NHS

National Cancer Peer Review Programme 2004-2007

Handbook for the National Cancer Peer Review Process

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Introduction

1 Introduction

This handbook describes the method and procedures for carrying out the National Cancer Peer Review Programme in England. National Cancer Peer Review is undertaken by peer reviewers and user reviewers resulting in assessments on the quality of cancer services for NHS patients in England. The National Cancer Peer Review Programme is an integral part of the NHS Cancer Plan and modernisation of cancer services. The Programme supports quality assurance of cancer services and enables quality improvement.

The National Cancer Peer Review Programme provides a ready mechanism by which cancer services will be able to demonstrate that they are meeting the Standards for Better Health; in particular, in the domains of safety, clinical and cost effectiveness, governance and patient focus.

The process of cancer peer review is concerned not only with the review of an organisation's compliance against a set of detailed measures, but also with the qualitative assessment of a broad set of objectives for the delivery of services which will encompass the whole system of patient care and the patient and carer experience. Cancer peer review therefore provides a mechanism to enable the overall quality of cancer services to rise.

Development of the National Cancer Peer Review Programme has been supported by the Service and agreed by Strategic Health Authorities following the positive evaluation of the 2001 cancer peer review visits. The National Cancer Peer Review Programme has not been centrally imposed.

Peer Review teams will carry out reviews of all Cancer Networks in England during the period November 2004 – March 2007.

1.1 Background and Context

The Calman-Hine Report "A Policy Framework for Commissioning Cancer Services" (1995) and subsequent evidence based "Improving Outcomes Guidance" on individual cancer sites (for example, breast, colorectal, lung and gynaecological cancers) provided the basis for establishing the national standards for cancer care. The original manual of standards was used to support the peer review programme of 2001.

Since publication of the Calman-Hine Report, there have been a range of reports and policy documents that have had direct impact on planning for, and delivering cancer services. These subsequent publications include the NHS Cancer Plan; "Shifting the Balance of Power: Next Steps"; and Improvement, Expansion and Reform the Next Three Years. Most recently there was the NHS Cancer Plan Three Years Progress Report published in October 2003.

In addition to the documents listed above, since publication of the Manual of Cancer Services Standards in December 2000, further Improving Outcomes Guidance has been published by National Institute for Clinical Excellence (NICE).

The National Cancer Peer Review Programme is underpinned by the new Manual for Cancer Services 2004 which now refers to standards as measures, to ensure that a distinction is made with the high level standards contained within the Standards for Better Health, but it should be emphasised that the change of name does not result in a change in their meaning or value. The new Manual incorporates the recommendations contained within the relevant national publications and the new guidelines published by NICE. Changes have also been made as a result of feedback from the use of the Manual of Cancer Service Standards during the peer review visits in 2001, and following a detailed evaluation of the first national round of Cancer Peer Review visits undertaken by the Controls Assurance Support Unit (CASU), based at the University of Keele.

There is a clear commitment to the establishment of an active and positive relationship between the Healthcare Commission (formerly CHAI), and the National Cancer Peer Review Programme within the principles set out in the new Healthcare Concordat to help reduce the burden of regulation, including the minimisation of duplicate visits to organisations including voluntary hospices.

The Healthcare Commission supports the aims of the Cancer Action Team's National Cancer Peer Review Programme, and intends to monitor health organisations' progress in implementing the findings from the reviews. The Cancer Action Team will share the findings from Cancer Peer Review visits with the Healthcare Commission, including progress on implementing agreed remedial action within a clear timescale, along with self-assessments by NHS trusts against the Manual for Cancer Services and annual monitoring of networks' Cancer Improving Outcomes Guidance action plans.

These findings will be viewed as an important source of

information to the Healthcare Commission over the next few years on assessing progress on core and developmental standards and on progress made by cancer networks, and the bodies that make them up, on meeting the targets and objectives set out in the NHS Cancer Plan. This includes the implementation of relevant NICE Improving Outcomes Guidance, technology appraisals and guidelines.

The Healthcare Commission recognises that the way in which a Cancer Network functions is a good generic indicator of effective partnership working between the organisations within a local health economy. The National Cancer Peer Review process takes account of the journey which patients make across organisational boundaries, and helps assess how well the journey is managed in the interests of the patient. And because the cancer patient visits many of the teams and directorates within a hospital, National Cancer Peer Review findings are a good indicator of the general governance and effectiveness of an acute trust.

1.2 Aims and outcomes of National Cancer Peer Review Programme

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.

These aims relate closely to the domains in the Standards for Better Health.

The Outcomes of National Cancer Peer Review Programme are:

- confirmation that cancer services are of approved quality;
- 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;
- used to inform and be informed by on-going quality monitoring and enhancement.

Cancer peer review visits should be conducted in a spirit of dialogue and cooperation between the Cancer Network, Localities, their staff and the review teams. The process is one of peer review, carried out by specialist teams of professional peers and user/carer reviewers. Wherever possible the professional peers will be those trained and working in the same discipline that they are reviewing. Peer review enables assessments to be made by those who understand the service. It enables assessments to be credible and to command the respect of those being reviewed. For the peer review process to have credibility with external stakeholders, assessments must be made in a consistent and transparent manner, and reported publicly.

It is essential that peer review visits are undertaken with proper regard to issues of equality and diversity, including the needs and interests of people with disabilities and black and minority ethnic communities. This principle should be emphasised during each of the peer reviewer training sessions.

1.3 Management of the National Cancer Peer Review Programme

A National Peer Review Steering Group has been set up as a subgroup of the National Cancer Taskforce to oversee the National Cancer Peer Review process and ensure consistency of approach.

Six Zonal Coordinating Teams have been established, each with a Quality Director, Clinical Lead, Quality Manager/s and Process Co-ordinator. These teams will manage the peer review process at a local level. The Six Zones are:

The North	i.e. North East, Yorkshire and the Humber
The West (South)	i.e. West Midlands
The West (North)	i.e. North West
The East	i.e. East Midlands & East of England
The South	i.e. South East & South West
London	

Within each of the Zones a Zonal Reference group has been established. These groups are responsible for ensuring local ownership and implementation of the Cancer Peer Review Programme, for supporting consistency of interpretation of the measures within the Manual for Cancer Services, for maintaining an overview of implementation of agreed remedial action following peer review visits and for taking

appropriate action if progress is not satisfactory. The groups also have responsibility for identifying strategic issues identified through the peer review visiting process. Core members of the Zonal Reference Group will include:

- Cancer lead from each constituent Strategic Health Authority.
- One representative from each constituent Cancer Network.
- One Tier 1 specialised services commissioning representative.
- User/Carer representative.
- Zonal peer review co-ordinating team .

A National Peer Review Co-ordinating Team, consisting of a National Co-ordinator and Associate National Co-ordinator, has been established as part of the National Cancer Action Team. The National Co-ordinating Team will ensure consistency in both the interpretation of the Manual for Cancer Services and the implementation of the peer review process in each Zone.

1.4 Scope of Peer Review

The National Cancer Peer Review Programme will review compliance with measures contained within the Manual for Cancer Services 2004. The focus of the peer review visit will be on the pursuit of any issues that emerge from the self-assessment as well as a more qualitative assessment of cancer service provision and the co-ordination of patient care across the Cancer Network.

At present, the Manual for Cancer Services does not cover all cancer types and all stages of the patients' journey. All cancer services for which measures have been developed will be included in the peer review programme. There will be flexibility for Zones to review services in advance of their inclusion in the national programme, for example, using the generic MDT standards. Such reviews will be undertaken only with the agreement of the relevant Zonal Reference Group and will be commissioned by the relevant Strategic Health Authority. Links will be made with the National Specialist Commissioning Advisory Group (NSCAG) before reviews of NSCAG-commissioned services are undertaken.

