

National Cancer Peer Review Programme Handbook

March 2011





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1. Introduction

This is the handbook for the *National Cancer Peer Review Programme 2011* (the Handbook), which will be used for activity starting from April 2011.

It describes the revised method and procedures for carrying out the National Cancer Peer Review Programme (NCP) in England.

The programme continues to adhere to the founding principles:

- An emphasis on being clinically led

- National consistency in the delivery of the programme
- A focus on improvement
- A focus on system and services within and across organisations in a cancer network to ensure co-ordination of patient care
- A focus on coordination of patient pathways
- Peer on peer review
- Integration with other review systems
- Patient and carer involvement

In addition the following principles have informed the development of the revised process:

- Greater focus on self assessments and internal quality assurance
- A targeted and proportionate visit programme
- Better use of resources
- Responsiveness to NHS changes
- Greater emphasis on outcomes

1.1 Background

In implementing these revisions the National Cancer Peer Review (NCP) programme has taken the opportunity to reduce the burden on the NHS service in line with the efficiency gains asked of all NHS organisations. This reduction in burden is supported by the QIPP programme.

The programme will maintain annual self assessment (SA) in order to provide up to date information for commissioners, patients and the public but reduce the burden of providing documentary evidence to support the SA annually. Instead teams/services will be accountable for the accuracy and honesty of the SA confirmed by the Lead Clinician. The documentary evidence will only be required every other year. This will reduce the bureaucracy for clinicians while maintaining the quality assurance of cancer service for the public and commissioners.

The Internal Validation (IV) process has been reduced to

every other year rather than an annual process so the documentary evidence for SA will only be required when Internal Validation or a Peer Review visit is taking place.

Another significant change is to reduce the burden of inspection. Peer review visits will only be undertaken to teams/ service when there is considered to be a risk or an opportunity for significant learning. This will reduce the number of comprehensive peer review visits. Where new measures are introduced to the Manual of Cancer Service these will be self assessed in the first instance enabling services to develop before potentially receiving a peer review visit.

In order to better address outcomes within the peer review programme, the Clinical Lines of Enquiry pilot for Breast and Lung services is being extended to another four cancer sites this year and it is planned to be introduced for all teams in future.

The revised programme is aligned with the Coalition Government aim: to deliver health outcomes that are among the best in the world. It also aligns to the White Paper, Equity and Excellence – Liberating the NHS, and the ethos of better regulation.

The Care Quality Commission (CQC) and the NCP are collaborating to promote the delivery of high quality care in England specifically in relation to the delivery and quality assurance of cancer services. The outcomes of the NCP programme will now feed into the CQC Quality and Risk Profiles (QRPs).

The NCP Programme is an integral part of the Improving Outcomes: A Strategy for Cancer, published in January 2011. It will support quality assurance of cancer services and enable quality improvement.

1.2 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.

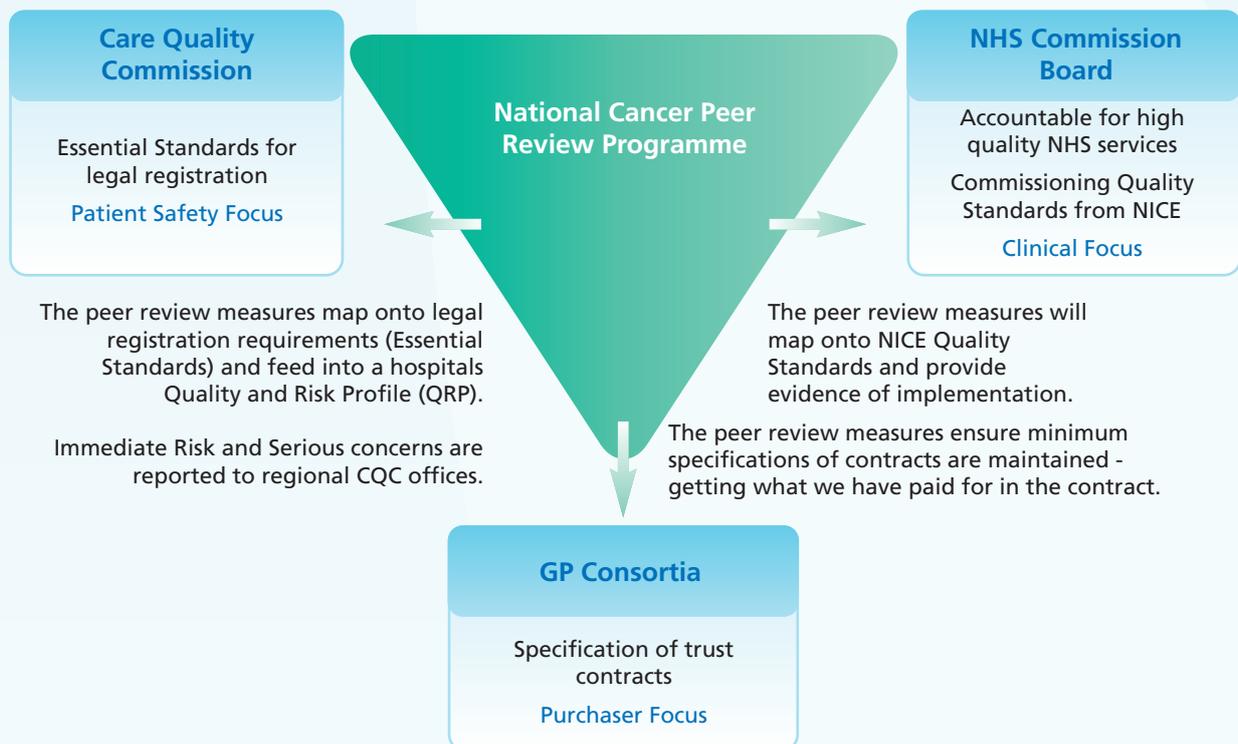
The strategy sets out how the future direction for cancer will be aligned with *Equity and Excellence: Liberating the NHS*. It aims to: save an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive

information about cancer services being available to individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

National guidance will continue to play a vital role as cancer services develop over the next five years. Much of this guidance has been developed by the NICE with *Improving Outcomes Guidance (IOG)* for cancer services now covering the vast majority of all cancers. The revised *Manual for Cancer Services* has been drawn up to incorporate the recommendations contained within such guidance including the new guidelines and quality

standards published by NICE. The *Manual for Cancer Service* is used by the NCPR Programme as part of the assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality. It identifies the characteristics of a service that are likely to have a significant impact on health outcomes. It is intended that those characteristics should help those involved in planning, commissioning, organising and providing cancer services to identify gaps in provision and to support the quality assurance of services enabling quality improvements. This is illustrated below.



1.3 Aims and Outcomes of the National Cancer Peer Review Programme

The 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 outcomes of the NCPR Programme are:

- confirmation of the quality of cancer services;
- speedy identification of major

shortcomings in the quality of cancer services where they occur so that rectification can take place;

- published reports that provide accessible public information about the quality of cancer services;
- timely information for local commissioning as well as for specialised commissioners in the designation of cancer services;
- validated information which is available to other stakeholders.

The NCPR Programme should be conducted in a spirit of dialogue and cooperation between the cancer networks, trusts, their staff and the review teams. Cancer networks have delegated responsibility from SHAs and

PCTs (while they continue to exist and in future the NHS Commissioning Board and GP Consortia) to ensure that services are appropriately commissioned and have robust clinical governance processes. It is expected that the NCPR Programme will also have dialogue and co-operation with SHAs and PCTs and in future the NHS Commissioning Board and GP Consortia.

It is essential the peer review process is 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 review training sessions.

1.4 Management of the National Cancer Peer Review Programme

Overall responsibility for the governance of the programme sits with the Cancer Programme Board via the NCPR Executive Group.

A national team, consisting of a National Programme Director, Deputy Programme Director, Senior Analyst and Project Assistant has been established as part of the National Cancer Action Team. The national team is responsible for ensuring the effective delivery of the programme.

Four Zonal Coordinating Teams have been established (see **appendix 2** for the networks and SHAs they cover), each with a Quality Director, at least one Clinical Lead, two Quality Managers, at least one Assistant Quality Manager and an Administrator. These teams will manage the peer review process at a local level. The four zones are:

- North;
- Central;
- South;
- London.

The National Programme Director, Deputy Programme Director and the Quality Directors from each zone will form an Executive Group with responsibility for ensuring the delivery of a nationally consistent programme of peer review.

Within each of the four zones, Zonal Advisory Groups have been established (see **appendix 1** for terms of reference). These groups will support the implementation of the cancer peer review programme at a local level.

1.5 Scope of Peer Review

It is intended that the NCPR programme will cover all cancer types and all stages of the patient's journey. All cancer services for which measures have been developed will be included in the peer review programme.

The NCPR Programme will review compliance with measures contained within the Manual for Cancer Services.

