

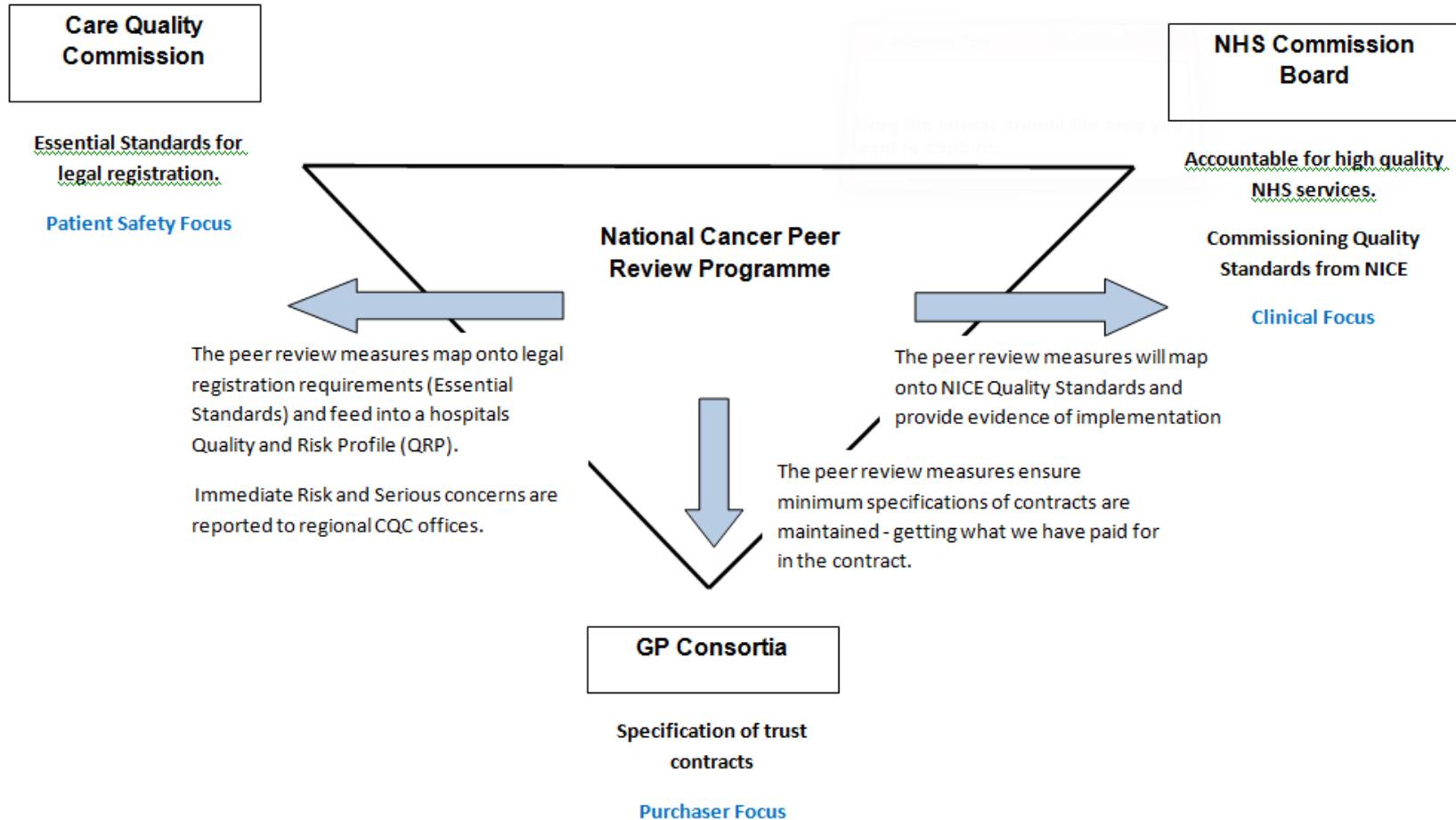
National Cancer Action Team  
Part of the National Cancer Programme

# National Cancer Peer Review Programme

Ruth Bridgeman

Acting National Co-ordinator

# The New Healthcare Environment



# Ensuring Effective Levers

- Ensuring Peer Review outcomes are fed into the Care Quality Commission legal registration requirements
- Embedding Peer Review outcomes into the commissioning process
- Providing evidence that services are meeting the NICE Quality Standards



# Improving Outcomes: A Strategy for Cancer

*January 2011*

# Reducing the Burden of Peer Review on the NHS

- Peer review has provided critical insights into the quality of cancer care across England. Links are now being made between the results from Peer Review and the work of the Care Quality Commission. **We recognise, however, that Peer Review is very time consuming for Trusts, and work is underway to consider how the burden of peer review might be reduced by 40%**