It is proposed that over time the remit for the National Cancer Peer Review Programme should be extended to include those services provided for patients with a diagnosis of cancer, whether they are private patients or NHS patients, in the independent sector. However at present the Care Standards Act 2000 requires the Healthcare Commission to undertake inspections of all registered independent establishments once a year, using national minimum standards. Currently they are not able to delegate this function.

Within the context of the Concordat between bodies inspecting, regulating and auditing healthcare, Cancer Peer Review, along with other regulatory bodies, are working with the Healthcare Commission to adopt a more collaborative approach towards the review and inspection process in order to reduce the burden of inspection.

For example, discussions have taken place between the National Cancer Peer Review Co-ordinating Team, and the Healthcare Commission with a view to the peer review processes and the Commission's inspection processes converging.

The Healthcare Commission has indicated that their inspection teams are willing to use the relevant measures in the Manual for Cancer Services as their framework when they visit private hospitals, and links are being established between those inspection teams and the cancer peer review Zonal Co-ordinating Teams.

With regard to Specialist Palliative Care, where a Specialist Palliative Care Team is based within a voluntary hospice, or where staff from a voluntary hospice participate in the Specialist Palliative and Support Multidisciplinary Team, peer review will be concerned with the work of that team and those staff. The main focus of peer review will be on how well the hospice participates in the work of the multidisciplinary team, and in cooperative working across boundaries in planning and providing service. It will also wish to focus on issues such as the commissioning of services, inter-professional communication and the co-ordination of care.

2

The Peer Review Process

2 The Peer Review Process

The peer review process consists of the following three key stages:

- Pre-assessment - to include a self-assessment of the degree of compliance against the measures contained within the Manual for Cancer Services, and the collection of additional evidence, particularly to support the implementation of Improving Outcomes Guidance.

- The peer review visit to a Cancer Network, which is likely to take place over a period of up to eight weeks, which will provide the opportunity for a more qualitative assessment.

- Agreeing remedial action against a clear timetable, implementation and follow up, and dissemination of good practice.

Depending on the size and complexity of the Cancer Network, the complete review process can take up to a maximum of 12 months, but the peer review visits will normally be conducted over a period of 4 to 8 weeks.

The National Cancer Peer Review Programme has a number of stages, from the notification of a visit to a final report. These are shown in table 1.

Activity	Weeks before or after visit
Date of visit agreed	-24
Preparation of Self-assessment	–24 to -12
Self-assessment submitted	-12
Analysis of Self-assessment together with key information/evidence sent to review team	-12 to -4
Pre - visit	-10 to -4
Notification of review teams	-4
Locality Visits	+2 to +7
Network Overview Visit	+4 to +8
Feedback meeting	+2 to +5
Draft reports	+6 to +9
Agreement on any remedial action	+18 to +21
Zonal Reference Group sign off of Report	+24
Publication of Report	+24

3

Preparing for Review

3 Preparing for Review

3.1 What will be reviewed and when?

This handbook refers to the Manual for Cancer Services. All services covered by the Manual will be reviewed across the Cancer Network. Other services not included in the Manual will be reviewed either at a later date when the phase 2 measures are published, or when commissioned by a Strategic Health Authority in discussion with the Zonal Reference Group.

The Cancer Network and Localities have been asked to complete a 'Scope and Preference' information exercise. This was designed to gather information about the range of cancer services offered, the other quality assurance activities occurring in the review period and the Cancer Networks and Localities preferred timing for the review. This advanced information has provided the basis for further discussions to plan and agree the scope and timing of the Cancer Peer Reviews for the three-year period November 2004 - March 2007.

As far as possible the Zonal Co-ordinating Teams have sought to accommodate the preferences for the timing of reviews expressed by the Cancer Networks and Localities. However the balance of the National Cancer Peer Review Programme workload needs to be maintained across the three years of the programme and the overall schedule must take into account the availability of the reviewers with appropriate expertise. Particular effort will be made to accommodate the requirements / activities of the Healthcare Commission and screening reviews when decisions are made about the timing of reviews. E.g. it has been agreed that a peer review visit will normally not take place within 3 months of a screening review.

3.2 How do the Cancer Networks and Localities prepare?

A self-assessment must be prepared for each review. It and the related evidence are central to the process. The Zonal Co-ordinating Team will require the self-assessment normally three months before the start of the review.

The self assessment fulfils three main functions:

- It enables reviewers to assess how the Cancer Network meets the measures, and the extent to which cancer services meet the Better Standards for Health.
- It encourages the Cancer Networks to evaluate the quality of the cancer services they provide. It is an opportunity for the staff of a Cancer Network to reflect on 'What do we do?', 'Why do we do it?', and 'Why do we do it in the way that we do?'
- It provides a framework for a process of cancer peer review based on testing and verification of the measures. It should reflect on current services and highlight the improvements that have taken place since earlier external reviews, and consider what may be necessary to change in the future.

3.3 Use of Cancer Quality Improvement Network System (CQuINS)

3.3.1 Introduction

CQuINS provides the functionality for system users to attach documents to their records to support the evidence that their organisations comply with the measures. This has three immediate benefits:

- It allows assessments and supporting evidence to be kept together.
- It provides reviewers with access to the evidence on-line.
- It encourages the transfer of good practice between organisations by providing the potential for other users to access exemplar (or just examples of) documents for use in their own organisations.

3.3.2 Principles for Uploading Documents

There should be no limit to the number of documents that can be uploaded and system users should not be discouraged from uploading documents subject to the other principles being adhered to.

System users are actively encouraged to upload documents that they believe will be of benefit to other users (e.g. operational policies, patient questionnaires), especially where the potential number of downloads could be quite high.

CQuINS records should be automatically flagged where a document upload is expected or desired.

No uploaded documents should contain patient identifiable information.

The preferred format for uploaded documents is pdf (Adobe Acrobat Portable Document Format) or Microsoft Office (MS Word .doc, MS Excel .xls, MS PowerPoint .ppt).

The uploading of documents in a format that is not in general use and unlikely to be accessible to other users should be discouraged.

In consideration of other users who are downloading, file sizes should be kept to an appropriate level. In general:

- Most documents should not be more than 1 Mb in size though it is recognised that on some occasions it will be appropriate to upload larger documents.
- Documents of more than 4Mb should not be uploaded except in very exceptional circumstances.
- Scanned documents are permitted and should generally be saved in Jpeg (.jpg) format at 80% quality. A scanned sheet of A4 will generally occupy no more than 500Kb while remaining perfectly legible.
- Scanned documents with signatures should not be uploaded if the purpose of the upload is simply to demonstrate the signature to a reviewer.
- Before uploading documents, system users should question the potential number of downloads that might result and take a view as to whether the upload adds benefit to other users or reviewers. This particularly applies to scanned documents where the effort required to scan and upload means that the effort is not cost effective.
- Subject to the other principles being applied and considered, it is acceptable for system users to upload documents simply to attach evidence to an assessment, as a means of keeping all the evidence together or to provide a backup of documentation.

3.4 The Use of Background/Contextual Information

In addition to the assessment of a Locality's or Network's position in relation to the measures contained within the Manual for Cancer Services, it is intended that a balanced profile should be developed to enable reviews of given networks/localities to be carried out on an informed basis.

In particular it is intended to enhance the information that is provided as a result of the self-assessment process, described above, with a range of data to be available, consistently at national level and to be updated / reviewed at local level prior to a peer review visit.

The range of Background Information to be collated, much of it giving a comparative profile of a Network, may include the following:

- Waiting times data including the 31 day benchmarking completeness of cancer waiting times.
- Incidence and Mortality rates for Network and PCTs.
- Screening results and comparison with National figures and between the Network PCTs.
- Usage of NICE drugs.
- HES data analysis including numbers of procedure per network and per trust, compared to national averages and within the network.
- A range of key clinical quality indicators for specific tumour types.
- Data re availability of equipment e.g. LINACS, CAT scanners, PET scanners etc.
- IOG Action Plans and milestones.
- Tracking Investment.
- Gold Standard roll out to PCTs.
- CSC Project and Service Improvement data.
- Data on cancer registrations.