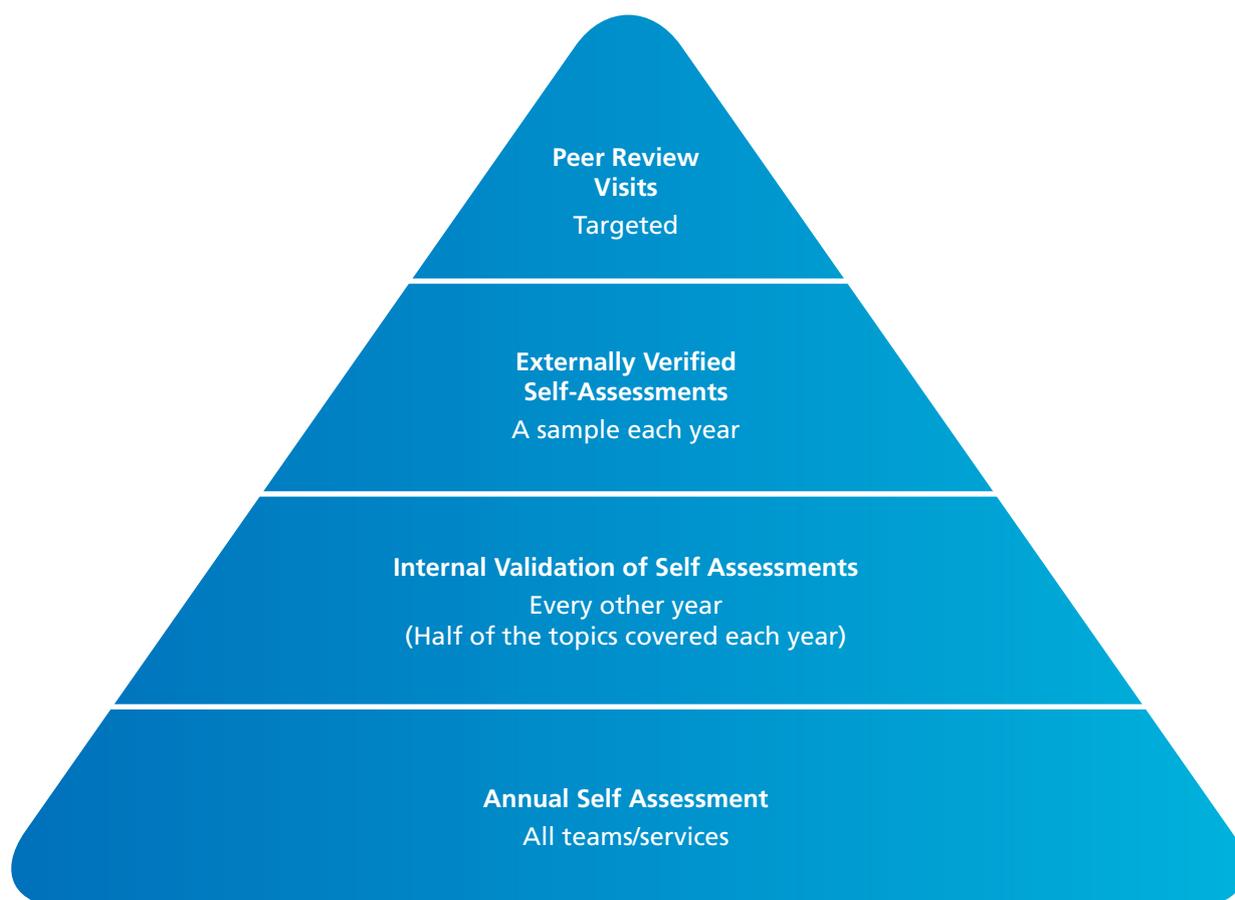
The process of cancer peer review is concerned not only with the review of an organisation's compliance

against 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 quality and safety in relation to patient experience and clinical outcomes.

2. The Peer Review Programme

2.1 The Four Stages of the Peer Review Programme

The peer review programme consists of the four key stages illustrated in the following diagram:



- **Annual Self Assessment**
Completion of an annual self assessment by the team/service who deliver the cancer service.

- **Internal Validation of Self Assessments**
Internal validation of the self assessment should be undertaken by the host organisation or coordinating

body for that service. Internal validation of a service should be undertaken every other year (see **appendix 5 IV** schedule).

- **External Verification of Self Assessments**
An external check of selected internally validated self assessments led by the zonal

cancer peer review coordinating teams. This check will take the form of a desktop exercise. The schedule for which topics are to be externally validated each year can be found on the CQuINS website. This process will ensure that every team/service will be externally verified at least once every five years.

• **Peer Review Visits**

Each year a targeted schedule of peer review visits will take place. The schedule of peer review visits will be agreed with each cancer network by the end of December. The teams/services selected for a peer review visit will be informed in January each year. Each visiting cycle will commence in May and be completed by the following March.

being made towards achievement of the measures. Compliance with the measures will be appraised as yes, no or not applicable. Evidence to support a self assessment will only be required every other year. Teams/services are accountable to ensure assessments are accurate and reliable. If a team/service is subsequently found not to be accurate this information will be published.

within agreed timescales, building on the strengths identified and addressing any aspects in need of improvement. Actions should be included in strategic development plans and the relevant team's/service's work programme. It is important to recognise that approval and follow up of agreed actions is primarily a function of clinical and corporate governance systems and not a function of the peer review process. There is, of course, the scope to involve zonal quality teams and the zonal advisory groups in follow up where this is considered helpful.

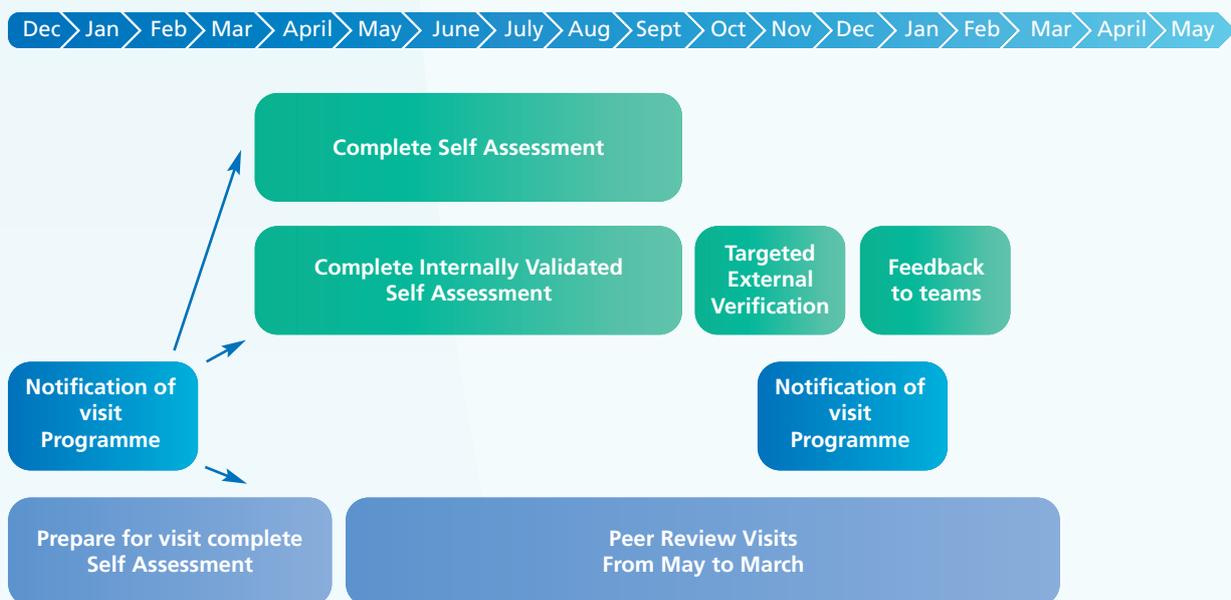
Each of the above stages of the peer review process should determine whether each measure has been achieved or not and whether progress is

Following the outcomes from the different stages in the peer review process, the cancer network and its constituent organisations should agree the actions that need to be taken

2.2 The National Cancer Peer Review Process

The cycle for the peer review process is shown below. In any one year a service will be completing a self-assessment

only, or completing a self-assessment for internal validation, or preparing for a peer review visit.



2.3 Clinical Indicators / Outcomes

Clinical Indicators are being developed by NCPR and the National Cancer Intelligence Network (NCIN) Site Specific Clinical Reference Groups (SSCRGs) for all tumour types, in order to ensure a much stronger focus on clinical issues and ensure reviews are clinically relevant. Where Clinical Indicators are not yet available the teams/services will be asked about generic indicators in relation to clinical outcomes.

It is the intention to feedback and review these Clinical Indicators at the SSCRG on an annual basis. Details of the clinical Indicators will be included in each of the evidence guides.

Data

Where national data is available this will be provided to both the review teams and service being reviewed to enable discussion against the clinical indicators. If local data is required to enable discussion against the clinical indicators this may be uploaded as an appendix in the Key Evidence Document section on Cancer Quality Improvement Network System (CQuINS)

(‘Clinical Outcomes’).

Reporting on Clinical Indicators through Clinical Lines of Enquiry

A briefing sheet will be available that highlights the Clinical Lines of Enquiry that should be discussed in relation to the clinical indicators. As part of self-assessment, MDTs and NSSGs should include a commentary on the Clinical Indicators in their Annual Report, and in the self assessment report.

A commentary on the Clinical Lines of Enquiry will also be included in the Peer Review reports.

3. The Annual Self Assessment

3.1 What will be Self Assessed?

All teams/services covered by the Manual for Cancer Services will be required to complete an annual self assessment. Other

services not included in the manual will be required to complete a self assessment either at a later date when new

measures are published, or when commissioned. Peer review is based on self assessment.

3.2 How to Self Assess

Each team/service should complete the self assessment for their service, which demonstrates compliance against the measures contained within the Manual for Cancer Services. A number of key themes have been identified which will assist teams/services to make a holistic assessment as to whether the service is meeting the measures. The key themes also provide a broad set of objectives for the delivery of a quality and safe service in relation to clinical outcomes and patient experience.

The lead clinician should complete a short self assessment report about their team/service based on the key themes. This report should reflect the level of compliance with the measures, their clinical outcomes and patient experience. This report will provide up to date information for commissioners, patients and the public.

Assessment against the measures and the supporting report should be uploaded on the CQuINS national database each year using the national report, supporting evidence need only be uploaded every other year (see section 11).

