Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Complementary Therapy (Safeguarding Practice) Measures

Version 2.0

DH INFORMATION READER BOX

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For Recipient's Use	

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Introduction

1.1 Aim of the Manual for Cancer Services

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and patient/carer representation, provides important information about the quality of clinical teams and a national benchmark of cancer services across the country.

National quality standards/measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services (e.g. chemotherapy, radiotherapy). It is intended that the National Cancer Intelligence Network (NCIN) clinical reference groups will review the measures within the manual for cancer services annually to ensure they are clinically relevant and it is intended that the measures will underpin the NICE Quality Standards relating to cancer.

An independent evaluation of the National Cancer Peer Review Programme demonstrated strong support for the programme to continue, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when data becomes available.

In response to this the number of measures has been reduced by over one third in 2008 and more recently by a further 10%. In addition "Clinical Lines of Enquiry" (CLE) have been introduced, based on outputs/outcomes to support the Manual for Cancer Services. The revised process for peer review will be implemented in April 2011 but the measures contained within this manual will remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Although the NHS is not mandated to adhere to the measures in the Manual for Cancer Services, it is currently used by the National Cancer Peer Review Programme as part of their local assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality.

1.2 Background and Context

Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy sets out how the future direction for cancer will be aligned with Equity and Excellence: Liberating the NHS in addition to meeting its stated aim to saving an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive information about cancer services for individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

1.3 Measures within the National Cancer Peer Review Manual

The peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, 'Clinical Lines of Enquiry' have been introduced and it is intended these outcome indicators will form part of the measures along with a reduced number of structure and process measures.

The development of cancer measures is an ongoing process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new initiatives such as Iapco, information prescriptions.

The relationship between the NICE Improving Outcomes Guidance and Quality Standards and the Manual for Cancer Services is explained in more detail in appendix A.

1.4 Reviewing the Measures

The National Cancer Peer Review (NCPR) 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.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The NCPR programme has been keen to take the opportunity to reduce the burden on the NHS in line with the efficiency gains asked of all NHS organisations. The revised methodology will reduce the burden on the service without substantially impacting on the quality assurance process. It is envisaged that these changes will reduce the burden on the service by almost 50% from the previous process.

Appendix A

Interpretation of the National Manual for Cancer Services

1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes Guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive and far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated.

It may use influential and important ideas and models, which are however complex or not precisely definable, such as "network-wide patient care pathways" or "culturally-sensitive information". It always contains useful and necessary value judgements which use words like "sufficient", "appropriate", "robust" and "comprehensive", but it often has to leave unanswered the key question - what exactly is it which makes the issue under examination "sufficient", "appropriate", "robust" and "comprehensive" or not? It uses concepts which, although crucial, may not be measurable. It ranges widely from things which everybody gets right as a matter of course already through to principles which, if taken literally, nobody would comply with ever.

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset, guidance would not inspire, lead, motivate or guide and would probably be almost unreadable. The Manual for Cancer Services has to take a different approach. It is written for and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit; state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous standards - in order to be developmental -not just arbitrarily moving the goal posts.

All this results in the rather esoteric style of the manual. Please judge the measures on their merits in the light of the above and not in comparison to the guidance.

1.2 "The Responsibility for Assessment Purposes"

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task - this can be delegated according to local discretion, unless it is clear that a given task really is limited to ascertain group.

1.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

1.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is under taken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

1.5 "Quality" Aspects of Cancer Service Delivery

Many of the measures expect that policies, procedures, job descriptions and other documents will be in place. In reviewing compliance with the measures (for instance measure met or not) during validation, verification and visits, reviewers will look only for the presence of such documents, unless aspects of the content are specified in the wording of the measure. Where some aspect of the content is specified then this will be taken into account in determining compliance. As part of the improvement of cancer services, reviewers may comment on the content of documents and agreements but this will not affect the determination of compliance.

Work is ongoing to enable us to subject more of the "quality" aspects of cancer service delivery to objective measures for future rounds of peer review.

Many reviewers have a legitimate and valuable contribution to make by way of comments on areas which are a matter of opinion rather than fact or authoritative and evidence based standards. This recognises the qualitative as well as quantitative approach to reviews. This contribution can be made by way of a textual report in addition to the objective recording of compliance against the measures. This report is separate from the review against the measures and is inevitably more subjective and open to debate. However, there are many ways in which it can add to the overall picture gained from the peer review.

1.6 Structure of the Measures

Each measure has a three part number, for example 11-1A- 201j.