- £50m Palliative Care spending.

The background information, referred to above, will be compiled by the Programme Manager Cancer Intelligence at the Cancer Action Team.

The following information will be drawn from relevant national groups and collated by the relevant Zonal Co-ordinating Team:

- Data on the number of newly diagnosed patients seen each year by each MDT, population's served and comparative data where possible. (registry to provide).
- Reports of screening QA visits (for relevant MDTs) Report of the most recent cancer peer review visit with the associated action plan.
- Data from the survey of cancer patients (where available).
- Most recent relevant Healthcare Commission visit report.

All the information will be made available to the Cancer Network to be reviewed before it is provided to peer review teams.

The background information will be used to provide a wider set of contextual information within which the self-assessment of compliance with the measures in the Manual of Cancer Services can be discussed at the pre-visit meeting, and will form part of the briefing pack for the peer review team.

3.5 Liaison between the Cancer Network, Localities and the Review Team

Appropriate mutually acceptable liaison arrangements between the Cancer Network and the Zonal Co-ordinating Team should be put in place as early as possible in the process.

3.6 Advance planning

Advance planning begins with the return by the Cancer Network of completed scope and preference information sent to them before the start of the review cycle. Once the review period has been agreed, the Cancer Network and Localities will know the exact dates of the review days that will be used for the review visits. These dates are fixed and cannot be changed, except in extremis by mutual agreement. The reviewers and review team leader(s) will be recruited for those dates. Although the zonal team will ask the Cancer Network to identify a preferred period for their review it may not be possible to accommodate their preferences. If this is the case, the matter will then be discussed with the Cancer Network and Localities with a view to reaching agreement on another period. In the absence of agreement the responsibility for finalising the programme of visits within a zone sits with the Zonal Reference Group. In the continuing absence of agreement, advice will be sought from the National Co-ordinating Team.

A common approach to planning the peer reviews will be adopted. The Zonal Co-ordinating Team will initiate a preparatory meeting with key Cancer Network staff. This meeting will take place before submission of the self-assessment , and the exchange of "background information", and before the start of the agreed review period. The purpose of the meeting is to establish effective relationships between all parties involved in the review; to agree protocols and responsibilities; and to agree the timetable of events that will make up the review.

3.7 Analysis of the self assessment

The Zonal Co-ordinating Team will use the self assessments prepared by the Cancer Network and Localities to produce an analysis which will help set priorities for and to plan the review, and to identify areas where further clarification or additional/new evidence is required prior to the peer review visit.

If the self-assessment documents are unclear as to whether measures have been achieved the Cancer Network or Locality will be asked for clarification.

The cut off date for the submission of any outstanding evidence in support of an organisation's self-assessment will normally be two weeks before the start date for the review visit.

3.8 Pre-Visit

The pre-visit will take place after the submission of the self-assessment documentation and following a period of time allowing for some analysis of the submission to have been undertaken. It is likely that this will be approximately two weeks after the self-assessment documentation is received by the Zonal Co-ordinating Team.

All pre-visit meetings within a Network will be completed before any formal review visits commence.

The purpose of the pre-visit can be summarised as follows:

- To enable the Zonal teams to review with a representative from the lead team all the remaining supporting evidence not previously provided on CQuINS.
- To engage in dialogue with Network/Localities on key findings from the self-assessment and review of all other supporting evidence.
- To provide a forum for points of clarification to be discussed with the Localities/Network with regard to the agreed level of compliance which will be included in the briefing packs for reviewers.
- To determine the extent to which an organisation is currently meeting the measures.
- To confirm logistical arrangements for the visit.
- To focus the actual visit on key issues.

It is likely that a pre-visit to a Network team will take one day, and that one day will also be required for each Locality within a Network.

The pre-visit to a Locality could take place before or after the Network pre-visit.

It is expected that at this stage in the review process there will be explicit contact between the Zonal Co-ordinating Team and the Strategic Health Authority(s) in which the Network sits. The purpose of this contact will be to clarify any issues concerning the focus for the peer review visit.

3.9 Briefing Packs for Reviewers

Review teams will be provided with a copy of the analysis undertaken by the Zonal Co-ordinating Team of the self-assessment return, together with relevant data gathered from the collation of background information, supplemented by, where available, clinical governance and audit reports, and previous cancer peer review reports.

In addition, reviewers will be provided with individual topic briefings that can be used to inform their interviews with appropriate groups such as NSSGs, and MDTs and with individual professionals and patients/carers.

It is intended that the information contained within the briefing packs will assist the review teams to conduct the review efficiently and effectively, targeting their enquires appropriately.

4

Conducting the Review

4 Conducting the Review

4.1 National Cancer Peer Review Teams

The Zonal Co-ordinating Team invites nominations of reviewers from the Cancer Networks. Cancer Networks have a responsibility to nominate an appropriate number of reviewers against the person specification.

These nominees are trained and reviewers' names are listed on the Zonal Reviewer database. The Zonal Co-ordinating Team selects an appropriate review team from this list. Visiting teams will be made up of a multi-disciplinary group of clinicians, managers and service users, with appropriate skills and training. As far as possible, 'peers' will be people who are trained and working in the same discipline as the people they are reviewing. The views of all team members from all backgrounds will be respected.

The number of reviewers in each team reflects the size, range and complexity of the cancer services provided. A cancer peer review team for a Cancer Network would have a total of 23-28 reviewers for each locality. These reviewers will be supported by the Zonal Co-ordinating Team members.

Potential members of visiting teams to Networks and Localities are:

- User/carer.
- Lead clinician and specialist nurse for each MDT being visited (initially 6 topic areas).
- Radiologist.
- Pathologist.
- Oncologist.
- Medical physicist or therapy radiographer (if radiotherapy provided).
- Oncology pharmacist (if chemotherapy provided).
- Chemotherapy nurse (if chemotherapy provided).
- Palliative care specialist nurse or palliative care consultant.
- Trust or Network lead cancer clinician, lead cancer nurse and/or cancer manager.
- PCT cancer lead/commissioner.
- Dietician (upper GI MDT).
- Primary care lead(s).

4.2 The Peer Review Visit

The visit itself has been designed around a modular structure with the norm being a 2-day visit to each Locality within a Cancer Network, and a 2-day visit to the Network. The visits to the Localities will take place before the visit to the Network, and in normal circumstances the peer review visit will be completed within a period of 8 weeks.

There should be at least two members of the review team present at any interview conducted as part of a module to ensure that there is corroboration of the evidence heard. Review teams will not be able to accept verbal information from a single source.

For some parts of the peer review, teams will be required to visit facilities within a Trust e.g. chemotherapy and radiotherapy facilities. It is important that prior to those visits taking place the review team, and those being visited are clear about the purpose of the visit, and whether or not the teams will wish to speak to members of staff and/or patients. If that is the case staff and patients should be told that a visit is taking place and the reason for it. Patients should be given the opportunity to decline to speak to a member of the review team.

Details of each of the modules that make up a peer review visit are shown below, together with an indication of who should be involved in each of the modules. It is not intended that members of network teams should be present for the Locality module visits. An MDT or cross cutting service group may choose to invite a member of the network team to be present, but this would be the exception rather than the norm, and would be in an observer capacity only.

4.2.1 Locality Visit – Visit Modules

Module 1: Locality Overview

Purpose: To ensure that the review team is fully prepared and briefed and to meet with a senior team from the Locality.