When supporting documentary evidence is required it is expected that a service will

make use of documentation and information that should already be in existence or collected for the effective functioning of that service.

The evidence guides cover the information requirements for the key documents that teams/services are required to submit as part of their self assessment every other year and also sets out how the key themes should be addressed in the self assessment report.

Appendix 3 provides further detailed information on the evidence that is required to be uploaded on the CQuINS database, what should be referenced in the IV report and what should be available at a peer review visit.

The Self Assessment Report

Shown below are the key themes for an MDT and an NSSG, together with guidance on the content of the commentary to be submitted. The requirements for other teams/services will be included within the appropriate evidence guide for that service.

Key Themes

The key themes are designed to provide a holistic assessment for a team's/service's performance against the measures in relation

to these issues. Briefly summarise areas of compliance. It is especially useful to concentrate on:

- Areas of non-compliance – giving the reasons and any plans or actions towards achieving compliance. For example where you do not have a particular core team member, indicate how you cover this role and plans to recruit this role;
- Any change in performance against the measures since the last assessment.

You should be commenting on the range of performance of the team/service against these issues.

MDT Key Themes

Structure and function of the service

This can be demonstrated through compliance to any measures that relate to MDT leadership, membership, attendance and meeting arrangements.

In addition, any measures within the operational policies section regarding patients which are reviewed by the MDT, percentage of time MDT core members devote to this cancer type, training requirements of

MDT members and responsibilities of nurse MDT members also help demonstrate this.

MDT workload data and surgical activity is also important here.

This section of the report requires specific answers to:

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

Coordination of care/ patient pathways

This can be demonstrated through compliance with any measures that relate to the existence of a coordinated and patient centred pathway of care. For example, any measures relating to agreement of network guidelines and patient pathways, recording of treatment planning decisions, key worker and principal clinician policies and communication with GPs.

Patient experience

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

- Enhanced recovery programmes,
- Communication, with and information for, patients and
- Other patient support initiatives and service

improvement initiatives such as process mapping and capacity and demand analysis.

Information from the National Cancer Patient Experience Survey should be included here. It is important to demonstrate any measurable change in performance regarding these parameters, compared to previous assessments.

The section of the report requires specific answers to:

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

Clinical outcomes/ indicators

Where available the data from the clinical indicators should be used. You should comment separately on each indicator. Where national clinical indicators for the team's cancer site have not yet been agreed for peer review please identify and comment on the top five clinical priority issues for your team.

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

Relevant measures include any relating to data collection, relevant network audits and research activity.

This section of the report requires specific answers to:

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

projects?

MDT Evidence Documents (only required every other year)

The Operational Policy

The operational policy should include the following:

- a description of how the team/service functions and how care is delivered across the patient's pathway;
- an outline of policies / procedures that govern safe / high quality care;
- agreement to, and demonstration, of the clinical guidelines and treatment protocols for the team/service.

Annual Report

The annual report should include the following:

- a summary assessment of achievements and challenges;
- the information (including data) that the team/service is using to assess its own service;
- MDT workload and activity data (activity by modality, surgical workload by surgeon, numbers discussed at MDT and MDT attendance by the core team); national audits, including information relating to the Clinical Lines of Enquiry/ outcomes; local audits; patient feedback; trial recruitment; work programme update;
- results from participation in network audits and research programmes;

Work Programme

The work programme should include the following:

- how the team/service is planning to address concerns and further develop its service,

including how any risks will be minimised;

- outline of the team's/service's plans for service improvement and development over the coming two year;
- audit programme, patient feedback, trial recruitment, actions from previous reviews.

Network Site Specific Group Key Themes

Structure and function of the service

This can be demonstrated through compliance to any measures that relate to NSSG membership, terms of reference and generic NSSG functions. It also includes any site specific network measures on the configuration of all that site's MDTs in the network and, where relevant, the relationship of MDTs and NSSGs with those in other networks forming site specific supranetwork arrangement.

In addition, there should be a particular focus in the report on progress towards implementing any IOG recommendations on network configuration issues.

Coordination of care/patient pathways

This can be demonstrated through compliance to any measures that relate to NSSG or site specific network measures involving guidelines and patient pathways across networks and supranetworks. This includes guidelines and pathways between the MDTs of the speciality under review and guidelines and pathways regarding shared care between these MDTs and other parts of the network infrastructure, such as children's, TYA and late effects MDTs, MDTs of the specialities, specialist palliative

care MDTs and 'cross cutting' groups. There may be information from related initiatives not covered by the measures. There should also be comments on the range of performance of the MDTs (with special focus on outliers).

Patient experience

This relates to the collection of information on and achievement of improvements to service delivery, patient experience and gaining feedback on patients' experience. It also includes information associated with enhanced recovery programmes, communication with and information for patients and other patient support initiatives and service improvement initiatives such as process mapping and capacity and demand analysis.

Information from the National Cancer Patient Experience Survey should be included here. It is important to demonstrate any measurable change in performance regarding these parameters, compared to previous assessments.

This section of the report requires specific answers to:

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

Clinical outcomes/indicators

The section should comment on the range of performance of the MDTs regarding their clinical indicators/clinical outcomes. There should be special focus on outliers in the network and the relative performance of the MDTs and the network in relation to the national range.

Results of network audit projects may also be relevant.

Where national clinical indicators for the team's cancer site have not yet been agreed for the peer review please comment on the outcomes of the top five clinical priority issues identified by the MDTs in the network, the MDTs' performance regarding these and the key metrics of major resection rates(where relevant); mortality within 30 days of treatment; recruitment to clinical trials and outcomes of key audit projects.

In addition this section also includes NSSG measures on clinical research, and the report should comment on the range of performances of the MDTs (with special focus on outliers), on this issue.

Network Site Specific Group - Evidence Documents (only required every other year)

Constitution

The constitution should include the following:

- the group's terms of reference including a description of how the group is constituted and how it functions;
- description of the processes with which the network group links to individual MDTs within the network;
- the current clinical and referral guidelines agreed by the group;
- the agreed structure and scope of the service delivered across the network.

Annual Report

The annual report should include the following:

- summary assessment of

- achievements and challenges;
- demonstration that the group is using available information (including data) to assess the network service;
- summary of patient feedback and audit data including that relating to the Clinical Lines of Enquiry/ outcomes;
- summary update on implementation of previous year's work programme

(including progress on implementing actions from previous reviews).

Work Programme

The work programme should include the following:

- how the group is planning to address concerns and further develop network services including how any risks will be

minimised;

- outline of the groups plans for network wide service improvement and development over the coming two year;
- how the group is addressing actions from previous peer reviews, where relevant.

3.3 Demonstration of Agreement

Where agreement for guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the relevant evidence documents, including agreement dates and versions.

The agreement by a person representing the group or team/service (chair or lead etc.) implies that their agreement is not personal; they are representing the consensus opinion of that group.

3.4 When will Teams/Services need to Self Assess?

The timetable for self assessment depends on which cycle a team/service falls into. A

team/service will be in one of the following cycles:

- **A team/service who are to self assess with no supporting documentary evidence.**

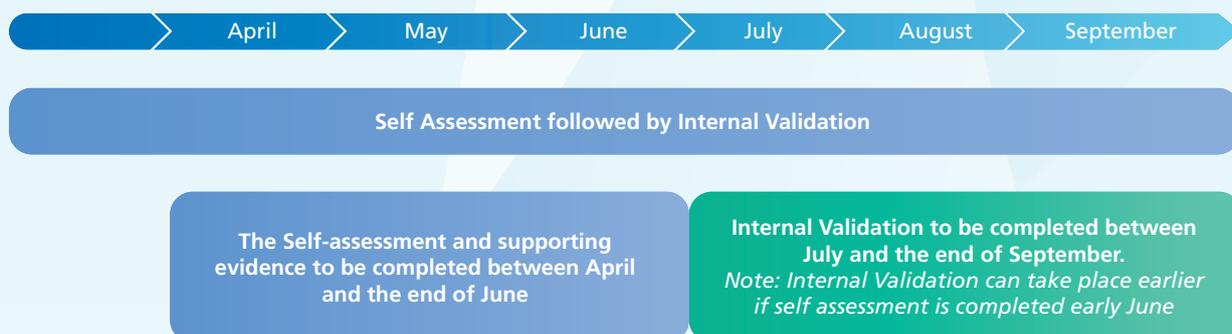
Teams/services that need to self assess should do so between April to the end of September.



The Self-assessment and commentary to be completed between April and the end of September.

- **A team/service who are to self assess and then be internally validated (This will be every other year)**
In order to stagger the workload for trusts and networks a team/service will be asked to complete self assessment by the end of June.

Appendix 4 shows which teams/services are to be internally validated in which year.



- **A team/service that is to self assess and then have a peer review visit**
The self assessment deadline is four weeks prior to the commencement of their network's first peer review visit. (This might require the self assessment to begin prior to April)

4. Internal Validation

4.1 Purpose of Internal Validation

The purpose of internal validation is;

- to ensure accountability for the self assessment within organisations and to provide a level of internal assurance;
- to develop a process whereby internal governance rather than external peer review is

the catalyst for change; that the organisation is using the self assessments for its own assurance purposes;

- to confirm that, to the best of the organisation's knowledge, the assessments are accurate and therefore fit for publication and sharing with stakeholders;

- to identify areas of good practice that could be shared.

4.2 What will be subject to Internal Validation

A team's/service's self assessment will need to be internally validated every other year. The schedule for which

year a team/service should be internally validated is shown in **appendix 4**. Teams/services who have undertaken a self

assessment in preparation for a peer review visit are not required to be internally validated.