# Peer Review Process

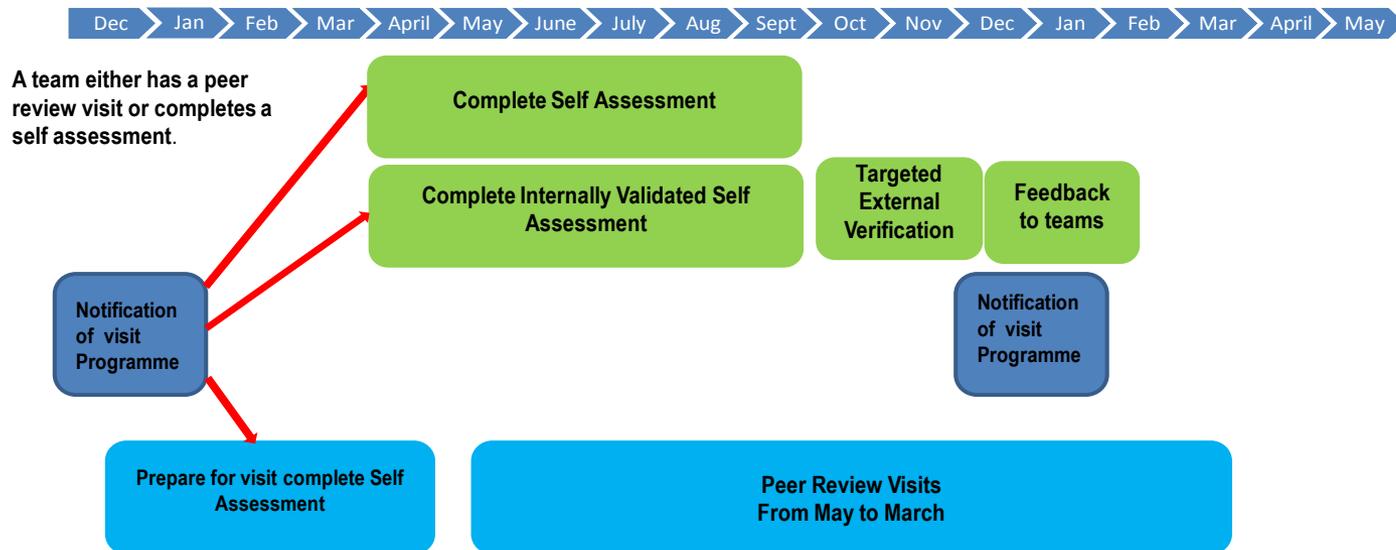
# What is Cancer Peer Review?

- 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 measures

# The Peer Review Programme



# The National Schedule



# 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.
- 3 month consultation on new measures

# Characteristics of the Measures

- Objective
- Specific
- Discriminating
- Clear and unambiguous
- Developmental
- Clear about who is responsible
- Measurable
- Verifiable
- Achievable

# Consultation Process

- Measures published on DH website and on CQuINS

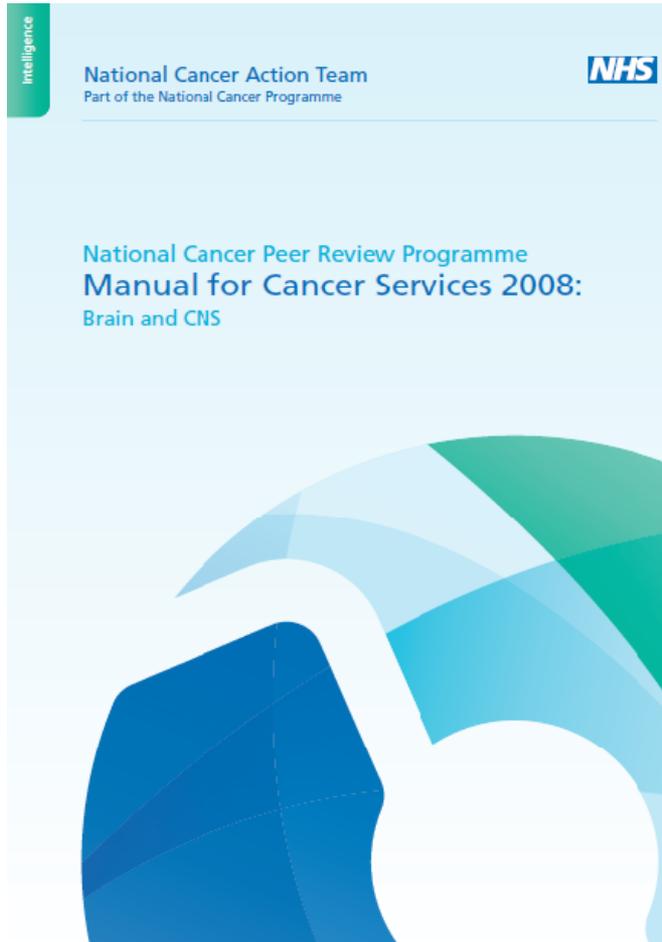
<http://www.cquins.nhs.uk/?menu=resources>