Review Team: Members of the Core Review Team
Quality Director

Activity	Who involved
Welcome and introductions	Core Team and Quality Director and Locality Lead Cancer Team
Review of pre-visit information and analysis	Core Team and Quality Director
Review of evidence folders	Core Team and Quality Director
Summary of key issues	Core Team and Quality Director
Trust presentation and questions	Core Team and Quality Director, Trust Chief Executive/Board Member & Trust

It is anticipated that an appropriate Chief Executive or an Executive Director from within the Locality will lead the presentation. The presentation, which should last no more than 10 minutes, should focus on key successes and future challenges in implementing the National Cancer Plan within that Locality.

Modules 2&3: Review of an MDT

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Objectives: To ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions.

To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/audit.

To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

Review Team: Consultant from specialty being reviewed
- Essential

Clinical Nurse Specialist
- Essential

Wherever possible the professional peers will be those trained and working in the same discipline that they are reviewing, but it is acknowledged that in exceptional circumstances the review may need to be undertaken by a clinician from another specialty.

Trust/Network/Commissioning Manager

Radiologist
Pathologist
Palliative Care Specialist
Oncologist

at least 2 of the 4 to be part of the team

The Zonal Co-ordinating Team will need to assess which two from the list of radiologist, pathologist, palliative care specialist, and oncologist it would be most appropriate to have on the team.

The question of whether or not a user is part of the MDT module team will be partly dependent on the issues that have been identified at the pre-visit stage, and whether or not there is an appropriate user reviewer available. Whether or not there is a user

reviewer on the team, it will be essential to ensure that account is taken of user issues during the review of an MDT.

It is intended that the review of a sample of case notes will form part of an MDT module, the main purpose being to ensure that the decisions of an MDT are implemented and followed up.

The case note review should be undertaken at the time of the visit, by clinical members of either the review team or the zonal co-ordinating team.

Closure with an MDT should be restricted to thanks, and a brief outline of the process to be followed after the visit.

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders	Review Team
Summary of key issues	Review Team
Discussion with MDT members to include group discussion, interviews, possible observation of MDT meeting, and where appropriate, viewing of facilities. Closure with MDT members.	Review Team plus all members of the MDT
Conclusions and Report Writing	Review Team

Module 4: Review of Chemotherapy Including Intrathecal Chemotherapy (ITC)

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Because of the importance which has been attached to the clinical governance of ITC, lack of compliance with any of the measures will be considered as a serious issue requiring immediate remedial action under the close supervision of the relevant SHA. Peer reviewers will therefore need to bring lack of compliance to the immediate attention of the relevant SHA.

Objectives: To ensure the establishment of clearly defined leadership and organisational arrangements.

To ensure the provision of dedicated and suitably equipped areas for the administration of chemotherapy.

To ensure co-ordination and control over the use of specified chemotherapy regimens within a network.

To ensure the supervision of chemotherapy prescribing by appropriate specialists (clinicians and pharmacists).

To ensure the administration of chemotherapy by appropriately trained staff.

To ensure the minimisation of delays in starting treatments.

To ensure the provision of facilities for the aseptic reconstitution of cytotoxic agents.

To ensure the existence of clear and comprehensive documentation of chemotherapy delivery

To ensure the existence of a single, written, local protocol covering the national ITC guidance, which clarifies how the guidance applies specifically to a Trust's own ITC service

To ensure the maintenance of a register for a

Trust of named personnel who are trained and certified competent to participate in ITC tasks

To ensure that appropriate policies and processes are in place to comply with measures dealing with induction and training, prescribing ITC, patient consent, collection and storage of issued drugs, checking and administering ITC.

Review Team: Oncologist/Head of Chemotherapy
Chemotherapy Nurse
Pharmacist
User/carer

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders including case note review	Review Team
Summary of key issues	Review Team
Meeting with the Trust Team	Review Team plus Trust Head of Chemotherapy Lead Nurse
Individual interviews	As above
Visit to facilities	Review Team
Conclusions and Report Writing	Review Team

An integral part of this module should be a visit to the chemotherapy suite, the pharmacy, (to look at storage, preparation areas, the aseptic suite etc), and the day unit. It should be noted that these facilities could be on different sites, which will have an impact on the time required to complete this module.

Module 5 Review of Clinical Imaging

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Objectives: To ensure that cancer imaging services are of a high quality through:

Clearly defined leadership and organisational arrangements

Compliance with network wide policies

Review Team: Consultant Radiologist
Diagnostic Radiographer
Medical Oncologist

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders	Review Team
Summary of key issues	Review Team
Meeting with the Trust clinical imaging team	Review Team plus Trust's Consultant Radiologist and Radiographer
Visit to facilities	As above
Conclusions and Report Writing	Review Team

Module 6 Review of Pathology

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the

achievement of the measures, and to identify and share good practice.

Objectives: To ensure that cancer pathology services are of a high quality through clearly defined leadership and organisational arrangements.

To ensure pathology services are delivered according to recognised guidelines with appropriate information being collected.

Review Team: Consultant Histopathologist
A.N.Other

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders	Review Team
Summary of key issues	Review Team
Meeting with the Trust pathology team	Review Team plus Trust's Histopathologist and A.N.Other
Visit to facilities	As above
Conclusions and Report Writing	Review Team

Module 7 Radiotherapy

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Objectives: To ensure that radiotherapy services are of a high quality through:
Clearly defined leadership and organisational arrangements;

Provision of adequate professional staffing and equipment;

Minimising delays for treatment and breaks in treatment;

Use of standardised processes for prescribing and checking radiotherapy treatments;

Use of standard principles for the delivery of radiotherapy;

Clear documentation of treatments delivered.

Review Team: Clinical Oncologist
Physicist
Therapy Radiographer
User/carer
Specialist nurse

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders including case note review	Review Team
Summary of key issues	Review Team
Meeting with the Trust radiotherapy team	Review Team plus Trust's Clinical Oncologist Physicist, Therapy Radiographer Specialist nurse.
Visit to facilities	As above
Conclusions and Report Writing	Review Team

Module 8 Specialist Palliative Care

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Where a Specialist Palliative Care Team is based within a voluntary hospice, or where staff from a voluntary hospice participate in the Specialist Palliative and Support Multidisciplinary Team, peer review will be concerned with the work of that team and those staff. The main focus of peer review will be on how well the hospice participates in the work of the multidisciplinary team, and in cooperative working across boundaries in planning and providing service. It will also wish to focus on issues such as the commissioning of services, inter-professional communication and the co-ordination of care. Peer review will not be concerned with the operation of the hospice, staffing levels, clinical protocols, and health and safety issues and so on which are more within the remit of the Healthcare Commission. In addition, the Healthcare Commission's attention in the Independent and Voluntary Sector will focus on the core Standards for Better Health, whereas the focus within peer review will be more on the developmental standards.

It is not intended that peer review teams will visit hospices in the voluntary sector unless they are considered to be an appropriate venue for the meeting between the peer review visiting team and the Specialist Palliative and Support Care Multidisciplinary Team.

Objectives: To ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions.

To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/audit.

Review Team: Consultant in SPC
Senior SPC CNS or Nurse Consultant
PCT Cancer Clinical Lead
User/carer

Activity	Who involved
Welcome and introductions	Review Team
Review of pre-visit information and analysis	Review Team
Review of evidence folders	Review Team
Summary of key issues	Review Team
Meeting with the Trust SPC team	Review Team plus Trust's Consultant in SPC Senior SPC CNS PCT Cancer Clinical Lead
Conclusions and Report Writing	Review Team

4.2.2 Network Visit – Visit Modules

Module 1 Network Board

Purpose: To ensure that the review team is fully prepared and briefed and to meet with the senior team from the Network.

Objectives: To ensure that all commissioners and providers of care to adult patients with cancer work effectively together to deliver co-ordinated care of consistently high quality throughout the Network and the patient care pathway, by means of:

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Establishing the structure and functions of the Network board, to develop and ensure implementation of the strategy for the Network in line with national policy, including the National Cancer Plan.