4.3 Responsibility for Internal Validation

The responsibility for IV normally lies with the host organisation or network for that team/service. Details of who conducts the internal validation are not specified, but clearly a service could not validate its own self assessment.

Responsibility for internal validation for teams/services is set out in the relevant evidence guide and shown in **appendix 5**.

The NCPDR requires organisations to organise and coordinate their own system for internal

validation, culminating in a report that is an accurate assessment of the teams/services and is agreed at Chief Executive Officer (CEO) level.

4.4 Process for Internal Validation

The process adopted for internally validating self assessments can be determined locally, examples can be found at **appendix 6**. Those responsible for internal validation should ensure that whatever process is adopted meets the following requirements:

- the process is agreed within the organisation and is

integrated with other internal governance procedures and can demonstrate that a robust and fair process has been implemented;

- the process adopted has the agreement of the commissioners within the locality and the cancer network;
- accountability for the self assessments is confirmed by

agreement of the CEO of the organisation;

- there is commissioner and patient / carer involvement within the process;
- the process and outcome of the validation is reported on the nationally agreed report.

The internal validation process should include a review of the self assessment measures

compliance, self assessment report and the supporting documentary evidence. It would be considered good practice for a meeting to take place with representatives of the specific team/service in question. This allows those undertaking the internal validation and submitting teams/services to clarify any questions that may have arisen following a review of the information. It also gives the opportunity to ensure that all the information is available

to demonstrate that the teams/services are constituted and functioning properly.

At the conclusion of the internal validation the following action should be taken:

- check and record any changes to the compliance with any of the measures (this needs to be recorded on CQuINS);
- ensure that each section of the national report is completed and suitable for publication

i.e. not containing the names of individual's;

- feedback to the team/service;
- ensure that the final internal validation compliance and report has the agreement of the CEO;
- upload onto CQuINS by the end of September (see **appendix 4**).

4.5 Categorisation of Issues

The validation report asks for identification of concerns (See section 10 of this handbook) and good practice / significant

achievements (see **appendix 4**). Where there are immediate risks and serious concerns these must be addressed through the local

management and governance of the organisation.

4.6 When Internal validation will be undertaken

Teams/services who are to self assess should be internally validated every other year.

In order to stagger the workload for cancer managers

and network managers involved in the internal validation process a team/service will be required to complete their self assessment by the end of June. Internally validated self

assessments will need to be uploaded on to CQuINS by the end of September.

Appendix 4 shows the schedule for Internal Validation.



The Self-assessment and supporting evidence to be completed between April and the end of June

Internal Validation to be completed between July and the end of September.
Note: Internal Validation can take place earlier if self assessment is completed early June

5. External Verification

5.1 Purpose of External Verification

The purpose of external verification is to:

- verify that self assessments are accurate and have been completed in a similar manner across organisations;
- ensure that a robust process of

self assessment and internal validation has taken place;

- confirm self assessed performance against the measures and any associated issues relating to IOG implementation;

- support identification of teams or services that will receive an external peer review visit in accordance with the selection criteria (see section 7.1).

5.2 What is External Verification?

An external check of selected internally validated self assessments led by the zonal

coordinating teams. This check will take the form of a desktop exercise. This process will ensure

that every team/service will be externally verified at least once every five years.

5.3 Responsibility for External Verification

External verification will be led by the zonal coordinating teams. The zonal coordinating teams will also have access to

expert clinical advisors and user reviewers during this stage, whose role is to clarify or advise on any clinical or user issues

arising from the review of the internally validated self assessments.

5.4 Process for External Verification

Following the submission of the internally validated self assessments a process of external verification will take place for a sample of teams/services.

In addition to this a random selection of teams/services outside the nationally selected topics will also undergo an external verification process. Therefore in any given year, any service's internally validated self assessment could be selected for external verification.

The process of external verification will include the following steps:

- desk top review of internally validated self assessments using the evidence up loaded on CQuINS
- a request for further information if required
- obtaining advice from specialist clinicians or user reviewers where necessary

External verification reports will then be completed using the national report and agreed by the Quality Director and or Clinical Lead for the relevant zone.

Externally verified compliance against the measures will also

be recorded on CQuINS and any changes to compliance will be explained.

Organisations will have the opportunity to comment on the outcome of the external verification at this stage and any issues should be submitted in writing within two weeks, for consideration by the zonal coordinating team. In the event of a resolution not being reached at zonal level a peer review visit to the team / service should be considered in order to clarify the position.

5.5 When Does External Verification Take Place?

External verifications will take place between October and November each year.

The completed reports will be publicly available on CQuINS by the end of January each year.

5.6 Outcomes of External Verification

The actual percentage of compliance against the measures will not be stated on the EV report.

The EV compliance box on the report contains a traffic light system –Red, Amber and Green. The box will also have text which confirms if the IV is within an acceptable tolerance.

Green - Internal validation confirmed

Amber - Internal validation confirmed with exceptions

Red - Internal validation unconfirmed

There are three key triggers for identifying if an IV report is red, amber or green. These are:

A The identification of immediate risk(s) not identified and resolved on the IV report. If an immediate risk (IR) is identified as part of the EV process and this IR has not been identified and action planned to be resolved on the IV report, then the IV report should be reported as red -IV unconfirmed

B The identification of serious concern(s) not identified and resolved on the IV report. If a serious concern (SC) is

identified as part of the EV process and this SC has not been identified and action planned to resolved on the IV report, then the IV report should be reported no higher than IV confirmed with exceptions – Amber. However, if another trigger is identified at amber or red this will result in an IV unconfirmed – Red.

C The percentage difference in compliance between the IV and EV. This is based on the percentage number of differences between the IV and EV compliances. It should be noted that the threshold percentage will be reviewed annually.

The overall outcome of the EV report is then acquired using the three triggers. The principles for doing this are:

- Any trigger showing as **red** = An overall IV unconfirmed - **Red**
- Any trigger showing amber but no other trigger showing red or **amber** = An overall IV confirmed with exceptions - **Amber**
- Two or more triggers showing **Amber** = An overall IV unconfirmed - **Red**
- All triggers showing **green** = IV confirmed - **Green**

It should be noted that the overall outcome shown on the EV report is an automated process run through the CQuINS database. In exceptional cases the Quality Director within a Zonal Team may override this system. It is anticipated this will only occur where the number of measures under review is less than 10 and statistically the results of EV do not reflect the robustness of the IV process.

6. National Schedule for Peer Review Visits

Each cancer network has a fixed time when peer review visits will occur each year to enable networks to pre-plan for review visits and help the zonal coordinating teams plan their

annual work programme. Dialogue will occur between networks and the zonal team to agree the exact visiting dates within this allocated review period.

Month	South Zone	London Zone	Central Zone	North Zone
April				
May	KMCN	SWLCN	3CCN	LSCCN
June	DCN	ECN	ArCN	NTCN
July	TVCN	NWLCN		HYCCN
August				
September	ASWCN	MVCN	AngCN	GMCCN
October	SWSHCN	SELCN		
November	SCN	NELCN	PBCN	NECN
December				
January		NLCN & WECCN	EMCN	MCCN
February	CSCCN			
March	PCN		GMCN	YCN

Key to network abbreviations can be found at **appendix 2**.

7. Annual Meeting with Each Cancer Network

The zonal coordinating team will meet with each network management team annually in November/ December to discuss the visit programme for the following year.

It is expected that the zonal Clinical Lead, Quality Director and Quality Manager, network clinical director, network director and nurse director and a commissioning representative will attend.

The purpose of the meeting will be to;

- inform the zonal team of any key issues within the network such as implementation of Improving Outcomes Guidance
- provisionally agree the teams/services to be visited in the following year
- to confirm the configuration of teams/services within the cancer network with the zonal coordinating team

The zonal team will provide a list of those teams/services that have been identified as priorities for inclusion in the visit programme.

There will then be a process of negotiation between the zonal coordinating team, the network team and the national peer review team to agree the final programme. The process will include the opportunity for a network to request a visit for specific teams/services, in line with criteria three below.

Following the meeting the zonal team will formally notify the network of the agreed programme of visits.

7.1 Criteria for Selection of Visits

Prior to the network meeting and following the external verification exercise the zonal teams will notify the network which teams/services are identified using the following criteria as priorities for inclusion in the visit programme:-

1. Those teams/services which have not implemented the IOG action plan

Where appropriate progress has not been made against implementation of the NICE IOG plans, agreed by the National Cancer Action Team these services will be subject to a peer review visit. This will normally be in relation to configuration of specialist services.

2. Immediate risks identified and not resolved

Where an immediate risk has been identified in a previous IV, EV or peer review but has not been subsequently resolved then this team/service should be reviewed at the earliest possible date within the timetable for

the host Cancer Network. However, it should be noted that only in very exceptional circumstances should a service / team have a peer review visit in two consecutive years.

3. Request from organisations

Where a Specialist Commissioning Group, Strategic Health Authority, Cancer Network or the National Cancer Action Team request a peer review visit to a team/service this will be reviewed at the earliest possible date within the timetable for the host Cancer Network. Requests from trusts will be considered but in principle the trust should be able to implement its own internal review of the service.

4. Low performing teams

Teams/services with a level of compliance against the measures below an agreed threshold percentage will be selected for a peer review visit. The threshold for the level of compliance will be calculated

for each tumour type and automatically generated from the CQuINS database. The threshold level will identify the lowest performing teams/services in that particular topic.

5. Concerns regarding the robustness of the internal validation (IV) process

The EV reports will indicate if the IV is within tolerance. If an IV has an EV report which is indicated a red - IV unconfirmed then the team/service will normally be subject to a peer review visit. Teams indicated amber may also be considered for a visit.