- The first part indicates the year the measure was first issued, for example 11 is 2011.
- The second part relates to a particular topic see below, for example 1A.
- The third part is made up of a unique measure number in the topic and where relevant a suffix letter indicating a specific tumour and cross cutting services, for example 201j (see below).

Index of Suffix Letters

a - Generic to all tumour sites	**r** - Specialist Palliative Care specific
b - Breast specific	**s** - Chemotherapy specific
c - Lung specific	**t** - Radiotherapy specific
d - Colorectal specific	**u** - User Group specific
e - Gynaecology specific	**v** - Rehabilitation specific
f - UGI specific	**w** - Complementary Therapy specific
g - Urology specific	**x** - Psychological Support specific
h - Haematology specific	**y** - Acute Oncology
i - Head and Neck specific	
j - Skin specific	

Each network will be made up of several localities/trusts and several NSSGs / cross cutting groups, each with multiple MDTs and services. These MDTs and services will each need to demonstrate compliance with the relevant quality measures. A network overview will be developed by bringing together the findings relating to individual MDTs and services as well as those concerning network organisation and structures.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at http://www.cquins.nhs.uk.

COMPLEMENTARY THERAPY (SAFEGUARDING PRACTICE) MEASURES

INTRODUCTION

Although it is, in general, recommended that complementary therapy is made available to patients, the actual range of and the levels of service provision of such therapies are not subject to agreed boundaries, and NHS commissioners do not have a mandatory requirement to provide them. Therefore, the measures have not been used to set a minimum service level or range of therapies. Instead, they focus on a different, but important aspect. Because the area of complementary therapy is less regulated than that of conventional therapy, the measures set out the clinical governance requirements for the network to exercise over such complementary therapy as might be provided. It deals with the case of practitioners offering therapy or consultations on the network's NHS premises and also the case where practitioners or organisations are endorsed and cited in the patient information of the network's MDTs, chemotherapy services and radiotherapy departments.

If the network as a whole, or in one or more of its localities, does not provide complementary therapy on its NHS premises, this is not a case of non-compliance. In this case, the relevant measures would be considered as not applicable. It is unlikely, however, that a network would fail to mention complementary therapy in any of its patient information material, so the measures relevant to this are usually likely to apply.

The measures intentionally focus on those clinical governance issues which are directly relevant to the welfare of patients rather than those dealing with the professional development of staff providing complementary therapy.

Definition of Complementary Therapy

The definition used here is solely for the purposes of the measures and the National Cancer Peer Review. There may be other ways of defining complementary therapy. A complete and logically satisfying definition is not the purpose here - it is purely to differentiate what should be reviewed under this heading from, perhaps more precisely, what should not.

The term 'complementary therapy' is used here, to cover a range of specific therapies, which are offered to patients with cancer, as having potential benefit, but which are not offered as an alternative tumour reduction (cancer reduction, tumour ablation or removal) method to any of the conventional treatments offered by the network (surgery, radiotherapy, chemotherapy, endocrine therapy or biological therapy). Hence the term is 'complementary' not 'alternative'.

Complementary therapy may for example include any or all of the following: acupressure, acupuncture, aromatherapy, healing, homeopathy, hypnotherapy, massage, reiki and shiatsu. This list is not comprehensive. The network may offer, or cite, practitioners in other therapies which it agrees are covered by the term complementary therapy. However, the term and these measures are not intended to apply to any of the following since although they are not cancer reduction treatments, they are largely covered by conventional arrangements and regulatory systems: Symptom control using oral, parenteral or topical drugs from the National Formulary; symptom control by neuro-ablative methods; nutritional advice by qualified NHS dieticians; osteopathy; chiropractice; the various treatments offered by qualified NHS physiotherapists; lymphoedema massage offered by qualified NHS staff; consultations and therapy offered by qualified clinical psychologists.

Reviewing Complementary Therapy

The Network Board is required to produce criteria which should be agreed network-wide, and which should be met by practitioners in the network or those cited in the network's patient information.

Producing the criteria is the responsibility for review purposes of the Network Board and is reviewed under Topic 1A. The results count towards the compliance of the Network Board.

Since complementary therapies are not usually specific to individual types of cancer, agreeing and implementing the criteria throughout the network is not considered an MDT responsibility, but review purposes is the responsibility of the locality groups. This is reviewed under Topic ID and results count towards the compliance of each individual locality group.