Establishing the structure and functions of PCT collective commissioning to ensure co-ordination of cancer commissioning across the Network.

Declaring the services, which constitute the Network, and their division into Localities appropriate to the Network's concentrations of population and provider facilities, to provide a basis for local management and organisation via established Locality Groups.

Establishing the structure and functions of cancer-type specific groups, recognised by the board, to ensure co-ordination and consistency of clinical practice across the MDTs of the Network, and to advise the board and commissioners.

Establishing the structure and functions of groups, recognised by the board, to ensure co-ordination and consistency of clinical practice across the Network within services, which "cut across" the different cancer types, and to advise the board and commissioners.

Ensuring that, in parallel with, and integrated into, the above structure, each of the statutory bodies – acute Trusts and PCTs, have appropriate leadership of their cancer services, and representation on the Network's organisation.

Ensuring that the Network is recognised by, and integrated into, the decision-making apparatus of the statutory bodies.
Ensuring that the perspectives of users and carers are incorporated into the Network's functions.

Integrating the service improvement methodology into the Network's functions.

The Network as a whole acting as a major instrument of corporate and clinical governance, ultimately accountable to the statutory bodies which it encompasses.

Review Team: Members of the Core Review Team to include:

Team Leader
Network Manager/Nurse/Clinician
SHA Cancer Lead
Specialist Commissioner
Service Improvement Lead

Quality Director

Activity	Who involved
Welcome and introductions	Core Team and Quality Director and the Network Team
Review of pre-visit information and analysis	Core Team and Quality Director
Review of evidence folders	Core Team and Quality Director
Summary of key issues	Core Team and Quality Director
Meeting with the Network Board	Core Team and Quality Director and the Network Chair Network Team Chairs of Network Groups Relevant SHA Cancer leads

Module 2 NSSGs and Cross Cutting Groups

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Review Team: As for Module 1.

Activity	Review Team
Series of discussions/interviews with chairs and representatives of all network groups including NSSGs, and cross cutting groups. Discussion/interviews with SHA cancer leads and chairs of locality teams.	At least two members of the review team in each discussion/interview.

Module 3 PCT Collective Commissioning Group

Purpose: To review compliance with relevant measures contained within the Manual for Cancer Services, to identify issues related to the achievement of the measures, and to identify and share good practice.

Review Team: As for Module 1.

Activity	Review Team
Discussion / interview with chair and representatives of the PCT Collective Commissioning Group.	At least two members of the core review team.

Module 4 Conclusions/Report Writing

Purpose: To draw conclusions, prepare draft report and draw the visit to a conclusion.

Activity	Review Team
Draw conclusions and prepare draft report	All plus Quality Director
Closure of the visit	All plus Quality Director

Reviewers assume a collective responsibility for gathering, verifying and sharing evidence that enables them to test statements made in the self-assessment documents and to inform robust judgements on the quality of cancer services.

All reviewers are expected to identify, share, consider and evaluate issues related to the cancer services under scrutiny. Reviewers should keep notes of all meetings with staff and patients, of their observations, and of any comments on the quality of the cancer services. Notes should be analytical rather than merely descriptive, should summarise strength and weakness and refer to sources of information.

It is the responsibility of team leaders to ensure that reports are written up at the end of each module, and before team members leave the visit at the end of the module.

While it is intended that each peer review visit will consist of the modules detailed above there can be local flexibility in the order in which the various modules are taken in the visit programme. The only exception to this is that the network wide modules must be taken after the Locality modules.

At the end of the review period, a "Closure" meeting of the review will be held led by the Zonal Quality Director and the Review Team Leaders. It is intended that the meeting should be comparatively brief, and should consist of thanks to those who have contributed to the visit, and an explanation of what happens next, but should not be an opportunity for a debate on the findings of the review team. There will be no immediate feedback on the conclusions reached by the review team.

4.3 Identification of Good Practice

Review teams have the opportunity to identify good practice in any of the settings under scrutiny. The good practice:

- Should be directly linked to the cancer services under scrutiny;
- Could be of an innovative nature but it also could be ordinary practice that is undertaken very well.
- Review team leaders and the quality manager need to be kept informed by the reviewers and to ensure the review team has robust evidence for the identification of good practice. Good practice will be commented

upon in the summary of the report.

- The identification of good practice for later dissemination and recommendation is an important positive component of the review process. A nationally agreed method for the identification of 'good practice' observed during the 2004-2007 peer review visits is proposed.

- Fraser (2002)1 states: – "In healthcare the number of variables that are constantly adapting and changing makes scientific analysis very difficult and time-consuming. The adoption of potential improvements may be delayed whilst large and often inconclusive studies are conducted to identify 'best practice' . ... The term 'good practice' is used to cover any substantiated practice that has delivered positive results elsewhere."

- Areas that may be identified by the reviewers as examples of "good practice" will be based on their personal opinions. These practices may be being undertaken elsewhere in other Trusts, Networks or Zones.

It is suggested the following definition is used:

- Good practice: practice that has delivered or has the potential to deliver positive improvements in care elsewhere.

  Good practice may have:

  - Contributed to the delivery of safe, high qualitypatient centred services;
  - Successfully integrated services through constraining/complex circumstances;
  - Facilitated improved compliance with the Manual for Cancer Services;
  - Improved the patient and carer experience;
  - Improved outcomes of care for patients;
  - Improved teamwork within the service;
  - Improved the efficiency of service organisation.

Areas of good practice will be agreed by the visiting team when they are drawing their conclusions. Areas identified as 'good practice' will be identified within the visit report.

CQuInS provides the functionality to search for good or exemplar practice. It is proposed that the Exemplar Practice flag is not used for all good practice identified as defined above.

It is proposed that Exemplar Practice is defined as:

- Very high standard of service.
- Significant innovation.
- Potential significantly to improve care if adopted in other places.

Where a review team identifies practice that might be considered exemplar practice this should be considered by the zonal reference group and then referred to the national co-ordinating team for ratification, so ensuring national consistency in the application of this flag.

4.4 Service Improvement

Service improvement and redesign is an important part of improving services for cancer patients. Using the proven service improvement methodology and implementing high impact change principles, significant and sustainable improvements can be made to the patients' experience and simultaneously reduce waiting times.

Service improvement work has been localised within all 34 Cancer Networks since 2001. Supported by dedicated resources and the Cancer Services Collaborative Improvement Partnership (CSC-IP).

Since 2003 the Network Service Improvement Leads (SIL), the Network Clinical Leads for Service Improvement supported by Service Improvement Facilitators (SIFs) have worked with Multidisciplinary Teams within Trusts (both primary and secondary). They have focused on embedding the service improvement methodology into their day-to-day business of improving patient centred services.

The Teams are trained to use proven tools and techniques such as mapping the patients journey (process mapping)

assessing how effectively resources are used, identifying the real demand for services (capacity and demand) and involving patients in the redesign of services. This work has led to significant improvements in the patient experience as well as gains in quality and staff experience.

It is now nationally and locally recognised that service improvement and re-design is an important part of the day-to-day improvement of any NHS service. In line with this peer review of cancer services includes generic quality measures for service improvement applicable at all levels, e.g. Network, TSSG, and MDT. Appendix 1 serves as a guide to help inform cancer and peer reviewers about the sort of questions they need to ask to give an indication of how much each service has embedded service improvement and has undertaken redesign in order to continually improve the service offered to patients. The questions have undergone extensive ratification involving a wide consultation.

4.5 Guidance on handling serious service issues and personal / professional concerns

4.5.1 Introduction

Peer review visits have been shown to be an effective method of improving the quality of services. Occasionally an issue will arise during a visit that relates to either personal or professional conduct or competence or to the well being of an individual. This concern may be closely related to issues about the service within which the individual is working. Action may be necessary to address either the service issue or the individual-related issue or both. This guidance to Team Leaders and Zonal Co-ordinating Teams gives a framework within which such issues should be handled.