6. Percentage of a stratified random sample

One of the underlining principles for a stratified random sample is to include a number of high performing teams to facilitate the sharing of good practice. Where a Zonal team has capacity, they may select a high performing team /service for review in order to

share good practice.

7. Revisits

Where a team has performed badly on a peer review visit the team should have their next self assessment externally validated by the Zonal Team. If insufficient progress has been made at that stage then a revisit should be planned for the following peer review cycle.

It should be noted that only in very exceptional circumstances should a team/service have a peer visit in two consecutive years. It is felt that a second peer review visit would not allow teams/services sufficient time to make improvements prior to the visit.

8. Peer Review Visit

8.1 What is a peer review visit?

The purpose of the peer review visit is to provide an opportunity for a team of peers to meet with members of the service being reviewed. The peer review visit will allow discussion and questioning with the aim of

determining compliance against the quality measures, and identifying a broader set of issues concerned with the delivery of a quality and safe service in relation to patient experience and clinical

outcomes. In addition the visit will provide a further external check on the robustness of internal quality assurance processes.

8.2 Who is responsible for peer review?

The zonal coordinating team invites nominations of reviewers from the cancer networks. Cancer networks and service providers have a responsibility to nominate an appropriate number of reviewers against the person specification (see **appendix 7**).

These nominees are trained and reviewers' names are listed on the reviewer database. The zonal coordinating team selects an appropriate review team

from this list. Visiting teams will be made up of a multi-disciplinary group of clinicians, managers and patient/carers, 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.

Reviewers have a collective responsibility for gathering,

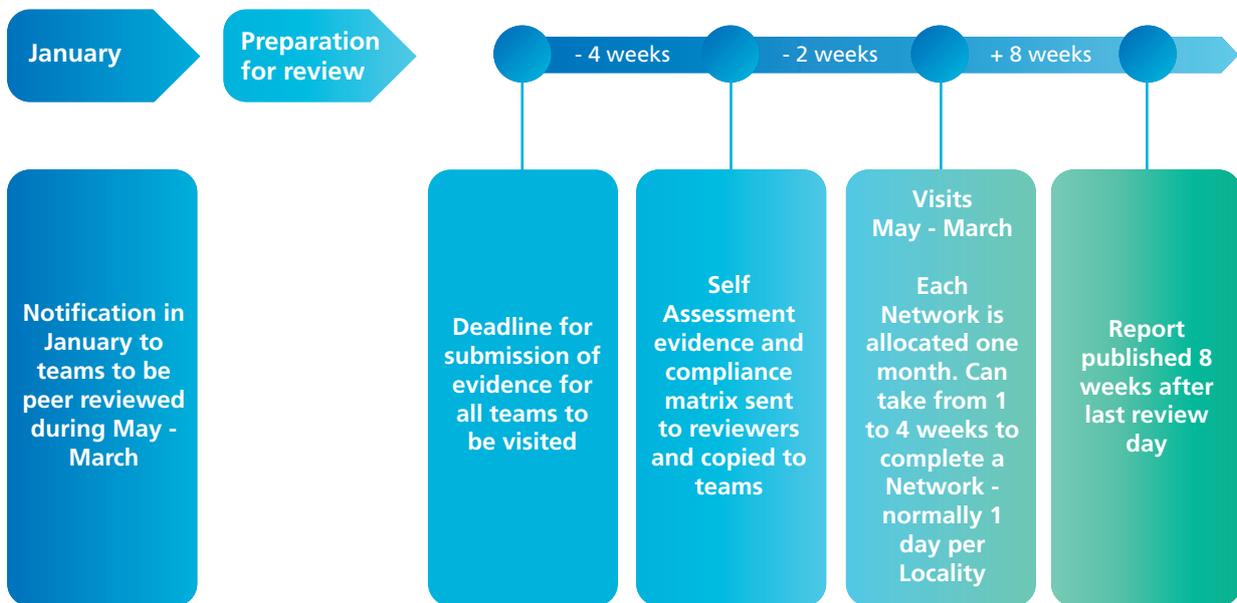
verifying and sharing information that enables them to reach robust conclusions about compliance with the national measures and about the quality of cancer services. While undertaking a review, reviewers are acting on behalf of the NCPR Programme and are not expected to pursue any individual or organisational interests.

8.3 The Peer Review Visit Process

8.3.1 Notification of visits

Teams/services, if selected for a visit during the following financial year, will be notified of the dates for that visit in January. The list of

teams/services to be visited will be available on the CQuINS web-site. The following diagram illustrates the different stages of the visit process.



8.3.2 Deadline for submission of self assessments

The deadline for the submission of self assessment and supporting evidence is **four weeks** prior to the commencement of the network

peer review visit. The success of the visit will be dependent on the ability of teams/services to meet this deadline.

8.3.3 Information Available for Reviewers

Four weeks before their visit, visiting teams will be able to access via the CQuINS web-site or the Visits Information Management System to obtain the following information:

Self Assessment Documentation

- Compliance against the measures
- Self assessment report
- Supporting evidence

At the visit reviewers will need access to one hard copy of the self assessment documentation provided by the service under review.

In addition the review teams will receive:

Logistical Information

- Directions, emergency contact number;

- membership of the visiting team;
- timetable;
- access to CQuINS or the Visit Information and Management System – to allow review of any evidence and relevant reports;
- travel expenses form;

Contextual Information

The peer review visit team will be provided with appropriate contextual information which will include:

- A general description of the organisation and its cancer services
- Any issues relating to the configuration of services or patient pathways that are outside the relevant Improving Outcomes Guidance

- Items from previous peer review visit or assessment reports of relevance to the visit
- Outcomes of the National Cancer Patient Experience Survey Programme
- Data and interpretation guidance relating to clinical indicators
- Any other key intelligence obtained from other sources such as clinical governance, audit or Care Quality Commission reports.

It is intended that information contained within the reviewers briefing packs or available at the visits will assist the review teams to conduct the review efficiently and effectively.

8.3.4 Visit

The visit itself will be designed around a sessional structure with the norm being a one day visit to each locality/trust within a cancer network and a one day visit to the network teams. In general visits will be timetabled to run reviews of up to three individual teams/services concurrently in both the morning and afternoon. The majority of sessions will mirror the example below, though it is likely that some reviews such as chemotherapy and radiotherapy may take longer.

Activity	Approx. Time
Review team to review evidence in preparation for meeting	1.5 hours
Meeting with the service	1.5 hours
Review team to write report	1.5 hours

MDT review module - 4.5 hrs

The visits to the trusts will take place before the visit to the network teams and normally the peer review visit across any given network will be completed within a period of four weeks.

8.3.5 Preparation of visit reports

The draft reports will be written by the reviewers and signed off by the zonal quality director and or clinical lead. The cancer network and its trusts will be given the opportunity to comment on the factual accuracy of the report before it is made available on the CQuINS web-site.

Any comments relating to the draft report should be submitted in writing to the

zonal team within two weeks of receipt of the draft. Any queries will be resolved locally with the zonal team in the first instance. Any unresolved queries should be referred by the zonal team to the national coordinating team.

The circumstances where an appeal against the contents of a report will be considered are where reviewers have concluded that a team/service gives cause for serious concern /immediate

risk or the reviewers have concluded that the team/service'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.

The appeals and complaint policy is shown in **appendix 8**.

9. Outcomes of the Peer Review Process

As a principle it should be recognised that the implementation and follow up

of actions resulting from the peer review process is primarily a function of trust and network

clinical corporate governance systems, and not a function of peer review.

9.1 Following Self Assessment

Following self assessment a completed report agreed by the lead clinician of the service will

be available on the CQuINS web-site by the end of September each year. This will

provide up to date information for commissioners, patients and the public.

9.2 Following Internal Validation

Following internal validation a completed report agreed by the host CEO will be available on

the CQuINS web-site by the end of September each year. This will provide feedback to the

teams/services and will confirm the level of compliance with the measures.

9.3 Following External Verification

Following external verification a completed report agreed by the zonal Quality Director and/or Clinical Lead will be available on the CQuINS web-site by the end

of January each year. This will provide external feedback to the teams/services, will confirm the level of compliance with the measures and will inform the

development of the following year's visit programme.

9.4 Following Peer Review Visit

Following a peer review visit an individual report for each team/service, prepared by the visiting review team, will be available on the CQuINS web-site eight weeks after the completion of the visit to the network. This will provide external feedback to the teams/services, will confirm the level of compliance with the

measures, and comment on a broader set of issues concerned with the delivery of a quality and safe service in relation to patient experience and clinical outcomes.

Following the publication of any of the above on the CQuINS web-site the cancer network and its constituent organisations

should agree the actions that need to be taken within agreed timescales, building on the strengths identified and addressing any aspects in need of improvement. Actions should be included in strategic development plans and the relevant team's/service's work programme.

9.5 Annual Cancer Peer Review Reports

9.5.1 Cancer Network Reports

Following the completion of every peer review cycle, the zonal team will write an overarching report for each Network compiled using information from each stage of the peer review process. These

reports will include an executive summary prepared by the Quality Director for each Zone. The reports will appear on the CQuINS web-site.

9.5.2 National Peer Review Report

Following the completion of every peer review cycle the National Programme Director will produce a national report which will include an overall analysis from all the published reports, including a focus on individual tumour sites and cross cutting services. The reports will appear on the CQuINS web-site.

dissemination and recommendation is an important component of the review process and therefore will be reflected in both of the above reports.

The following will be notified that the reports are available on the CQuINS web-site:

specialised commissioning groups, National Coordinating Team, Care Quality Commission, National Cancer Director – In future the NHS commissioning board and GP consortia will be notified of reports.

