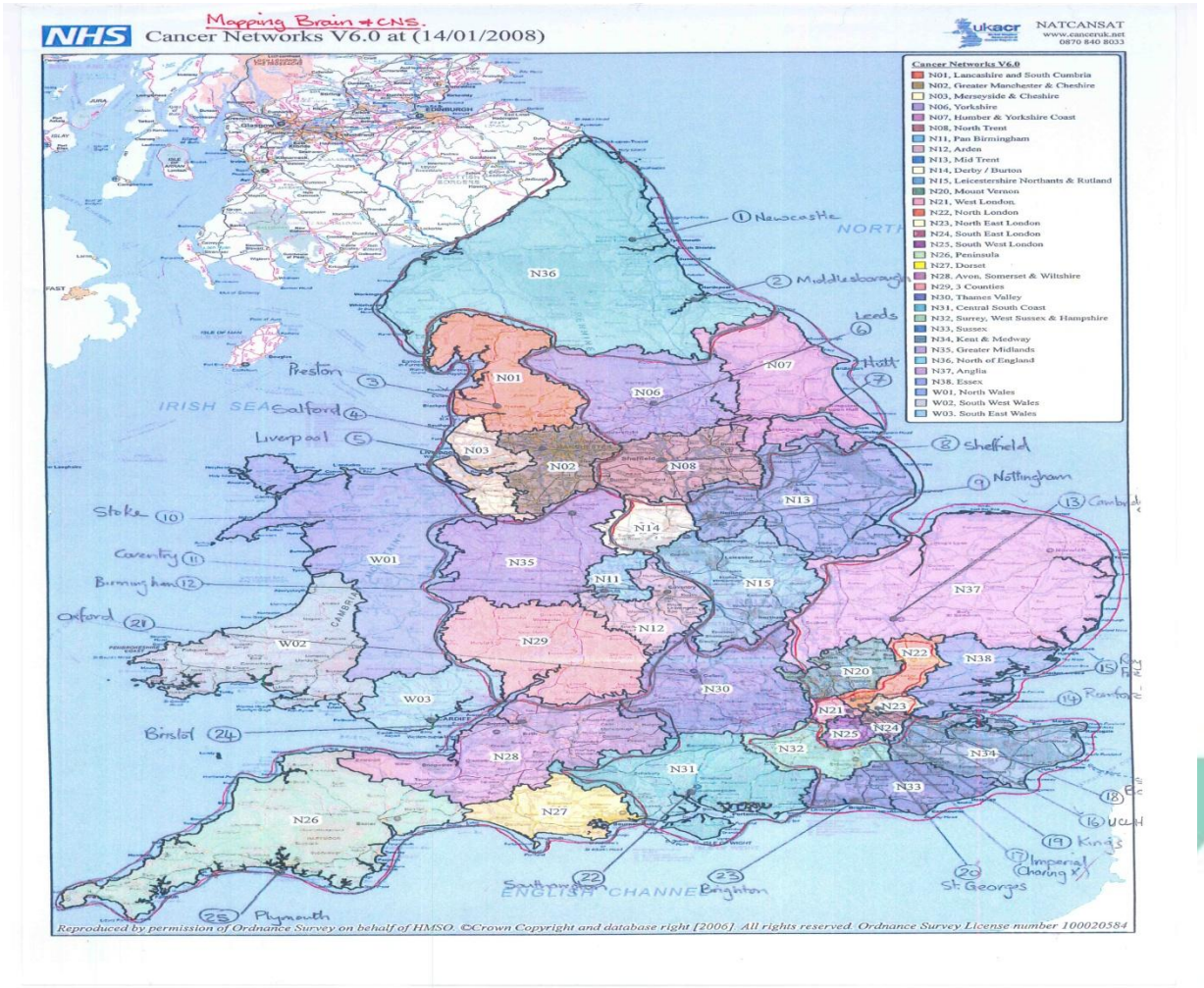

National Cancer Peer Review (NCPR)

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- Measures for Brain and CNS are currently being developed and should be out for National consultation by Summer 2010.