Individual circumstances vary considerably and the visiting team's judgement of the circumstances should take precedence over rigid adherence to this guidance. Where there is doubt, or differences of opinion, about the action to be taken then the Zonal Clinical Lead for Peer Review and / or the Strategic Health Authority Director to whom the Zonal Co-ordinating Team is accountable should be consulted.

The National Clinical Assessment Authority (NCAA) is also available for advice. In order to access the NCAA advice service, phone 020 7084 3850 and ask to speak to an Adviser. Please inform the Adviser that this guidance has been discussed with Dr Rosemary Field (Deputy Medical Director and Director of Professional Support and Programmes at NCAA) and, if time permits, ask him / her to contact Dr Field before giving advice.

Training for cancer peer reviewers will encourage reviewers to raise concerns about serious personal and professional issues with the Team Leader for the visit. Training for Team Leaders will cover this guidance.

4.5.2 Service issues

Cancer peer review visits often identify concerns about services. Sometimes these are serious issues or immediate risks to clinical safety or clinical outcomes. Table 1 contains the guidance on handling such issues during and immediately after a visit (i.e. within the following two weeks). Serious service issues should always be included in the report of the visit, even if they have been resolved by the time the report is finalised.

Because of the importance which has been attached to the clinical governance of intrathecal chemotherapy by the Chief Medical Officer, lack of compliance with any of the measures will be considered as a serious issue requiring immediate remedial action under the close supervision of the relevant SHA. Team Leaders and Zonal Co-ordinating Teams should bring lack of compliance to the immediate attention of the relevant SHA.

Action during the visit should be taken by the Team Leader and Quality Director / Manager. Actions after the visit are the responsibility of the Quality Director with the support, if necessary, of the Team Leader. Serious service issues and immediate risks to clinical or clinical outcomes should be reported to the National co-ordinating team.

4 Table 1

Type of issue	Example	Action
'Whole system'	Hospital with several under-developed MDTs and services, some serious issues, weak leadership within the cancer team, little awareness of the problems and no clear mechanisms or approach for improving the care provided.	Feedback to Trust and network in the usual way. Feedback to Trust Chief Executive (C.E.) and Network Chair if not previously involved. Contact relevant Strategic Health Authority (SHA) cancer lead. Ensure that a SHA Director / C.E. is briefed. Ensure that the National Co-ordinating Team is briefed Confirm the concerns in writing to the Trust C.E., Network Chair, SHA Director / C.E. and SHA cancer lead. Copy all correspondence to the National Co-ordinating Team.
Individual MDT / service / department	Hospital undertaking care for a group of cancer patients that is outside Improving Outcomes Guidance and where this has not been recognised or linked to an MDT. MDT with poor organisation, little commitment to multi-disciplinary working and some serious incidents. Chemotherapy service with poor leadership, few policies and procedures, evidence of adverse clinical incidents and little learning from these incidents. Pathology service is so understaffed that the visiting team consider there is significant potential for error.	Contact C.E. of Trust / relevant organisation. Brief the SHA Cancer Lead and Network Manager / Lead Clinician. Ensure that the National Co-ordinating Team is briefed Confirm the concerns in writing to the Trust C.E. This confirmation may take the form of a draft report or may be a separate communication. Copy all correspondence to the National Co-ordinating Team.
Operational issue	Dual reporting of bone marrow trephines with no clear system for identifying the final report. Visiting team observed that drugs, including chemotherapy, were left unobserved in a public area.	Notify the relevant Trust Director / C.E. Ensure that the National Co-ordinating Team is briefed Confirm the concerns in writing to the relevant Director / C.E. This confirmation may take the form of a draft report or may be a separate communication. Copy all correspondence to the National Co-ordinating Team.

4.5.3 Issues relating to individuals

Concerns about the personal or professional conduct, competence or well being of an individual arise rarely and require sensitive handling. Sometimes these concerns are related to service issues – and may be the cause of, affected by, or caused by the service problem. Sometimes there is clear evidence for the concern – in others the 'formal' evidence is scanty but, in the judgement of the visiting team, there may be a problem. Sometimes the concern is about the potential for personal or professional issues to arise in the future.

The guidance on handling such issues has five steps (see Table 2). Step 1 applies only if the issue was identified before the visit.

Step 1 – Issues identified before a visit

Issues about individuals may be raised with the Zonal Co-ordinating Team before the visit takes place. If this happens then the Quality Director should:

Brief the Zonal Clinical Lead and Team Leader for the visit and agree whether the visiting team should be informed.

If appropriate, brief the visiting team at the start of the visit.

If appropriate, ask the visiting team to investigate the issue during the course of the visit. In particular, the reviewer who will talk to the individual concerned about the issue should be identified.

If appropriate, advise the Trust / employing organisation to contact NCAA for advice.

Step 2 - During the visit

Avoid single-source verbal information. If a concern is raised with the visiting team then seek to confirm this with written or verbal information from another source.

Involve the Team Leader and Quality Director as soon a sensitive personal or professional issue is identified.

If possible, someone from the visiting team should talk to the individual concerned about the issue. The best person to do this should be agreed with the Team Leader and / or Quality Director. This conversation should aim to cover a) whether the individual agrees that there is a problem and its nature and b) what action is either already being taken and c) action the individual is proposing to take. Discussion with the individual concerned may not always be possible or appropriate.

If possible, speak to the Medical Director (or Chief Executive) of the Trust/employing organisation about the issue.

Do not identify the issue in any verbal feedback. If necessary, verbal feedback can say that a sensitive personal / professional issue has been identified and will be followed up outside the main meeting.

Step 3 – Post-visit action

Advise the Zonal Clinical Lead of the issue and action taken, and agree the next steps.

Contact the Medical Director (or Chief Executive) of the Trust / employing organisation to discuss the issue if this did not happen during the visit. If discussion with the individual concerned did not take place during the visit, ensure that the Medical Director informs them of the concerns raised.

Confirm the concerns in writing to the Medical Director (or Chief Executive), copied to the individual concerned. Make a file note of any details not covered by this letter.
Very occasionally, the Trust Medical Director, Zonal Clinical Lead, Team Leader and Quality Director will agree that confirming the concerns in writing would be unhelpful / counterproductive. If so, a file note must be made of the concern, action taken and reasons for not confirming this in writing to the Trust and individual concerned.

These actions should normally be completed within two weeks of the end of the visit.

Step 4 – Visit Report

The Team Leader and visiting team will need to make a judgement as to whether personal and professional issues should be included in the visit report. If inclusion in the report is considered appropriate and helpful, the individual should not be named.

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Step 5 – Follow up

Follow up of personal and professional issues is the responsibility of the Trust or individual's employing organisation. It is not the responsibility of the Peer Review Team. The Zonal Co-ordinating Team and, if necessary, Team Leader should cooperate with follow-up action taken by the Trust / employing organisation. The Zonal Co-ordinating Team should monitor whether the issue has been addressed by the Trust / employing organisation. If the Trust / employing organisation does not take action within an agreed, reasonable timescale, then the Zonal Co-ordinating Team and Team Leader have a responsibility to raise the matter with an appropriate body (for example, SHA, NCAA, GMC and / or NMC).