- Proforma for comments
- Consultation Events
  - Brain & CNS
    - 17<sup>th</sup> March London Holiday Inn Bloomsbury
    - 29<sup>th</sup> March Leeds Queens Hotel

# Consultation Process

- Consultation closes on 31<sup>st</sup> March 2011
- All comments collated and considered
- Panel / Editing Meeting
- Final Publication April 2011

# Brain and CNS Measures



# Draft Brain and CNS Measures

Divided into sections with linked compliance required:

- 1A-1** Network Board Measures For Brain and CNS
- 1C-1** Functions of the Network Neuro Oncology Disease Site Group
- 1D-1** Functions of the Locality/Trust Group
- 2K-1** The Neuroscience MDT
- 2K-2** The Cancer Network MDT

# 1A: Network Measures

## The Shape of Neuro-oncology Services

- Brain and CNS Network configuration
- Establishment of the Neuro-oncology Disease site Group
- Agreeing Arrangements for NDSG
- Location of Multidisciplinary Specialist Clinics
- Neuropathology Workforce Neuro-rehabilitation Facilities

# 1C: Functions of Neuro-Oncology Disease Site Group

- General Activities
- Clinical Guidelines
- Data Collection
- Patient Pathways
  - » The Presentation Pathway
  - » The Diagnostic Pathway
  - » The Treatment Pathway
  - » The Follow Up Pathway
- The Communication Framework
- Protocol for Emergency Surgical Interventions
- Area Clinical Leads
- Area Audit
- Cancer Research

# 1D: Functions of the Locality/Trust Group

- Trust Lead Clinicians for Brain and CNS Malignancy
- The Multidisciplinary Specialist Clinic
- Patient Pathways (In conjunction with the measures in 1C)
- The Communication Framework
- Neuro-rehabilitation Facilities

# 2K-1 Neuroscience Multidisciplinary Team

- MDT Structure
- Operational Policies
- MDT Nurse Specialist Measures
- Area-Wide Patient Pathways
- Area-Wide Communication Framework
- Area Audit
- Cancer Research Network
- MDT Workload

# 2K-2 Cancer Network Multidisciplinary Team, Stand Alone Team

- MDT Structure
- Operational Policies
- MDT Nurse Specialist Measures
- Area wide Clinical Guidelines
- Area wide Patient Pathways
- Area wide Communication Framework
- Area Audit
- Cancer Research Network

# The Self Assessment Process



# Completing the Self Assessment

1. Upload Key Documents - (Alternate years only)
2. Enter compliance against the measures on CQuINS
3. Complete Team Report

# Self Assessment 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.

# Self Assessment Report – Key Themes

Structure and Function

Co-ordination of Care/Pathways

Patient experience

Clinical Outcomes/Indicators

# MDT Key Themes

# Structure and Function

This can be demonstrated through compliance to:

- any measures that relate to MDT leadership, membership, attendance and meeting arrangements;
- any measures within the operational policies section regarding patients which are reviewed by the MDT;
- % time MDT core members devote to this cancer type;
- training requirements of MDT members;
- responsibilities of nurse MDT members ;
- MDT workload data and surgical workload data.

# Structure and Function

This section of the report requires specific answers to:

- Are all the key core members in place?
- Does the MDT have a clinical nurse specialist?
- What is the compliance with waiting time standards?
- How many patients by equality characteristic( race, age and gender) were diagnosed /treated in the previous year?

# Coordination of Care/ Patient Pathways

This can be demonstrated through compliance to any measures that relate to the existence of a coordinated and patient centred pathway of care, for example;

- any measures relating to agreement of network guidelines and patient pathways;
- recording of treatment planning decisions;
- key worker and principal clinician policies;
- communication with GPs.

# Patient Experience

This relates to the collection of information on and achievement of improvements to service delivery, patient experience and gaining feedback on patients' experience. It may include information associated with:

- enhanced recovery programmes;
- communication with and information for patients;
- other patient support initiatives;
- service improvement initiatives such as process mapping and capacity and demand analysis;
- information from the National Cancer Patient Experience Survey;

It is important to demonstrate any measurable change in performance regarding these parameters, compared to previous assessments.