- Brain and CNS visits are planned May 2011

- Notification of visits Nov each year - Brain and CNS is scheduled for notification of visits Nov 2010

- All Brain and CNS teams will be visited in the first year

What is Cancer Peer Review

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The National Cancer Peer Review programme is:

- A process undertaken by peer and service user reviewers to assess the quality of cancer services against IOG for NHS patients in England
- It is an integral part of the NHS Cancer Reform Strategy
- The process is supported by a set of detailed measures

The aims of NCPR

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- 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

Benefits of Peer Review

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Provision of disease specific information across the country together with information about individual teams which has been externally validated

Provision of a catalyst for change and service improvement

Identification and resolution of immediate risks to patients and or staff

Engagement of a substantial number of front line clinicians in reviews

The Peer Review Process

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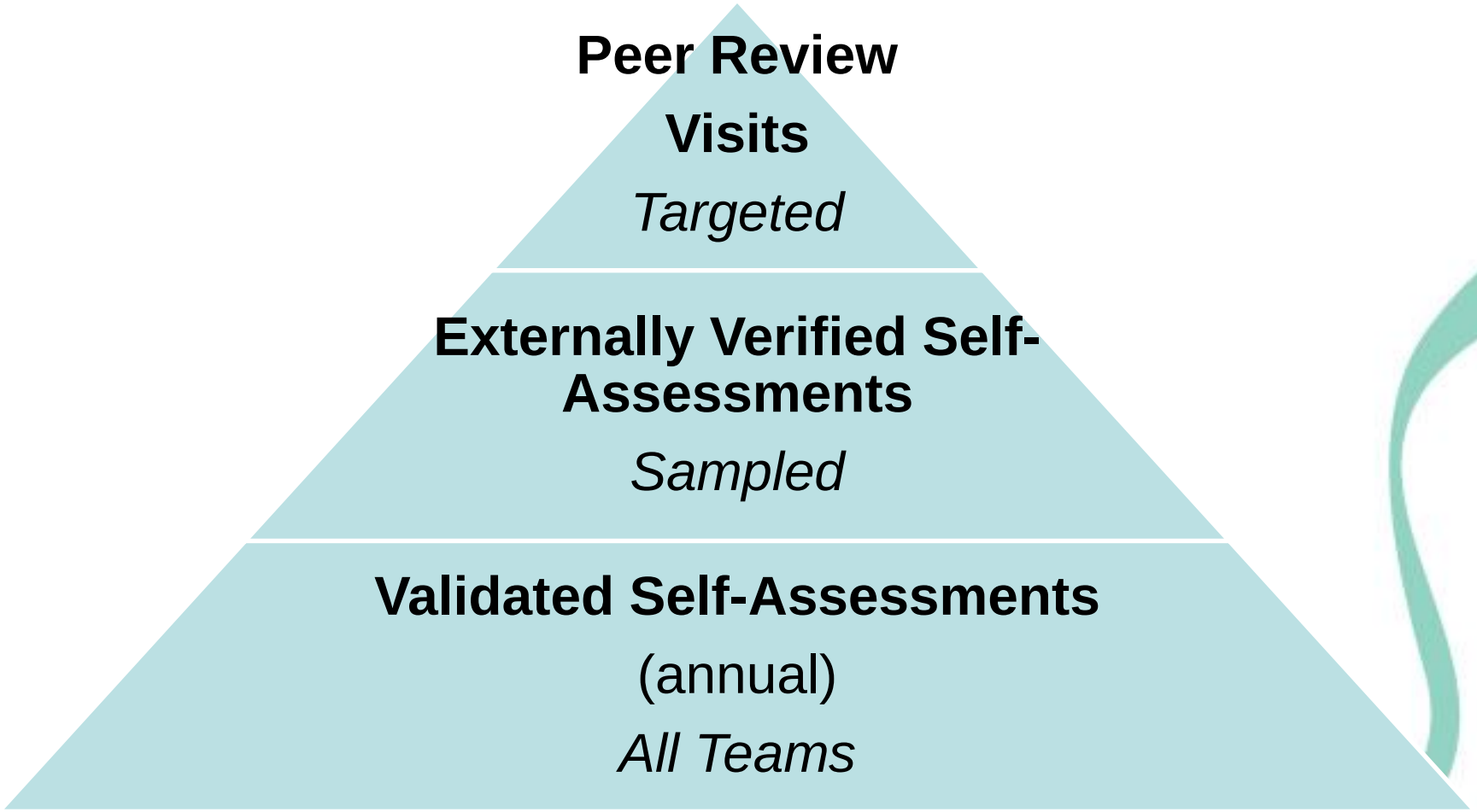