The identification of good practice/significant achievements for later

CEOs of trusts, network board chairs, commissioners, strategic health authority cancer lead(s),

9.6 Joint Working between the Care Quality Commission (CQC) and the NCPR Programme

The CQC and the NCPR are collaborating to promote the delivery of high quality care in England specifically in relation to the delivery and quality assurance of cancer services.

The outcomes of this work to date are set out below:

- The measures within the Manual for Cancer Services have been mapped to CQC registration outcomes. Cancer Peer Review outcomes data is fed into the CQC Quality and Risk Profiles (QRPs);
- Immediate risks and serious concerns are reported to CQC;
- Names of the MDTs with poor performance are shared with CQC;
- Partnership working with CQC visits in relation to cancer services.

The details of the work with CQC is shown in **appendix 9**.

10. Identification of Concerns

Reviewing cancer teams/services either during self assessment and validation or as part of external verification or a planned visit may identify concerns. There will be occasions when these concerns are more serious and pose an immediate risk to patient safety or clinical outcome. The following guidelines provide a framework for organisations involved in validating self-assessments and for members of review visit teams to identify and manage the different levels of concern.

Within the peer review process there are three categories of concern, all require action to be taken, however timescales and management will vary.

Immediate Risk

An "Immediate Risk" is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

Serious Concern

A "Serious Concern" is an issue

that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

Concern

A Concern is an issue that is affecting the delivery or quality of the service that does not require immediate action but can be addressed through the work programmes of the teams/services.

10.1 Management of Immediate Risks and Serious Concerns

Immediate Risks and Serious Concerns Identified at internal validation or self assessment

If identified through the self assessment or internal validation it is expected that these will be addressed through the organisation's risk management process and details of actions included on the Validation Report.

Immediate Risks and Serious Concerns Identified at External Verification

Immediate risks and serious concerns found at external verification are identified by members of the zonal team based on written evidence, not by peer reviewers that have had the benefit of meeting the team being reviewed. Therefore these can only be considered to be 'potential' immediate risks and serious concerns, and require further consideration.

- Potential immediate risks and

serious concerns identified during the external verification process are raised at the time by the zonal team with the organisation's cancer manager (or equivalent) to establish the details of the situation.

- If the concern is felt to be valid by the zonal team this is included in the EV report for the service/NSSG.
- On publication of EV reports, the quality director emails the network and the cancer manager (or equivalent) of the trust and ask them to review the potential immediate risks and serious concerns and to provide the zonal quality director with a brief report.
- Where the response is adequate, this is included in the overall network reports. Inadequate responses should be followed up by the cancer network and the team considered for a full peer review visit.

Immediate Risks and Serious Concerns Identified at Peer Review Visit

- Zonal team notify the organisation on the day of the review.
- Quality Director emails a formal letter to organisation's CEO or, where the organisation is a cancer network, the Network Director within 5 working days of the visit and copies in:
 - SHA Cancer Lead
 - National Programme Director for peer review
 - CEO of commissioning organisation or host PCT
 - Network Director, or where the organisation being reviewed is a cancer network, the Chair of the Network.
- For immediate risks the formal response from the organisation is required within 10 working days of the email to Trust CEO or Network

Director; for serious concerns the response is required within five working days.

- There may be occasions when the action required to fully address the problem cannot be achieved immediately, however it is expected that interim actions be taken to reduce risk and for the organisation to submit a credible action plan with milestone dates.
- Where the response from the Trust is deemed to adequately address the immediate risk or serious concern by the

quality director (in consultation with the review team if appropriate), the quality director emails that the response is satisfactory to the Trust CEO or network director, copying in as for formal letter (above)

- Where no response is received, or the response is deemed inadequate to address the immediate risk or serious concern, after five working days for an immediate risk or ten working days for a serious concern, this will be followed up by the quality director.

- Where the quality director continues to receive what they consider to be an inadequate response from the trust or network, they will escalate the matter to the CEO of the PCT or appropriate Specialist Commissioner, the SHA, and the Programme Director for Cancer Peer Review and the Care Quality Commission. Such Teams/NSSGs will also be considered for a repeat visit in next cycle of peer review.

10.2 Use of Risk Assessment Matrix

In some cases it will be clear which of the categories should be assigned, however there will be issues in which individual circumstances may vary significantly and would need to be taken into account when assessing the risk.

In assessing the risk it is important to identify the actual risk. For example "*Low numbers*

of neck dissections are being undertaken by surgeons" is a risk to patient safety due to inability to maintain adequate competence. Further questions should then be asked to determine the impact of the risk, the likelihood of this happening and whether any action has been taken to remedy or ameliorate the situation.

Having determined the exact nature of the risk it is recommended that a risk scoring matrix is used to identify the appropriate category as shown below.

Likelihood		Consequence				
		Insignificant	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	7	10
Possible	3	3	6	9	12	16
Likely	4	4	7	12	16	20
Almost certain	5	5	10	15	20	25

 Concern

 Serious Concern

 Immediate Risk

Consequence descriptor

Insignificant	Minor	Moderate	Major	Catastrophic
Reduced quality of patient care	Unsatisfactory quality of care	Mismanagement of patient care	Minor injury to patient or staff	Fatal/Major injury to patient or staff

For the purpose of The National Cancer Peer Review these guidelines have focussed on Safety and Quality of patient care.

11. Use of Cancer Quality Improvement Network System (CQuINS)

11.1 What is CQuINS?

CQuINS is a secure web-based database that supports each stage of the cancer peer review process. It provides the functionality for system users to attach documents to their records to support the evidence that their organisations comply with the measures. It allows trusts and networks to have an

interactive tool to manage quality and improvements; it allows assessments and supporting evidence to be kept together; it provides those validating and verifying evidence access to the evidence on-line; it encourages the transfer of good practice between organisations by

providing the potential for other users to access documents for use in their own organisations; it provides information for national analysis and reporting; it provides information to NHS choices, the Care Quality Commission and the Cancer Commissioning Toolkit.

11.2 Principles for Uploading Documents as Evidence

A self-assessment can only be completed if the self assessment report is completed and support evidence documents (for teams being Internally Validated) required for the topic area being self-assessed has been uploaded to the CQuINS database. For details of evidence see **appendix 3**. Failure to supply this information on CQuINS in accordance to the national schedule (on CQuINS) may trigger a peer review visit.

For teams/services self assessing on the annual cycle, once a self-assessment has been internally validated then the assessment and evidence documentation cannot be changed. The external verification by the zonal teams will be undertaken using this evidence.

For teams/services that are identified for a peer review visit, final evidence should be uploaded on to CQuINS four weeks before the visit.

No uploaded documents should contain patient identifiable information. In addition, organisations should not upload any documents that have patient identifiable data that has been anonymised by using a marker pen or any other correction type substances, as this is often visible once scanned.

The preferred format for uploaded documents is pdf (Portable Document Format). This will enable maximum functionality of the CQuINS database.

Scanned documents should not be uploaded (see note above in bold).

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

- a. Most documents should not be more than 1Mb in size

though it is recognised that on some occasions it will be appropriate to upload larger documents.

- b. Documents of more than 4Mb should not be uploaded except in very exceptional circumstances.
- c. Should a scanned document need to be uploaded it should be saved in Jpeg (.jpg) format at 70% quality. A scanned sheet of A4 will generally occupy no more than 500Kb while remaining perfectly legible.

The address for the CQuINS web-site is www.cquins.nhs.uk and this will provide open access to the public web-site.

The CQuINS database is on the closed section of the web-site and can be accessed via the above web address by registered users only.

Appendix 1

Cancer Peer Review Programme Zonal Advisory Group

Purpose

The overall purpose of the Zonal Advisory Group is to ensure consistent implementation of the quality assurance of cancer services, by engaging local stakeholders in the operational and strategic development of the Cancer Peer Review Programme.

Key Principles

1. Communication & Information Sharing

- Establish and maintain effective communication with local stakeholders in the zone.
- Facilitate two-way dissemination of information and communication ensuring the National Executive Group and Clinical Outcomes Group receive feedback on the views of the zone.
- Support collaborative working and share learning, experience and good practice / significant achievements across all agencies within the zone.

2. Operational and Strategic Development & Implementation of Peer Review

- Support networks in the implementation of the National Cancer Peer Review Programme.

- Maintain an overview of key operational and strategic themes and issues arising from the peer review programme.
- Evaluate and provide feedback on the National Cancer Peer Review Programme within the zone and identify areas for improvement.

3. Quality Assurance

- Ensure consistency of implementation of the manual for cancer services and peer review programme and identify interpretation issues, seeking advice from the National Coordinating Team.
- Facilitate the integration of the manual for cancer services and peer review into organisations' corporate and clinical governance systems.

Membership

Core members of the Zonal Advisory Group are:

- SHA Cancer lead
- Acute trust cancer lead / clinical lead representation
- PCT / commissioning representation
- Director / medical director representative
- Specialist commissioning group representative

- Zonal peer review coordinating team.
- Two patient/carer representatives – one of whom should be a member of the National User Steering Group

There is a standing invitation to representatives of the following organisations;

- Care Quality Commission
- Quality Assurance Reference Centres for Screening
- Cancer Registries

Frequency of Meetings

The group shall meet at three times a year

Reporting arrangements

The group should report to the National Executive Group.

Review

These terms of reference will be reviewed annually by the National Steering Group.