# Patient Experience

This section of the report requires specific answers to:

- What are the national patient experience survey results / local patient experience exercise feedback results?

# Clinical Outcomes/ Indicators

- Where available the data from the clinical indicators should be used.
- You should comment separately on each indicator.
- Where national clinical indicators for the team's cancer site have not yet been agreed for the peer review please identify and comment on the top five clinical priority issues for your team.
- It is important to demonstrate any measurable change in performance regarding these parameters, compared to previous assessments.
- Relevant measures include any relating to data collection, relevant network audits and research activity.

# Clinical Outcomes/ Indicators

This section of the report requires specific answers to:

- What are the major resection rates?
- What are the mortality rates within 30 days of treatment?
- What is your recruitment to trials?
- Outcomes of any key audits projects?

# Self Assessment Report

- Will be a public document
- Will form basis of Annual Peer Review Report for those teams not subject to internal validation
- Handbook contains guidance on identifying Immediate Risks, Serious Concerns and Concerns

# MDT- Evidence Documents (only required every other year)

Operational Policy	Annual Report	Work Programme
<p>Describing how the team functions and how care is delivered across the patient pathway</p> <p>Outlining policies/processes that govern safe / high quality care</p> <p>Agreement to and demonstration of the clinical guidelines and treatment protocols for team.</p>	<p>Summary assessment of achievements &amp; challenges</p> <p>Demonstration that the team is using available information (including data) to assess its own service</p> <ul style="list-style-type: none"> <li>-MDT Workload &amp; Activity Data (activity by modality, surgical workload by surgeon, numbers discussed at MDT, MDT attendance)</li> <li>-National Audits</li> <li>-Local Audits</li> <li>-Patient Feedback</li> <li>-Trial Recruitment</li> <li>-Work Programme Update</li> </ul>	<p>How the team is planning to address weaknesses and further develop its service.</p> <p>Outline of the teams plans for service improvement &amp; development over the coming year</p> <ul style="list-style-type: none"> <li>-Audit Programme</li> <li>-Patient feedback</li> <li>-Trial Recruitment</li> <li>-Actions from Previous reviews</li> </ul>

# 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 Indicators/Outcomes

# Development of Clinical Indicators

- 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 Indicators

- 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

# Principles of Clinical Indicators

- The data should be available nationally or readily available locally. Not intended to require further audit in themselves
- Metrics which can be used as a lever for change and for reflection on clinical practice and outcomes
- They may be lines of enquiry around clinical practice, or around collection of data items, rather than enquiry focused on the data itself
- May cover key stages along the patient pathway, including diagnosis, treatment and follow up
- There should be some consensus on national benchmarking data which can be used to inform the discussions

# Development of Clinical Lines of Enquiry

- Clinical Indicators
- Data in relation to the indicators – National/Local
- Clinical Lines of Enquiry – Briefing sheet identifying the questions reviewers will ask in relation to the clinical indicators based on the data

# 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 Indicators

- Key clinical issues will be highlighted through discussion and review of existing evidence and information
- Not intended to identify IR or SC

# Progress to Date

- Progress to date
  - Pilot with Lung and Breast almost complete – feedback positive
  - CLEs developed in Upper GI, Gynaecology, Colorectal and Head & Neck for implementation 2011 – 2012 reviews
  - CLEs to be developed for Sarcoma, Brain and CNS, Skin and Urology

# Lung Clinical Lines of Enquiry

## Key headline indicators

- The % of expected cases on whom data is recorded
- The % histological confirmation rate
- The % having active treatment
- The % undergoing surgical resection (all cases excluding mesothelioma)
- % small cell receiving chemotherapy

# Breast Clinical Lines of Enquiry

## Key headline indicators – National Data

- Percentage of women offered access to immediate reconstruction surgery by MDT or by referral onto another team and rate of uptake
- Ratio of mastectomy to Breast Conserving Surgery (BCS)
- Each surgeon managing at least 30 new cases per year
- Average length of stay for breast cancer with any surgical procedure
- The one-, two- and five-year survival rates

## Key headline indicators – Local Data

- Proportion of women tested for HER2 prior to commencement of drug treatment (if undergoing resectional surgery and receiving adjuvant or neo-adjuvant chemotherapy)
- Availability of Screening and estimated impact on workload of extended Programme
- Availability of Digital mammography

# 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

# Suggestions received to date for Brain and CNS

## BNOS

- 1/ The current diagnostic interval prior to diagnosis.
- 2/ What proportion of patients (not requiring emergency surgical intervention) are currently discussed in a properly constituted MDT prior to surgery, and further the proportion of patients subsequently surgically managed exclusively by a surgeon who is a core member of the MDT.
- 3/ The percentage of patients who proceed to adjuvant therapy – as a rule radiotherapy – within 4 weeks of this decision to treat having been made in the MDT.
- 4/ The percentage of patients who are entered into eligible clinical trials (RCTs and non randomised RCTS)
- 5/ The availability and uptake of current molecular diagnostic techniques (e.g. 1p 19q, MGMT, IDH1) to MDTs in England.