TOPIC 11-1A-3w - NETWORK BOARD MEASURES FOR COMPLEMENTARY THERAPY

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
For this measure, for its compliance, the board should produce the criteria and the individual locality groups, for their compliance with the relevant locality group measure should agree to abide by them in their locality.
Network Criteria for Practitioners of Complementary Therapy

11-1A-301w The Network Board in consultation with the Network Palliative Care Group should produce a single set of network-wide criteria, the relevant parts of which should be met by practitioners of complementary therapy as a pre-condition for their practising on the NHS premises of the network or being endorsed or cited in the written patient information of the network's MDTs, chemotherapy services or radiotherapy departments.

The criteria should include the following:

For practitioners who provide their therapy or consult with patients on NHS premises:

(i) Clearance

If employees, they should be an NHS employee or they should have been employed by an organisation with an employment policy which covers at least the following issues to the network's satisfaction: Occupational Health Clearance; Clearance for working with vulnerable adults (or children if relevant) and Criminal Records Bureau Clearance, agreement to adhere to Trust policies and procedures, possession of professional indemnity insurance.

If volunteers or self-employed they should have gained the above clearances from an NHS personnel department or an organisation whose volunteer recruitment policy covers these issues to the network's satisfaction.

(ii) Qualifications

They should provide written evidence of a qualification in their area of practice, agreed as acceptable by the network, if the practitioner has no written qualification, the network should decide whether it is acceptable for them to continue practice on the NHS premises of the network or be endorsed or cited in the Network's written information.

Note:

At the time of publication of these measures it is not possible to cite nationally agreed minimum qualifications for most individual therapies. Where there are nationally recognised professional/registration criteria for a given therapy, these should be used by the Network. For example Complementary & Natural Healthcare Council (CNHC) for the therapies covered by them.

(iii) Written Information for Patients

They should provide written information for their patients covering at least the following:

- A statement to the effect that their therapy is not an alternative method of tumour reduction to the conventional therapies (surgery, radiotherapy, chemotherapy, endocrine or biological therapy).
- A description of what undergoing the therapy entails for the patient.
- If relevant, the arrangements (in terms of time of day, place and length of therapy or number of treatments/consultations) under which the therapy would be offered as a private, paid for therapy, as opposed to free-of-charge provision.
- A statement of their network-agreed qualification or a declaration that they do not possess such qualification.

(iv) Informed Consent

They should provide a written consent form allowing the patient to confirm that they have

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	received and understood at least the information itemised above, and then have agreed to the therapy. *Note:* *Items (i) - (iv) above are also the pre-conditions for complementary therapy practitioners practising on NHS premises to be endorsed or cited in the network patient information.* *It is recommended that written information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio materials.* **For practitioners who are endorsed or cited in the patient information but who do not practice on NHS premises:** Items (i) to (iv) apply and in addition the following applies: **(v) Equipment & Materials** The network should agree a policy regarding the sterility and safety of equipment and toxicity of substances used by the complementary therapy practitioner. *Note: Those working in organisations inspected by the Care Quality Commission could be exempt from this (v)* The criteria should be distributed to all locality groups, Trust CEOs voluntary/independent sector providers of palliative care and any other organisations providing complementary therapy in the geographical area covered by the network.
Compliance:	The criteria, agreed by the Chair of the Network Palliative Care Group and the Chair of the Network Board. *Note: The network may agree additional criteria to those itemised above - this is not subject to review.* The reviewers should enquire as to the distribution. *Note:* *Documentary evidence of receipt of the criteria or of the exhaustiveness of distribution is not required for compliance.*