The National Schedule

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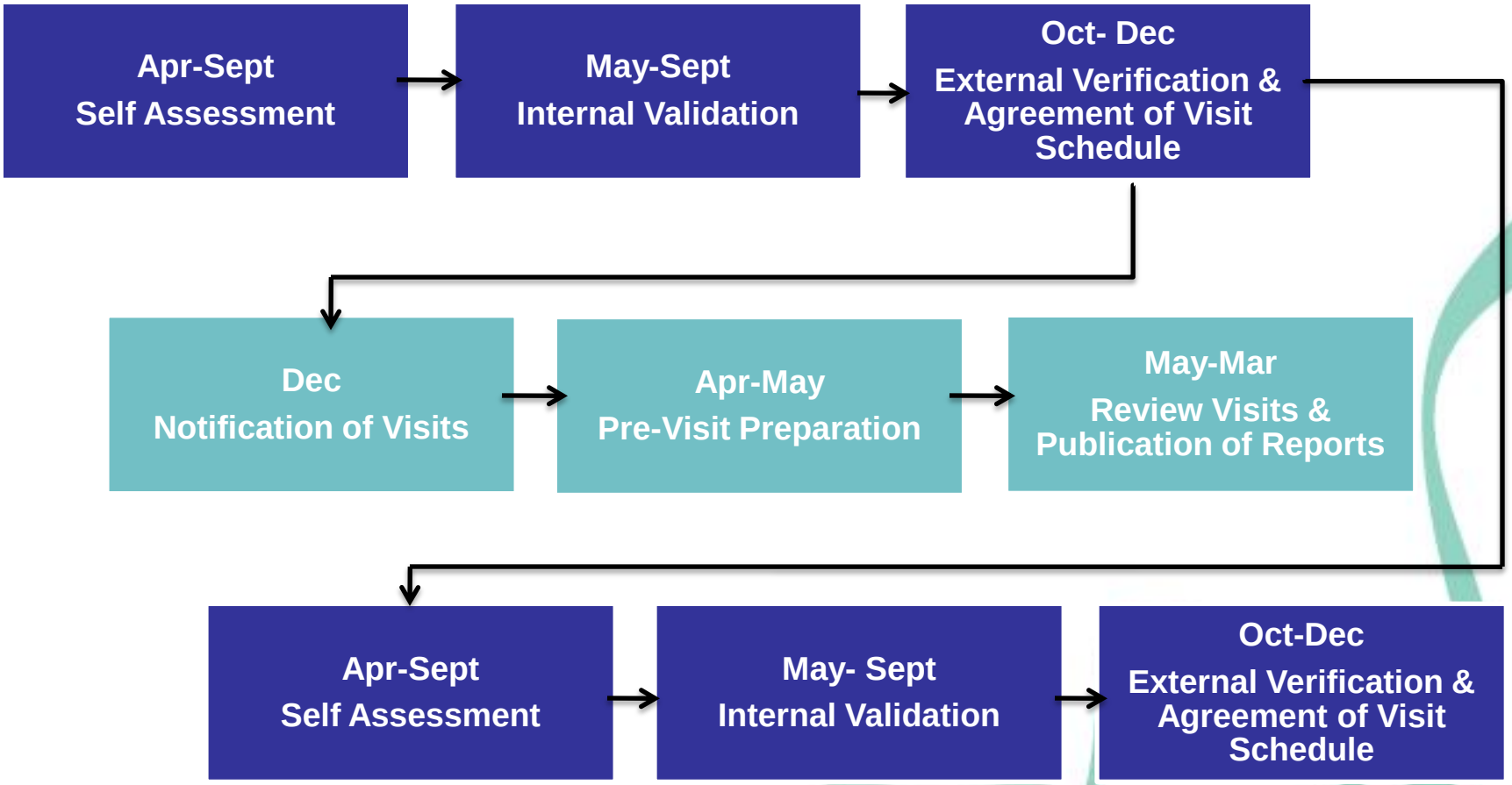