# Suggestions received to date for Brain and CNS

Mr D Porter. Consultant Neurosurgeon, Head of Speciality. Chair of the Brain and other CNS Tumours SSG

Malignant Tumours (Primary/Secondary)

- % patients discussed pre-operatively at MDT
- 1 + 2 year survival for low grades
- Chemo mortality/morbidity
- Surgical complications
- Length of Stay per surgery type
- 3 months performance status after stereotactic radiotherapy for low grades i.e. how many are back at work. The preference would be for this patient group to be either 0 or 1 on the WHO performance status.
- 12 month performance status (WHO) for high grades

## Benign Tumours (meningioma/acoustic/pituitary)

### Surgical complications

- In pituitary - endocrine cure rate  
% followed in joint pituitary clinic
- In meningioma- return to work rate  
10-year control rate
- In acoustic- hearing preservation rate  
% treated with SRS
- % discussed at MDT

I do not think that one can collect any clinical outcomes without some underpinning risk analysis.

However, some simple questions that could be asked might be the following:

- To provide a ratio of operated to combined operated/radiosurgery-treated to interval imaged to radiosurgery-treated for meningiomas and acoustic neuromas.

This would ensure that there wasn't an overenthusiasm re surgery and patients were having maximal healthy access to radiosurgery.

- To provide the location of treatment centre of patients above that have been treated with radiosurgery. For example, one practice of radiosurgery is to have gamma knife which is essentially an overnight stay and back to normal life (there are now four gamma knives in the country). Another practice of radiosurgery is using 'Lincac fractionation' over a number of weeks, with such centres often having small patient volumes.

- To provide a list of skull base cancer operations over say a four year period, detailing procedure, tumour type, and surgeons involved.
- Finally, one could just look for evidence to ensure that each neuroscience MDT is maintaining a database of co-morbidities/clinical outcomes but not specifically look at the content, i.e., putting a culture in place of such data collection for the future.