Table 2

Guide to handling issues of an individuals personal or professional conduct, competence or well-being

Level	Characteristics of the individual	Example	Action	Action by
A	Well-intentioned. Has insight / understanding Does not have significant problems relating to peers and other disciplines. 'Needs protecting' from their own good intentions.	Visiting team considered a clinician was too ill to be at work. Discussion took place with the individual who said they would 'go off sick' the next day. Clinician under stress due to high workload. Visiting team was concerned about the impact on the clinician's health and clinical judgement.	If possible, discuss with the individual concerned. Seek to agree the action that individual will take. If there is no agreement or concerns remain, go to level B.	Appropriate member of the visiting team, as agreed with the Team Leader and Quality Director/ Manager.
B	Well-intentioned. Does not have insight / understanding. Has difficulties relating to peers or other disciplines OR is working in isolation.	Visiting team worried about a clinician because of the apparent lack of interaction with the rest of the MDT. The reasons for this were unclear. Clinician not undertaking required checking of chemotherapy. Part of the cause was thought to be difficulties in inter-personal relationships.	If possible, discuss with the individual concerned. Speak to the Medical Director, hopefully with the individual's agreement. Following discussion with the Medical Director, it may be appropriate to go to level C.	Discussion with the individual concerned: Appropriate member of the visiting team, as agreed with the Team Leader and Quality Director / Manager. Subsequent actions: Team Leader and Quality Director / Manager
C	Motivation not clear. No insight/understanding. Has difficulties relating to peers or other disciplines OR is working in isolation. There may also be evidence that previous attempts to resolve the issue have failed.	Clinician working outside the MDT and agreed clinical guidelines. There were clearly difficulties in relationships with colleagues. Several attempts to tackle the issue had been unsuccessful.	If possible, discuss with the individual concerned. Speak to the Medical Director, hopefully with the individual's agreement. Confirm the concerns of the visiting team in writing to the Medical Director.	Team Leader and Quality Director / Manager

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Following the Review Visit

5 Following the Review Visit

5.1 The Cancer Peer Review Report

The draft report will be written by the reviewers and edited by the Team Leader(s) and the Zonal Co-ordinating Team, and signed off by the Zonal Quality Director.

The Cancer Network and its Localities will be given the opportunity to comment on the factual accuracy of the report before it is submitted to the Zonal Reference Group.

Prior to final publication of the reports, the Cancer Network will decide upon the remedial action that needs to be taken within agreed timescales, building on the strengths identified in the report and addressing any aspects in need of improvement. The agreed remedial action will be published as part of the final report.

It is important to recognise that approval and follow up of agreed remedial action is primarily a function of management systems and not a function of the peer review process. There is, of course, the scope to involve Zonal Quality Teams and the Zonal Reference Groups in follow up where this is considered helpful.

Following approval by the Zonal Reference Group, the final report will be circulated to the:

Chief Executives of NHS Trusts and Primary Care Trusts;
Network Board Chair;
Primary Care Cancer Leads within the Network;
Strategic Health Authority Cancer Lead(s);
National Co-ordinating Team;
Healthcare Commission;
National Cancer Director.

Reports will be in a form suitable to take to public meetings.

5.2 Annual review trends report

At the completion of each annual review schedule, an annual report of emerging trends will be produced and published by the National Co-ordinating Team. This report is designed to record the findings of the review teams and to promote best practice. It will focus on:

Learning gained about compliance with the quality measures across cancer services during the conduct of the Cancer Peer Reviews.

Site specific issues arising in each of the Zonal areas.

Good practice identified for dissemination through the sectors.

In the light of these reports, consideration will be given to any amendment deemed necessary to the Manual for Cancer Services.

5.3 Appeals and Complaints

A distinction is drawn between complaints and appeals. Complaints are concerned with the processes and conduct of peer review, while appeals are challenges to the conclusions drawn by reviewers in specific circumstances.

5.3.1 Appeals

The circumstances where an appeal will be considered are where reviewers have concluded that a Network/Locality gives cause for serious concern or the reviewers have concluded that the Network/Locality's performance in complying with the measures is assessed as being unsatisfactory. These are the only circumstances in which an appeal can be submitted against the conclusions of reviewers.

Any such appeal can only be submitted by a Chief Executive of one of the Trust's in the Network, or by the Chair of the Network Board. The appeal must be submitted within four weeks of the publication of the Peer Review Report.

Any appeal received will be considered initially by the relevant Zonal Reference Group, and, if it is not possible to reach local resolution, by a sub-group of the National Steering Group for Cancer Peer Review. The membership of the sub-group will be determined on a case by case basis by the Chair of the Steering Group, but may include a representative from the Healthcare Commission and a user/carer representative. No member of a sub-group will have had any prior involvement in the review at issue.

The sub-group will review the methodology and process used by the review team and the conclusions it drew. In doing so, it will examine whether, in the light of the points made in the statement of appeal the team's conclusions were reached reasonably and fairly. The sub-group will consider whether the team's conclusions were unreasonable or

disproportionate in the light of the available evidence. Reasonableness may be called into question if irrelevant matters are taken into account, or relevant matters not taken into account.

The sub-group will consider whether there was evidence within the appeal statement which might lead to different conclusions being reached from those contained within the report. Any such evidence must have been submitted during the period of the review.

The decision of the sub-group of the National Steering Group for Cancer Peer Review will be final with no further stage of appeal. Wherever possible the result of an appeal will be made known no longer than eight weeks from the date the appeal was submitted.

Administrative and clinical support to a sub-group will be provided by members of the National Co-ordinating Team for Cancer Peer Review.

5.3.2 Complaints

The vast majority of reviews will be carried out successfully and without incident. However it is recognised that sometimes Networks or their constituent elements will be unhappy about aspects of the review process. The opportunities for making complaints and the process for dealing with those complaints is set out below.

Networks and Trusts have the opportunity to agree with their Zonal Co-ordinating Team the details of the preparations for a review. Any complaints, for example about dates, timings etc should be made in the first instance to the Quality Manager with lead responsibility for the review.

Complaints about the conduct of a review should be made to the Quality Director of the Zonal Co-ordinating Team during, or, where this is not possible, immediately after the review.

Complaints about the conduct of a team, or a team member, or a member of the Zonal Co-ordinating Team should be addressed in the first instance to the Quality Director of the Zonal Co-ordinating Team. N.B. Complaints about the way teams and individuals have carried out their role are an entirely legitimate area of complaint. However, complaints about a person, as distinct from that person's conduct of their role and responsibilities, are not acceptable.

Complaints about the drafting of the peer review report should be resolved with the Quality Director for the Zonal Co-ordinating Team through the normal procedures for checking factual accuracy of draft reports with the organisation. If no resolution is achieved, the complaint should be addressed to the National Co-ordinator for Cancer Peer Review.

In general, any complaints that cannot be resolved with the Quality Director will be referred to the Zonal Reference Group. If no resolution is achieved the complaint will be referred to the National Co-ordinator for Cancer Peer Review, who in turn will refer the matter to the National Steering Group for Cancer Peer Review if it cannot be resolved at officer level.

Complaints concerning the peer review process must be submitted prior to the publication of the final peer review report.

5 Appendix 1

Peer Review Guide for Reviewers – Service Improvement

Introduction

This guidance relates to the measures identified in the Manual of Cancer Services. It aims to help reviewers assess compliance with the service improvement element of the measures in an informed and consistent manner.

Themes	Questions	Rationale	Desired Answers
Service Improvement Leads in NSSG/MDT	Who is responsible for Service Improvement in your Team? What are your responsibilities for service improvement? Who are you responsible and accountable to? How effective is the role? What experience have you had in service improvement & re-design? How do you liaise with other service improvement & modernisation roles in your organisation?	Named person accepting responsibility for the role (this should not be a SIL or SIF) Clarity of role & accountability Evidence of how the role works and its effectiveness Knowledge base & skills Evidence of implementation Knowledge of high impact change principles Evidence of integration and mainstreaming of service improvement	Clearly Identified named person responsible for service improvement within a team. Triangulation: Other team members being aware of the named individual and the role and how it works. Evidence of: Understanding of the role of service improvement. How it works within the team. Achievements of the role including sustained improvements Evidence of training in service improvement methodology and involvement in implementation. Demonstration of links with other service improvement roles and communication channels Service improvement plans agreed by Network Service Improvement Lead (SIL)
Process mapping	Describe the outcomes from the process mapping? What approach did you use? Who was involved in the process mapping exercise? How did you identify the areas for improvement?	Understanding of process mapping. Evidence of process mapping having been undertaken Awareness of the aspects of process mapping broader than the paper exercise.	Demonstration of understanding of process and purpose of mapping Perspectives of whole team included in process mapping. Evidence of stakeholder involvement, including user involvement Areas for improvement identified Reference to measures for improvement, working in systems, Bottlenecks, patient flows. patient experience.