The Peer Review Visit Plan

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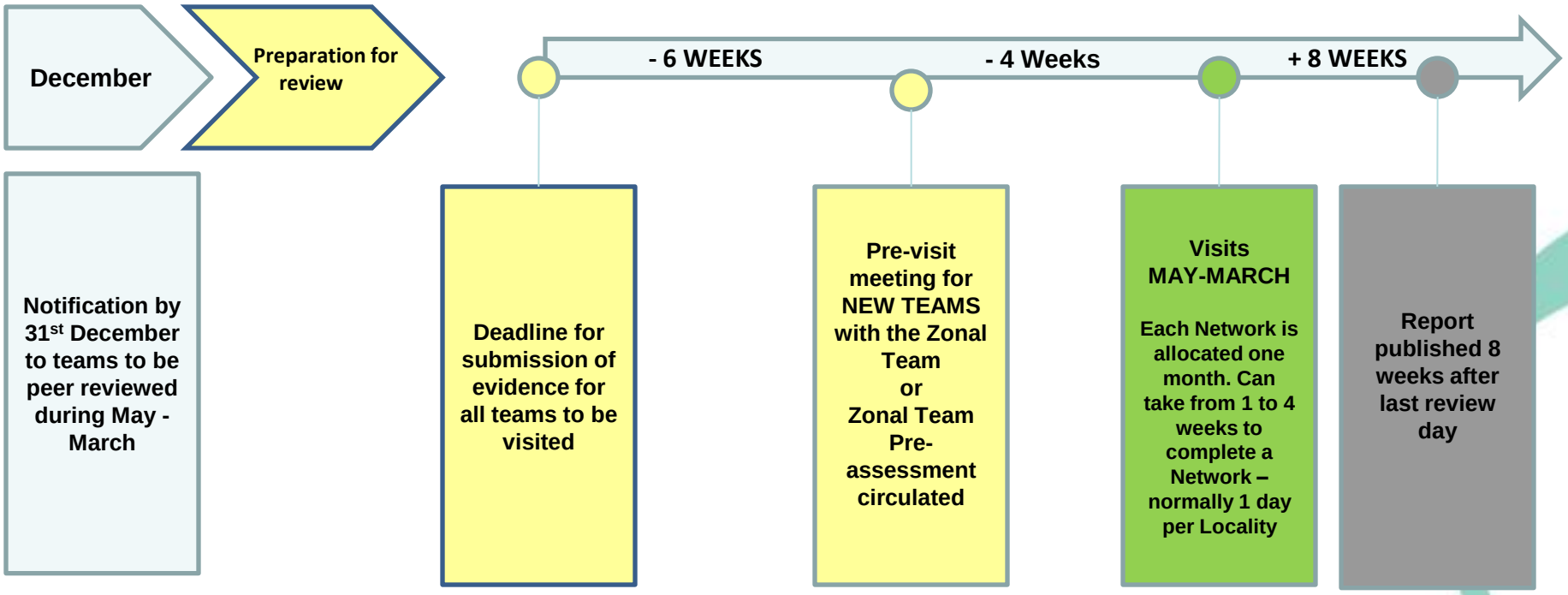

Handbook for the National Cancer Peer Review Programme

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Contains details of the process from start to finish including:

1. The Peer Review Programme
2. Annual Self Assessment
3. Internal Validation
4. External Verification
5. National Schedule for Peer Review Visits & Conducting the Review
6. Outcomes of the Peer Review Process
7. Identification of Concerns
8. CQuINS

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British Neuro Oncology Society (BNOS) / National Cancer Action Team (NCAT):

National Group for Rare Brain and CNS Conditions

British Neuro Oncology Society (BNOS) rare brain and CNS conditions group

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Chairs have been agreed for the sub groups

- David Walker - Optic gliomas
- Frank Saran – Medulloblastoma
- David Jellinek / Roger Taylor – Pineal
- Robert Marcus – Primary CNS Lymphoma

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Thank You