# The IOG

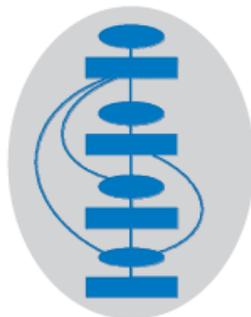


*National Institute for  
Health and Clinical Excellence*

Guidance on Cancer Services

## Improving Outcomes for People with Brain and Other CNS Tumours

The Manual



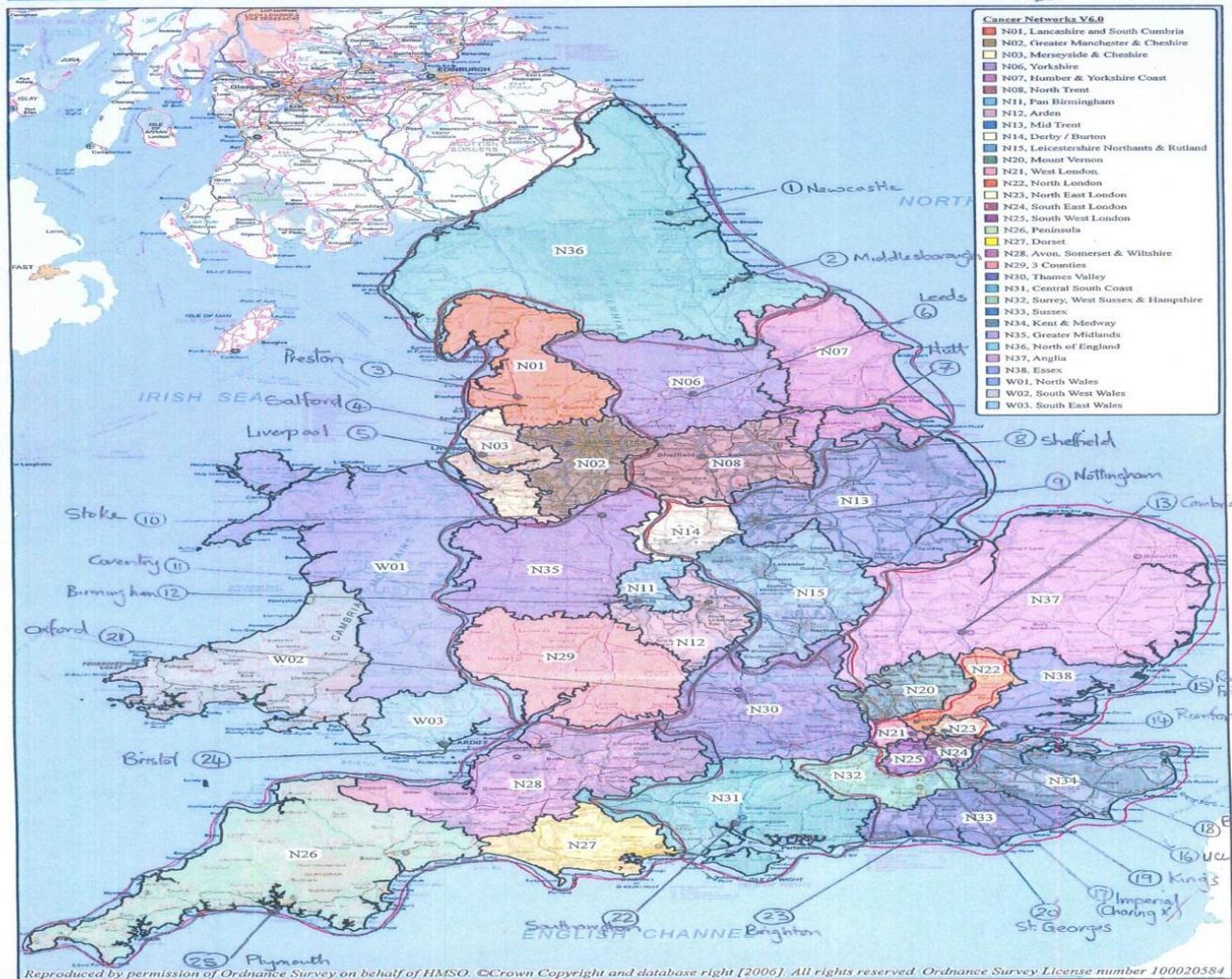
June 2006

Developed by the National Collaborating Centre for Cancer

# The National Picture

**NHS** Mapping Brain + CNS. Cancer Networks V6.0 at (14/01/2008)

**UKaCR** NATCANSAT  
www.canceruk.net  
0870 840 8033



# National guidelines

The NCAT has worked with SCG representatives and the British Neuro-Oncology Society (BNOS) to establish guidelines for the management of:

- Primary CNS lymphoma
- Adult medulloblastoma
- Pineal tumours
- Optic glioma tumours.