Themes	Questions	Rationale	Desired Answers
Process Mapping	Where were/are the bottle-necks/constraints in your patient pathway? What were/are the areas where the patients experience can be improved? What have you been able to do about them?	Evidence of issues identified/outcomes from process mapping Evidence of action taken/planned from issues/outcomes identified Approach and implementation of change	Action taken/planned to implement changes for improvement. Demonstration of impact of process mapping and changes for improvement made as a result Triangulation: ensuring not just a tick box exercise check awareness with other team members Evidence would include: Reporting changes on WILS. Sustained reduction in waiting times Team awareness/implementation of high impact change principles Patient satisfaction measures Reference to CSCIP tumour pathways
	When did the process mapping take place? What plans are there to review the process mapping? As the ideal process map/patients journey been established. No - What is the team plans in working towards the ideal journey?	Ensuring mapping and service improvement is ongoing & part of day to day business	Process mapping completed in last 12 months & reviewed on an annual basis Evidence of continuous improvement.
	Are patient's given fully booked appointments? Yes – how was this achieved? No – how is this being addressed?	Ensuring full booking is implemented – partial booking is not appropriate	Demonstration of full booking process

Themes	Questions	Rationale	Desired Answers
Service Improvement – implemented change	What high impact changes have you implemented? What impact have they had on waiting times and patients/ How can you demonstrate this impact?	Ensuring implementation of high impact changes and collection of data to support impact.	Demonstration of a least one high impact implemented change, demonstration of knowledge and understanding of resulting impact on waiting times.
Capacity Demand Improving patient flow across the patient's journey. Teams should have an awareness of the methodology The reviewer will need to clarify with the SIL where capacity & demand work has been required e.g. Clinical team, IOG work, whole system approach in diagnostics, Trust /SHA led work. To ensure appropriate focus of this measure.	Do you monitor/manage Capacity and Demand? How - what is the approach? How long have you been monitoring? Does the monitoring include capacity, & demand, activity and backlog/waiting times data? Is capacity demand//activity/waiting data measured in terms of both numbers of patients & time to process?	Testing understanding of the methodology and its local application. Checking understanding of definitions of terms. Evidence of use Improving access to diagnostic tests, managing variation, minimising the number of queues, optimising patient flow through service bottlenecks & constraints	Demand = number of referrals from all sources Activity = work done Capacity = amount of kit and staff available Backlog/waiting list = work waiting to be done All data collected in numbers of patients and time process takes Evidence of use: Plans to implement high impact change principles. Capacity & demand data analysed and used as the basis for all service developments.
	What is the time period for each measure?	Evidence e.g. daily, weekly, monthly	Data collected continually and ideally on a daily basis
	How is the data used?	Evidence of analysis of data and implementation of change. Have they used capacity and demand data to provide evidence to support an effective business case for more resources, changes in practice?	Data analysed and action for improvement taken

Themes	Questions	Rationale	Desired Answers
Capacity Demand (cont.)	What capacity & demand work as been undertaken to support the implementation of IOG?	Evidence of capacity & demand management included in implementation plans?	Capacity and demand data has been used to inform implementation plans and service reconfiguration
Workforce development	What workforce implications has the Service Improvement work identified? Is role redesign and development considered at the same time as process re-design? Who leads role redesign? Who has the authority/responsibility?	To identify strong working links between service improvement and workforce development. Identify redesign roles and extended roles to develop effective patient pathways.	Links between service improvement and workforce development ensure the right person is doing the right thing, for the patient at the right time. Service improvement plans are aligned to workforce development plans
Communication & integration	How does your teams service improvement work link with the Cancer Network Service Improvement Team? How do you link in with the Trust-wide and SHA modernisation strategies?	Demonstration of strong links and communication between Trusts and the service improvement team and the SHA. Sharing of learning and spreading best practice	High awareness of service improvement work done. Evidence of interfaces and joint working Service improvement plans agreed with SIL Robust communication strategies. Evidence of sharing of learning.

Glossary of Terms

Glossary of Terms

Terms	Relevant Reference material
Activity All the work done. This does not necessarily reflect capacity or demand	Improvement Leaders Guides **www.modern.nhs.uk**
Backlog Previous demand that has not been dealt with showing itself as a queue	Improvement Leaders Guides **www.modern.nhs.uk**
Batching Piling up a type of work as it comes in until a later time when all this type of work is done together	Improvement Leaders Guides **www.modern.nhs.uk**
Bottleneck Part of the system where patient flow is obstructed, causing waits and delays	Improvement Leaders Guides **www.modern.nhs.uk**
Capacity Resources available to do the work	Improvement Leaders Guides **www.modern.nhs.uk**
Constraint The actual cause of the bottleneck	Improvement Leaders Guides **www.modern.nhs.uk**
Cancer Services Collaborative Improvement Partnership CSCIP Demand All the requests/referrals coming in from all sources	
Hand off When the patient is passed on from one healthcare professional to another125	Improvement Leaders Guides **www.modern.nhs.uk**
High Impact Changes through service improvement Improve patient flow across the system by improving access to key diagnostic tests Manage variation in the patient admission process Smooth variation in patient length of stay and patient discharge Avoid unnecessary follow-ups and provide necessary follow-ups in the right care setting Increase the reliability of therapeutic interventions through a "care bundle" approach Minimise the number of queues by redesigning schedules Optimise patient flow through service bottlenecks using process templates Redesign and extend roles to develop effective patient pathways. Apply a systematic approach to care for people with chronic conditions Treat day care surgery (rather than inpatient surgery) as the default for elective surgery	DOH National Standards, Local Action Heath and Social care Standards Planning Framework. 2005-2008. **www.modern.nhs.uk.** Cancer Services Collaborative Service Improvement Guides. (SIGs) Cancer Top Tips **www.modern.nhs.uk/cancer/sigs** **www.modern.nhs.uk/diagnostics** **www.modern.nhs.uk/radiology** **www.modern.nhs.uk/endoscopy** **www.modern.nhs.uk/pathology**

Terms	Relevant Reference material
Measurement for Improvement Where a specific measure is linked to the service improvement objectives and aims to demonstrate whether the changes are making improvements.	Improvement Leaders Guides **www.modern.nhs.uk**
Process mapping A map of the patients journey, involving MDTs to understand the real problems from the patients' perspective and to identify opportunities for improvement. Having mapped the patient's journey the team needs to analyse it. Considering How many steps are there for the patients How many times is a patient passed on (hand off) what is the time taken at each step and between each step. Where does a patient join a queue. How many steps add no value to patients and staff. Where are the real problems? What do patients complain about? Is the patient getting the most appropriate care? Is the most appropriate person giving care? Is care given at the appropriate time and in the best place?	Improvement Leaders Guides **www.modern.nhs.uk**
Queue Work waiting to be done at a given point	Improvement Leaders Guides **www.modern.nhs.uk**
Re-design Redesign around the patient. Ideal patient pathways	
Scope A definition of the boundaries of the area under examination	Improvement Leaders Guides **www.modern.nhs.uk**
Service Improvement Lead (SIL) Cancer Network Lead for Service	
Service Improvement methodology: Process mapping, Analysis and redesign Matching capacity and demand Studies, Measurement for Improvement Working in systems Re designing roles Working with teams Building and nurturing an improvement culture	Improvement Leaders Guides **www.modern.nhs.uk**

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