National Cancer Action Team
Part of the National Cancer Programme

National Cancer Peer Review Programme

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What is Cancer Peer Review?

- A quality assurance process for cancer services.
- An integral part of Improving Outcomes – A Strategy for Cancer
- Assesses compliance against IOG for NHS patients in England.
- A driver for service development and quality improvement
- Supported by a set of detailed measures

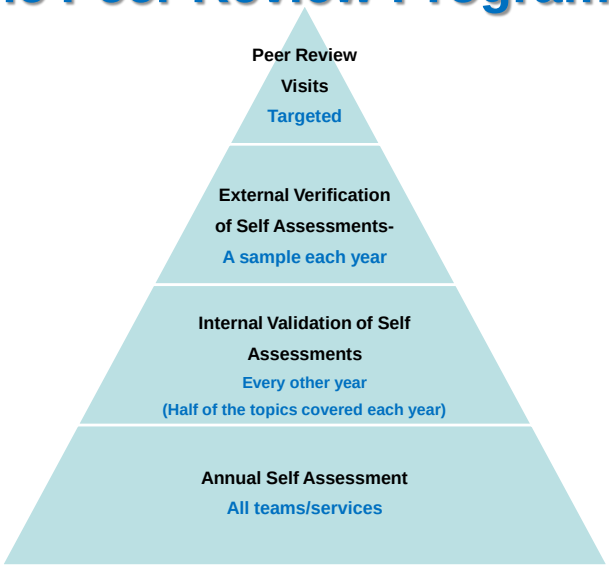
Purpose of Cancer Peer Review

- To ensure services are as safe as possible
- To improve the quality and effectiveness of care
- To improve the patient and carer experience
- To undertake independent, fair reviews of services
- To provide development and learning for all involved
- To encourage the dissemination of good practice

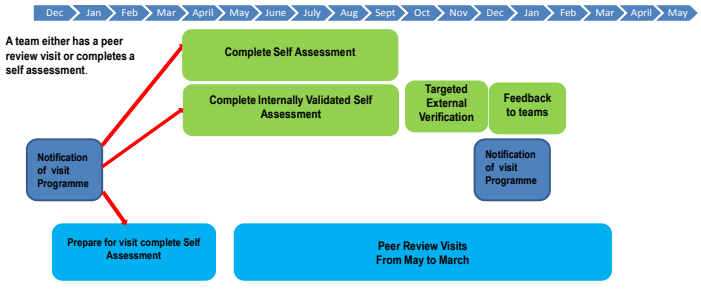
Outcomes of Peer Review

- 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

The Peer Review Programme



The National Schedule



MANUAL FOR CANCER SERVICES

Policy Documents, measures & Cancer Peer Review

Measures Development

- Developed by an expert group
- Aimed to measure areas detailed in the National documentation e.g. NICE Improving Outcomes Guidance and National reports such as NCAG and NRAG reports.

Measures Structure

Topic 1	Network Measures
Topic 2	MDTs
Topic 3	Cross cutting services
Topic 4	Cancer Registry
Topic 5	Cancer Research Networks
Topic 6	PCTs
Topic 7	Childrens

The Self Assessment Process

The Self Assessment Process

Team Summary Report

- Forms part of the self assessment
- Short summary report completed by the lead clinician
- Commentary that reflects the level of compliance with the measures, patient experience and clinical outcomes. Includes development and achievements over the past year.

MDT Summary

- Structure and Function
- Co-ordination of Care/Pathways
- Patient experience
- Clinical Outcomes/Indicators

MDT-
Evidence Documents

Operational Policy	Annual Report	Work Programme
Describing how the team functions and how care is delivered across the patient pathway Outlining policies/processes that govern safe / high quality care Agreement to and demonstration of the clinical guidelines and treatment protocols for team.	Summary assessment of achievements & challenges Demonstration that the team is using available information (including data) to assess its own service -MDT Workload & Activity Data (activity by modality, surgical workload by surgeon, numbers discussed at MDT, MDT attendance) -National Audits -Local Audits -Patient Feedback -Trial Recruitment -Work Programme Update	How the team is planning to address weaknesses and further develop its service. Outline of the teams plans for service improvement & development over the coming year -Audit Programme -Patient feedback -Trial Recruitment -Actions from Previous reviews

Demonstrating Agreement

- Where agreement to guidelines and policies is required there should be a statement on the front cover of the document indicating the groups and individuals that have agreed the document and the date of agreement.
- Evidence Guides will indicate the groups and individuals that need to be documented as agreeing the key evidence documents.