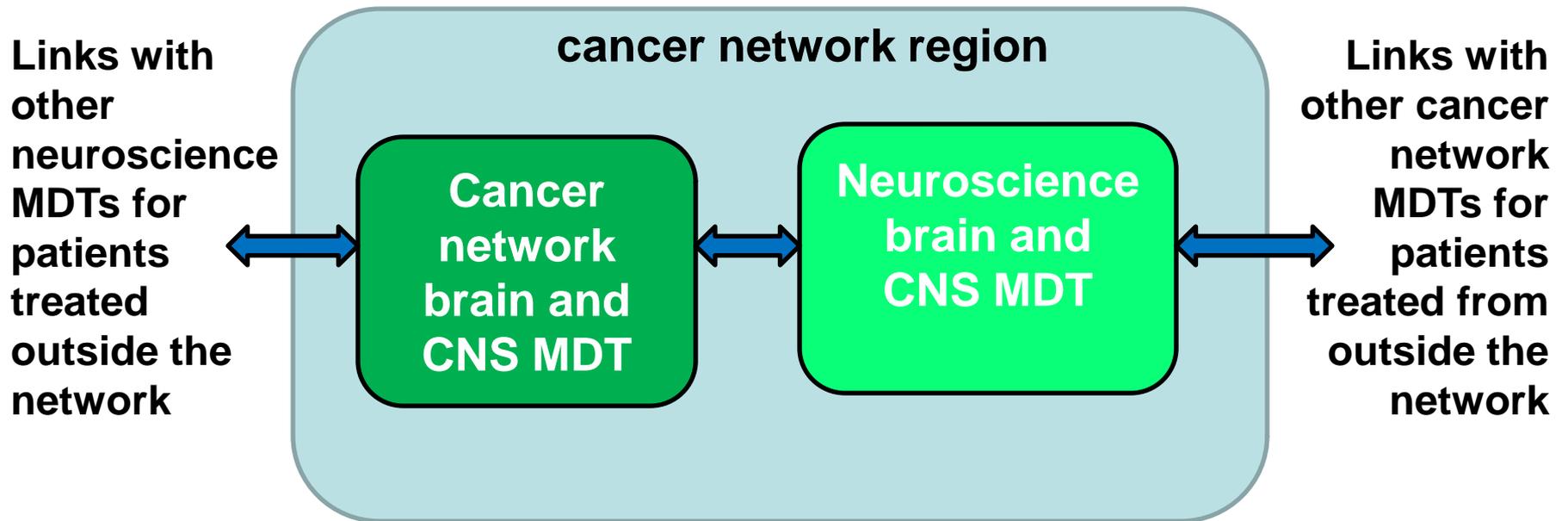
# Brain and CNS IOG – an update

- The IOG will now be monitored through NCPR
- The key IOG measurables are in the Brain and CNS measures
- Teams who do not meet the IOG will be identified as a risk through the peer review process and reports will be forwarded to commissioners and the CQC.