Appendix 2

Management Structure for Peer Review Programme

Zone	SHA	Cancer Network	Network Abbreviation
North	Yorkshire and the Humber	Humber and Yorkshire Coast	HYCCN
	Yorkshire and the Humber	North Trent	NTCN
	Yorkshire and the Humber	Yorkshire	YCN
	North East	North of England	NECN
	North West	Merseyside and Cheshire	MCCN
	North West	Greater Manchester and Cheshire	GMCCN
	North West	Lancashire and South Cumbria	LSCCN
Central	West Midlands	Greater Midlands	GMCN
	West Midlands	Arden	ArCN
	West Midlands	Pan Birmingham	PBCN
	West Midlands	Three Counties	3CCN
	East of England	Anglia	AngCN
	East Midlands	East Midlands	EMCN
London	London	North East London	NELCN
	London	North Central London & West Essex Cancer Commissioning Network	NLCN & WECCN
	London	West London	NWLCN
	London	South East London	SELCN
	London	South West London	SWLCN
	East of England	Essex	ECN
	East of England	Mount Vernon	MVCN
South	South West	Peninsula	PCN
	South West	Dorset	DCN
	South West	Avon, Somerset and Wiltshire	ASWCN
	South East Coast	Kent and Medway	KMCN
	South East Coast	Surrey, West Sussex & Hampshire	SWSHCN
	South Central	Thames Valley	TVCN
	South Central	Central South Coast	CSCCN
	South East Coast	Sussex	SCN

Appendix 3

Evidence Requirements for Self-Assessment, Internal Validation and Peer Review Visits

A key part of the Peer Review Programme is the evidence that teams/services upload to support their self-assessment and Internal Validation (IV). This document is intended to make explicit what evidence is required to be uploaded on the CQuINS database, what should be referenced in the IV report and what should be available at a peer review visit.

This guide is intended to give the general philosophy of the evidence requirements and should be useful to IV panels and cancer managers. It should be used in conjunction with the requirements identified in the cancer measures and the specific evidence guides which have been produced to provide support for individual teams/services.

General Principles

Set out below are some general principles in relation to evidence requirements. These general principles should be considered when developing evidence for the National Cancer Peer Review Programme. In line with the Improving Outcomes Strategy peer review should where possible reduce the burden of inspection and this guide is intended to identify the evidence that is not required along with that which is required.

Self Assessment

A fundamental part of the self assessment is completing the

assessment against the measures within the manual for cancer services. All teams/services should ensure they have indicated if they are compliant or not with each measure. Confirmation of compliance against a particular measure should ensure all the requirements of the measure have been met.

Once the compliance is established, teams/services should ensure the evidence requirement stated for each measure is included either in one of the key documents i.e. operational policy, annual report, work programme or if not in one of these key documents it should be included as an appendix. If the actual evidence is not included in the upload documents on CQuINS then the team should include a statement which makes clear this evidence requirement has been checked by the team/service and would be available if a peer review team were to visit.

The use of internet hyper links

It is acceptable for teams/services to include internet hyperlinks but these links must have open access and not be on the closed section of the trust or organisation intranet system. An example of this would be in the operational policy, where hyperlinks are given for the clinical guidelines. If a PDF document is used, the hyperlinks may not function and

hyperlinks should then be included in the assessment spreadsheet on the CQuINS database.

Evidence for Internal Validation

The IV process is an internal quality assurance process and as such it should ensure all the evidence required against the measures for teams/services has been checked and is available on the CQuINS database via the key documents. If any evidence is not available on the CQuINS system, the internal validation panel should confirm they have seen the evidence or give details of the spot checks they have undertaken. This should be made clear on the internal validation report form. It is not sufficient to give an overall statement that all evidence has been seen. Details of the specific evidence seen against measures should be identified and noted on the compliance spreadsheet.

Evidence on a Peer Review visit

A full copy of all evidence uploaded onto CQuINS must be available to reviewers on the peer review visit. This can be either hard copy or electronic. If the evidence is only available electronically the host organisation must ensure the peer reviewers have appropriate access to electronic evidence in the location the review is taking place. This evidence should be available for each individual review team.

Patient Records

Peer Review zonal teams will normally request 5 sets of patient notes in order to check compliance against the measures. Teams may sometimes require more than 5 set of patient notes but this should never exceed 10. Only clinical NHS staff will review patient notes.

Personal details / Patient information

It is essential that no identifiable patient data including hospital number should be uploaded on the CQuINS database. Particular care should be taken when documents are scanned. When scanning, a computer may pick up details that cannot be seen on the hard copy, for example when using a black marker pen to anonymise treatment records. Copies of patient letters should not be uploaded on the CQuINS database. It is sufficient to make a statement with regard to how patients receive a permanent record of a consultation or show a template without patient details.

The personal details of individual staff in a team/service should not be uploaded e.g. certificates or job plans. Identification of individuals should not be made on reports uploaded onto CQuINS. Reports should refer to the roles they carry out. It should be noted that the reports will be in the public domain when network reports are published in June each year. The host organisation should ensure reports are suitable for publication.

Agreements

The role of the person indicated on the agreement should include any delegated role they are undertaking for others. The front cover of any document uploaded should show the date, version and planned review date.

Configuration of the Network

The configuration of the network is essential to the review of a particular tumour site and ensuring compliance against the Improving Outcomes Guidance. Details of PCT referral pathway and populations are essential.

Membership

When a measure asks for the membership of a group then the name, role and organisation the individual represents should be indicated on the evidence. The role indicated should be specific, or example being clear if they are medical or clinical oncologist. Information should also be clear as to whether they are a core, extended or cover member of a team. Where a particular member is not in place, then the mechanism used to ensure a role's particular input should be clearly indicated in the evidence, for example where it has not been possible to recruit a user representative it should be made explicit in the evidence the mechanism used to obtain user input.

Qualifications / Certificates / Job plans

Qualifications, certificates and job plans should not be uploaded on the CQuINS database. The name or unit to

whom it applies along with the name of the qualification/certificate, date and provider should be included in the evidence. In the case of job plans, a statement should be made in the key document to confirm that a particular requirement is contained in a job plan and this has been checked the IV or peer review team. This should clearly indicate the name of the person the job plan is for and the name of the organisation who has issued it. If details of qualification, certificates and job plans are shown clearly in the key documentation it is not necessary to see them on the peer review visit or as part of the IV process. Only if details are unclear to either the IV or peer review team will it be necessary to see qualification, certificates and job plans for IV and peer review.

Patient Information

While it is not necessary to upload patient information onto the CQuINS database it is however necessary for this to be seen by the IV panel and peer review team. This should ensure that any national or regional materials used are supported or include appropriate local information for patients.

The IV report should confirm that the patient information has been seen and that it covers all the essential elements of the measure. At self assessment the teams/services should list the patient information they have in the key documents uploaded on CQuINS.

Patient Experience Exercise

A summary of the exercise including the key points and action implemented is sufficient in the key documents for self assessment. However, for both peer review and IV a copy of the patient exercise should be seen. IV assessment should confirm this has been seen. The national cancer patient survey would be acceptable for this measure.

Key Worker

The key documents should confirm that details of the key worker including contact number are given to each patient. IV should confirm the details of the key worker can be found in patient notes by completing a spot check. Peer review teams will spot check patient notes.

Specific Evidence Requirements

Working practice of a team/Spot checks

Where measures ask for reviewers to ask about working practice of teams/services or to undertake spot checks, they will do this when on a review. IV should mirror this and include comments in the IV report. For self assessment teams/services should state that they have completed a spot check and the results of the spot check or give details of the working practice.

Annual Meetings

It is only necessary to make a statement in the key documents to confirm the time/date of the meeting and that a record has been made. IV should confirm this meeting has taken place. If it is unclear that a meeting has

taken place reviewers on a peer review visit may ask for minutes of the meeting.

Attendance records/ Meeting dates

Records of attendance and meeting dates are required against a number of measures. This can often be satisfied by one clear piece of evidence showing:

- dates of the meetings
- name, role and organisation represented of those who have attended each meeting

The IV report form should comment about any roles not covered or attending appropriately. Any summaries of attendance should demonstrate individual attendance at each meeting for all members as well as the summary.

Policies /Guidelines/Plans

The date and version should be shown on all policies/guidelines and plans. These should be uploaded on CQuINS either as an internet hyperlink (see above) within the key documents or in the appendix. National guidelines have been adopted the local context should be explained. Flow charts are an acceptable means to explain details within guidelines. If it is unclear that a meeting has taken place to sign off the guidelines/policies and plans reviewers on a peer review visit may ask for minutes of the meeting.

Network-wide Minimum Dataset

It should be clearly shown what is collected and who is reporting on which parts of the dataset.

This should include data collection for national audits where they exist.

Audit

Audits should be clinical rather than performance i.e. not two week waits. National audits are acceptable as a network audit but outcomes against a national audit should still be demonstrated. Dates of the meetings where audits have been presented must be clearly shown in the key documents as should any outcomes.

Clinical Trials

Lists of trials should show which MDTs are expected to participate in which trials. The actions should indicate how recruitment will be improved not restate the problem.

Distribution lists

A list of who is on the distribution list is sufficient for self assessment. It is not necessary to see proof of distribution but a team should confirm if they have distributed a document or policy. It is not practical to be explicit about the evidence required for every measure but it is hoped this paper sets out the broad principles and give specific examples which can be applied to most of the measures. If you are unsure as to what evidence is required for self assessment or IV then please do ask for advice from either one of cancer peer review zonal team and the national coordinating team.

Appendix 4 - Internal Validation Schedule

Internal Validation Schedule

The following table indicates the timetable of topics for which the teams will be required to upload evidence to support their self assessment and where an Internal Validation report is to be completed.

From 2013/14 the schedule will repeat with teams allocated an even or an odd year.

All teams not in the IV cycle for that year are required to complete the self- assessment matrix and commentary on the key questions.