TOPIC 11-1D-1w - LOCALITY MEASURES FOR COMPLEMENTARY THERAPY

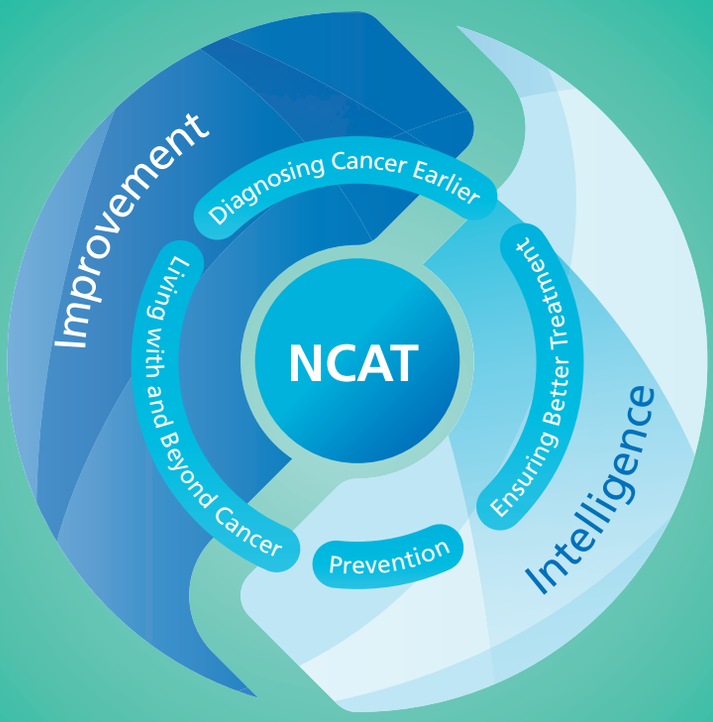
Introduction

For compliance with its measure in Topic 1A, the Network Board should produce the network criteria for complementary therapy and the locality group for its compliance with this measure, should agree to abide by them.

The locality group should agree the network criteria for complementary therapy as a pre-condition for practitioners practising on the NHS premises of the locality or being endorsed or cited in the written patient information of the MDTs, chemotherapy services or radiotherapy departments encompassed by the locality.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Network Agreed Criteria for Practitioners of Complementary Therapy	
11-1D-101w	The locality group should agree the network criteria for complementary therapy as a pre-condition for practitioners practising on the NHS premises of the locality or being endorsed or cited in the written patient information of the MDTs, chemotherapy services or radiotherapy departments encompassed by the locality.
Compliance:	The criteria, agreed by the Chair of the Locality Group and the Chair of the Network Board.
List of Complementary Therapy Practitioners Practising on NHS Premises	
11-1D-102w	The locality group should produce a list, updated annually, of the complementary therapy practitioners offering their therapy or consulting with patients on the NHS premises of the locality.
Compliance:	The list (or update, see below) for the last complete year prior to the peer review visit, agreed by the Chair of the Locality Group. For groups being reviewed two or more years since the publications of these measures, the list is needed from the first year, then the agreed updates for each subsequent complete year.
Complementary Therapy Practitioners Practising on NHS Premises	
11-1D-103w	The complementary therapy practitioners on the list of those practising on the NHS premises of the locality should meet the relevant, network complementary therapy criteria. See Topic 1A - Network Complementary Therapy Measures, criteria (i)-(iv)
Compliance:	For each practitioner: Criterion (i) Reviewers should enquire or see documentation that they are an NHS employee or that their employing or volunteer - recruitment organisation's clearance policies are agreed by the Chair of the Locality Group. Criterion (ii) The written qualification, agreed by the Chair of the Locality Group, or statement, that they are unqualified, agreed by the Chair of the Locality Group. *Note: The chair obviously need not necessarily agree that a person without an agreed qualification may practice on NHS premises.* Criterion (iii) The written patient information, used by the practitioner, agreed by the Chair of the Locality Group, demonstrating the items in criterion (iii). Criterion (iv) The consent form, agreed by the Chair of the Locality Group, demonstrating the requirements in criterion (iv). *Notes:* *For the compliance of the locality group, all the practitioners on the list should meet the criteria.* *'All practitioners' refers to those practising according to the list updated for the last complete year prior to the peer review.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
List of Complementary Therapy Practitioners Endorsed or Cited in Patient Information	
11-1D-104w	The locality group should produce a list, updated annually, of those practitioners of complementary therapy (and organisations providing practitioners) who are endorsed or cited in the patient information of the MDTs, chemotherapy services and radiotherapy departments, encompassed by the locality, but who do not practise on the NHS premises of the locality.
Compliance:	The list (or update, see below) for the last complete year prior to the peer review visit, agreed by the Chair of the Locality Group. For groups being reviewed two or more years since the publication of those measures, the list is needed from the first year, then the agreed updates for each subsequent complete year up to the peer review visit.
Complementary Therapy Practitioners Endorsed or Cited in Patient Information	
11-1D-105w	The complementary therapy practitioners on the list of those endorsed by the patient information, but not practising on the NHS premises of the locality, should meet the relevant, network complementary therapy measures - criterion (i) to (v).
Compliance:	The reviewers should enquire how the locality group ensure this for the practitioners and/or their employing/recruiting organisations. Note: Documenting evidence or verifying compliance for each individual named practitioner in this category is not practical. Reviewers should exercise judgement in this matter.



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