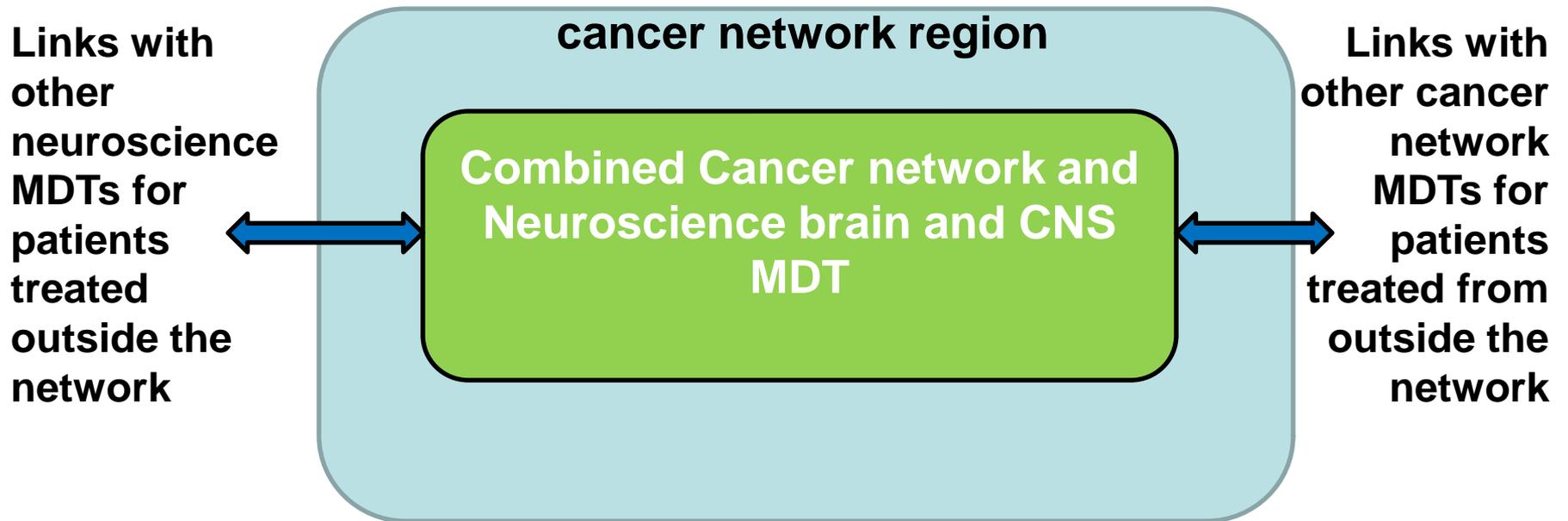
# Key Principles of the IOG

# IOG compliant models

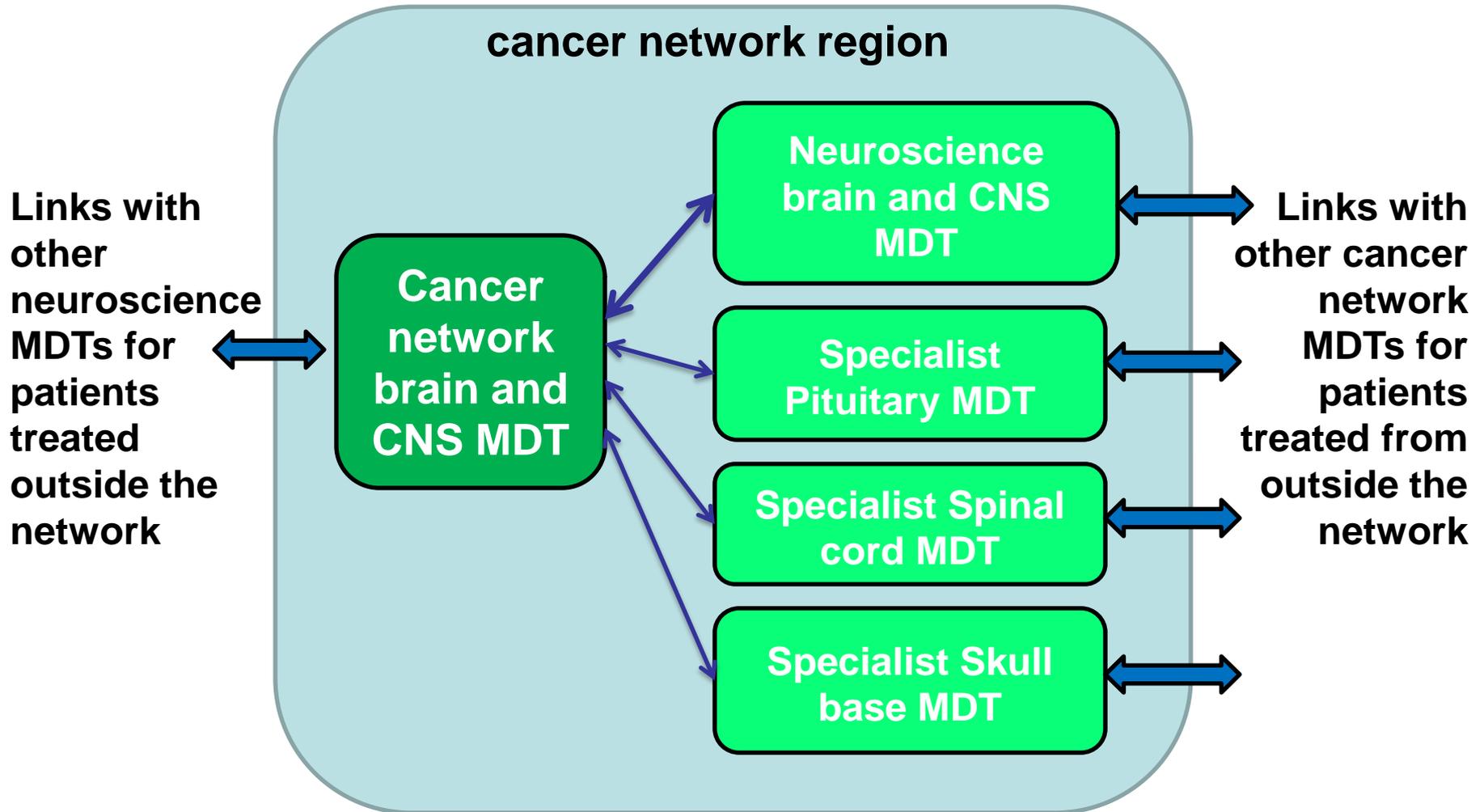
A separate cancer network brain and CNS MDT and neuroscience brain and CNS MDT.



# A combined cancer network and neuroscience brain and CNS MDT.



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



# The cancer network brain and CNS MDT - responsibilities

*Improving Outcomes for  
People with Brain and  
Other CNS Tumours*

*Multidisciplinary teams*

2

**Table 9. The cancer network brain and other CNS tumours MDT – responsibilities**

The cancer network MDT is the coordinating team for the non-surgical management of most adult patients with CNS tumours. Membership of this team is summarised in Table 10, and its responsibilities include the following:

- Implement the non-surgical aspects of the management plan produced by the neuroscience MDT
- Nominate and record a key worker to act as point of contact for patients, their relatives and carers. This should be agreed with the patient, their relatives and carers
- 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
- Re-refer patients to the neuroscience MDT where appropriate, as defined in local protocols
- Inform the local referring hospital and general practitioner of the current management plans
- 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
- Develop MDT protocols, in collaboration with the neuroscience MDT, to define appropriate follow-up imaging requirements for patients with CNS tumours
- Act as an educational resource for local service providers
- Develop and maintain evidence-based local management protocols covering all aspects of the patient pathway
- Participate in regular site-specific group meetings to review pathways of care and protocols
- Maintain data entry across the area of service provision
- Audit practice against this guidance and other national guidelines as they are published
- Facilitate entry of patients into appropriate NCRN and local clinical trials
- Liaise with the neuroscience MDT

# Combined neuroscience and cancer network MDT

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

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.

**Thank You**

**Any Questions ?**