Evidence Guides

- Guidance to help you structure your evidence documents
- Guidance for Compliance
- Additional Guidance
- Always refer to the full measure in making assessments against measures

Clinical Lines of Enquiry

Development of Clinical Lines of Enquiry

- Increasing focus on addressing key clinical issues and clinical outcomes
- Clinical indicators developed in conjunction with SSCRGs and relevant tumour specific national bodies.

Development of Clinical Lines of Enquiry

- Rationale
  - Increased range of possible diagnostic and treatment interventions
  - Subsequent guidance issued by NICE incorporated into peer review discussions
  - Supporting the overall aims of
    Improving Outcomes- A Strategy for Cancer
  - In step with commissioning function of cancer services

Clinical Lines of Enquiry

- Conclusions from clinical discussions with review teams will be supportive in
  - Highlighting significant progress and/or good clinical practice
  - Identifying challenges faced in providing a clinically effective service
  - Identifying areas where a team/service may require support/development to maximise its clinical effectiveness

Clinical Lines of Enquiry

- Key clinical issues will be highlighted through discussion and review of existing evidence and information

Preliminary Feedback

- The focus of discussion moved from structure and process to more clinically relevant issues
- Many teams have used the figures as the basis for audits on their practice to understand why they are outliers
- Highlighted issues with completeness of data collection, the process for clinical validation and whether outcomes are regularly reviewed and acted upon by the MDT
- Driven the impetus for clinical teams to work with the trusts to address the infrastructures to support data collection

Internal Validation

Internal Validation – The Purpose

- 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
- 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 and share areas of good practice

Internal Validation – The Principles

- the process is agreed within the organisation
- the process adopted has agreement with the commissioners within the locality and the cancer network
- accountability for the self assessments is confirmed by agreement of the chief executive of the organisation
- there is commissioner and patient / carer involvement within the process
- the process and outcome of the validation is reported on the nationally agreed proforma.

Internal Validation – The Process

Desk-Top Review

- Small panel review and validate assessment

Panel Review

- Small panel review assessment
- Meet with representatives of the MDT/NSSG to discuss key issues and finalise validation

Internal Validation – The Process

- Agreed Validation Process takes place
- Further clarification may be sought on some issues / opportunity of re-submission of specific evidence
- Validation proforma agreed
- Validated compliance recorded on CQuINS
- Validation proforma published

External Verification

External Verification – The Purpose

- Verify that self-assessments are accurate
- Check consistency across organisations
- Ensure that a robust process of self-assessment and internal validation has taken place
- Provide a report on performance against the measures and associates issues relating to IOG implementation
- Identify teams or services who will receive an external peer review visit in accordance with the selection criteria.

External Verification – The Process

- Desk top review of validated assessment undertaken by Zonal Quality Team
- Review of accuracy of self-assessment
- Zonal Team may request further information
- Zonal Team will have access to specialist clinical input and patient/carer input

External Verification – The Outcome

- Signed off by Quality Director and Clinical Lead
- If organisation unhappy with outcome there will be the opportunity for dialogue with a view to finding a solution
- Verified assessment scores recorded – changes will be explained on CQuINS
- National proforma uploaded to CQuINS / published

Peer Review Visits

Annual Meeting with Network

- December each year
- The purpose of the meeting will be to;
  - inform the Zonal team of key issues within the Network such as implementation of Improving Outcomes Guidance, Service Configuration changes
  - discuss the teams to be visited and schedule for the following year.

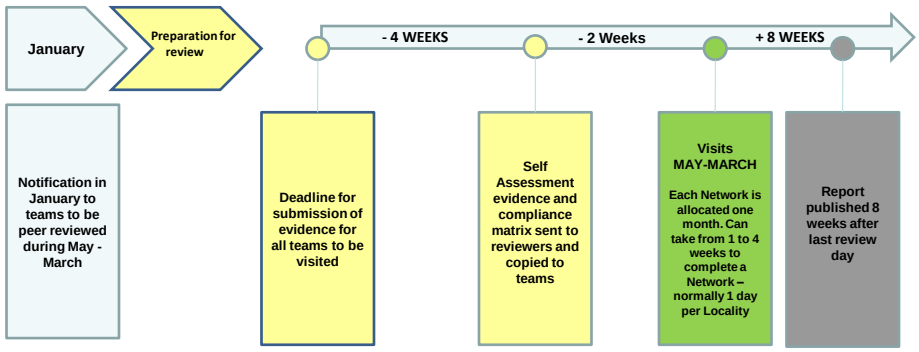
Peer Review Visit Criteria

- Milestones not met for implementation of an IOG as agreed with CAT
- Immediate Risks identified at previous peer review visits that have not yet been resolved
- Requests from organisations i.e. SHAs, local and specialist commissioners, PCTs, Networks, Acute Trusts
- % compliance with measures within lowest performance grouping
- Concerns regarding rigor of Internal Validation
- Stratified random sample based on % compliance (if available capacity)

The Peer Review Visits

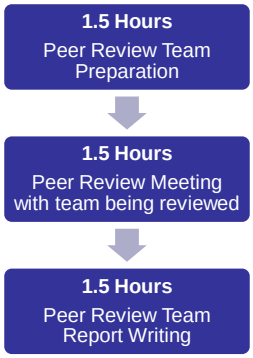
- Notified in January of each year
- Scheduled between April and March each financial year
- Each Network will be visited at same point of visit schedule each year

The Peer Review Visit Plan



The Visit Day

- Max of 3 concurrent sessions am & pm
- Max of 6 teams will be reviewed in 1 day
- E.g. Session:



Peer Review Teams

- Between 2 and 5 reviewers per session
- Plus a member of the Zonal Quality Team
- Reviewers should normally include “Peers”
  – people who are trained and working in the same discipline as those they are reviewing

Peer Review Teams May Include:

User/carer	MDT Lead Clinician	Clinical Nurse Specialist	Radiologist
Pathologist	Oncologist	Medical Physicist	Therapy Radiographer
Oncology Pharmacist	Chemotherapy Nurse	Palliative Care Consultant	Trust Lead Clinician, Nurse or Manager
Network Lead Clinician, Nurse or Manager	PCT Cancer Lead	Cancer Commissioner	Dietician

Which Team Members should attend the Review?

- MDT Review:
  - Lead clinician and CNS
  - with other core members (e.g. surgeon, oncologist, radiologist, pathologist, palliative care)
  - not the whole extended team
- NSSG Review
  - Chair of NSSG
  - Small group of other key NSSG members

Outcomes from the Process

Outcomes from the Process

- Annual Network Reports
- National “State of the Nation” Reports
- Joint Working between the Care Quality Commission (CQC) and the NCPR Programme
- Information for commissioners

Post Review Actions

- Recommendations from IV, EV or PR visits picked up within Work-Programmes / Reported on in Annual Reports
- Separate process for actions regarding Immediate Risks and Serious Concerns
  - Written notification and written response

Discussion

The role of the MDT facilitator in peer review

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The role of the MDT facilitator in peer review

- record attendance at meetings;
- take minutes at the multidisciplinary meetings;
- keep comprehensive diary of all team meetings;
- ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
- ensure all correspondence, notes, x-rays, results, etc are available for the meetings;
- help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed. ensuring patients' diagnoses, investigations, and management and treatment plans are completed and added to the patient's notes;

The role of the MDT facilitator in peer review

- managing systems that inform GP's of patient's diagnosis, decisions made at outpatient appointment etc;
- development of databases to capture patient information;
- data collection and recording of data;
- to manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
- assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;

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Thank You

Any Questions ?