2011/12 (Introduction Year)	2012/13 (Even Years)	2013/14 (Odd Years)
Acute Oncology	Breast	Gynaecology
Chemotherapy	Lung	Urology
Teenage and Young Adults	Colorectal	Haematology
Sarcoma	Upper Gastro-intestinal	Sarcoma
Brain and CNS	Head and Neck	Brain and CNS
Gynaecology	Radiotherapy	Skin
Urology	Specialist Palliative Care	Acute Oncology
Network Service User Partnership Group	Rehabilitation	Chemotherapy
	Complementary Therapy	Cancer of Unknown Primary
	Psychology	Children's
	Cancer Research Network	Teenagers and Young Adults
		Network Service User Partnership Group

Appendix 5

Responsibility for Internal Validation

Topic/Section	Responsibility for Internal Validation
11-1A-2b - Breast Network 11-1C-1b - Breast NSSG	Host Network Management Team
11-1A-2c - Lung Network 11-1C-1c - Lung NSSG	Host Network Management Team
11-1A-2d - Net Board - Colorectal 11-1C-1d - Colorectal NSSG	Host Network Management Team
11-1A-2e - Gynae Network 11-1C-1e - Gynae NSSG	Host Network Management Team
11-1A-2f - Upper GI Network 11-1C-1f - Upper GI NSSG	Host Network Management Team
11-1A-2g - Urology Network 11-1C-1g - Urology NSSG	Host Network Management Team
11-1A-2i - Net Board Head Neck 11-1C-1i - Head Neck NSSG 11-1C-2i - Thyroid NSSG	Host Network Management Team
11-1A-2j - Skin Network 11-1C-1j - Skin NSSG	Host Network Management Team
11-1A-2k - Net Board Brain & CNS 11-1C-1k - Brain & CNS NSSG	Host Network Management Team
11-1A-2l - Net Board Sarcoma 11-1C-1l - Sarcoma NSSG	Host Network Management Team
11-1A-3s - Net Board Chemotherapy 11-1E-3s - Chemotherapy Group	Host Network Management Team
11-1A-3t - Net Board - Rad 11-1E-1t - Net Rad Group	Host Network Management Team
11-1A-1u - Net Board Partnership Group 11-1E-1u - Partnership Group	Host Network Management Team
11-1A-3v - REHAB Net Board 11-1E-1v - REHAB Net Group	Host Network Management Team
11-1A-3w - Comp Therapy	Host Network Management Team
11-1A-3x - Net Board Psychological Support 11-1E-1x - Psychological Support Group	Host Network Management Team
11-1A-3y - Net Board Acute Oncology 11-1C-1y - Acute Oncology Group	Host Network Management Team
11-1A-5 - Net Measures - Research 11-5A-1 - Net Functions - Research	Host Network Management Team Host Network Management Team
11-7A-1 - CCNCG	Network Management Team which hosts PTC
11-7A-2 - TYA Coordinating Group	Network Management Team which hosts PTC
11-2B-1 - Breast MDT	Host Trust

11-2C-1 - Lung MDT	Host Trust
11-1D-1d - Colorectal Locality Group	Host Trust
11-2D-1 - Colorectal MDT	Host Trust
11-2D-2 - Stand Alone Liver Resection MDT	Host Trust
11-1D-1e - Gynae Locality Function	Host Trust
11-2E-1 - Local Gynae MDT	Host Trust
11-2E-2 - Spec. Gynae MDT	Host Trust
11-2F-1 - Local Upper GI MDT	Host Trust
11-2F-2 - Spec. Upper GI MDT	Host Trust
11-2F-3 - Spec. Pancreatic	Host Trust
11-2F-4 - Pancreatic / Liver	
11-2G-1 - Local Urology MDT	Host Trust
11-2G-2 - Spec. Urology MDT	Host Trust
11-2G-3 - Testicular MDT	Host Trust
11-2G-4 - Penile MDT	Host Trust
11-2I-1 - UAT & UAT/THYROID	Host Trust
11-2I-2 - THYROID ONLY MDT	Host Trust
11-1D-1j - Skin Locality Measures	Host Trust
11-2J-1 - Local Skin MDT	Host Trust
11-2J-2 - Spec Skin MDT	Host Trust
11-2J-3 - Melanoma MDT	Host Trust
11-2J-4 - Supra T-Cell Lymph	Host Trust
11-1D-1k - Brain & CNS Locality/ Trust	Host Trust
11-2K-1 - Neuroscience MDT	Host Trust
11-2K-2 - Cancer Network Brain & CNS MDT	Host Trust
11-1D-1l - Sarcoma Locality/ Trust	Host Trust
11-2L-1 - Sarcoma MDT	Host Trust
11-3S-1 - Chemotherapy Service	Host Trust
11-3S-2 - Pharmacy	Host Trust
11-3S-3 - Intrathecal Chemotherapy Service	Host Trust
11-3T-1 - Radiotherapy Generic	Host Trust
11-3T-2 - Radiotherapy External Beam	Host Trust
11-3T-3 - Radiotherapy IMRT	Host Trust
11-3T-4 - Brachytherapy	Host Trust
11-1D-1w - Locality Comp Therapy	Host Trust
11-3Y-1 - AOT General Hospital Measures	Host Trust
11-3Y-2 - Specialist Hospital AO Measures	Host Trust
11-3Y-3 - General AO Measures	Host Trust

11-3Y-4 - AO Input Assessment	Host Trust
11-7B-1 - Core PTC	Host Trust
11-7B-2 - Late Effects PTC	Host Trust
11-7B-3 - Diagnostic & Treatment PTC	Host Trust
11-7B-4 - Diagnostic & Treatment PTC	Host Trust
11-7B-5 - Diagnostic & Treatment PTC	Host Trust
11-7C-1 - Level 1 Core POSCU	Host Trust
11-7C-4 - POSCU MDT	Host Trust
11-7D-1 - TYA PTC	Host Trust
11-7D-2 - TYA MDT	Host Trust
11-1D-1z - Designated TYA Hospital	Host Trust
11-1D-1i - Head Neck Locality Group	Host Trust
11-6A-1s - Chemo measures for PCTs	Host organisation
11-6A-2 - Chemotherapy PCT	Host organisation
11-8A-1 - CCN Commissioning Function	SCG

Appendix 6

Approaches to Internal Validation

During the consultation exercise in the summer of 2007, several organisations piloted the new approach to internal validation. What became apparent was that organisations may wish to approach the process differently and this is acceptable providing the guiding principles remain:

- Maintenance of local ownership.
- Development of a process whereby internal governance rather than external peer review is the catalyst for change.
- Robustness and rigor in the process for determining the compliance with the measures. An audit trail will need to be evident rather than assumptions being made because the panel has local knowledge of the team's/service's workings.
- The process allows for the identification of any associated issues that are not directly covered by the measures but are closely related or precursors of their achievement.
- Encouragement of development and learning.
- Identification of areas of good practice / significant achievements that could be shared.
- Feedback is given to the teams/services and the report is agreed prior to submission on CQuINS.

1. 'Desk-Top Review'

One approach to internal validation is for a small panel to undertake a desk-top review of a team's/service's self-assessment. This approach offers advantages in that it is less time-consuming and does not need face to face input from MDT members. However, the approach does not allow for discussion and challenge between the panel and representatives of the MDT. The approach still achieves the benefit of having organisational agreement and ownership of self-assessments.

Suggested Panel Membership:

Cancer services manager, lead cancer clinician (or nurse), local commissioner and / or network manager and a patient/carer.

Preparation:

Before meeting, panel members are e-mailed the MDTs self-assessment documentation (including compliance by measure).

The Meeting:

The meeting should be chaired by any of the panel members other than the cancer services manager (who would have supported the MDT in developing their self-assessment).

The cancer services manager talks the panel through the assessment, concentrating on

measures where assessed compliance is not backed up by the evidence presented or measures that have been assessed as non-compliant. Panel members are asked to raise questions about particular measures or any concerns about the accuracy of compliance.

At the end of this discussion the panel should agree which measures (if any) to alter for the assessed compliance scores (either from no to yes or yes to no), and record why this decision was made. This information should be recorded on the CQuINS database following the meeting. In some circumstances the panel may wish to ask for further evidence or suggest amendments to the MDTs documentation.

The panel should then discuss what the MDT's evidence means at a broader level – by moving through the questions listed within the validation report. What are the overall conclusions against each of the key questions, where are the team's/service's strengths and weaknesses (based on their assessment evidence) against each of these. The panel may also wish to record any specific feedback about each of the three evidence documents.

If any 'immediate risks' have been identified then these should be recorded and the process for addressing

immediate risks should be implemented. In addition any identified good practice, significant achievements and overall conclusions / key recommendation should also be recorded.

Following the Meeting

The validation report will need to be feedback to the MDT's lead clinician and the report agreed by the chair of the validation panel prior to being agreed for submission by the organisation's CEO. The CEO, or delegated authority, is accountable for declaring that the information provides an accurate assessment of the cancer team reviewed. Information is then loaded onto the CQuINS database

2. 'Panel Review'

Another approach to internal validation is for a small panel to undertake a review of a team's/service's self-assessment together prior to meeting with the team. This approach allows the panel to review the evidence together prior to meeting with the team. The disadvantage to this approach is that it is more time consuming for the panel members on the day and it may be that not all the members need to make the initial assessment against all the evidence. Certainly some members of the panel, such as commissioners, may find that

adding a briefing session before meeting with the team is more appropriate use of their time. This approach allows for discussion and challenge between the panel and representatives of the MDT. If undertaken appropriately it should foster a process of development and learning whilst still achieving organisational agreement and ownership of self-assessments.

Suggested Panel Membership:

Cancer services manager, lead cancer clinician (or nurse), local commissioner and / or network manager and a patient / carer.

Suggested team/service representation at the Meeting Membership:

MDT meetings

MDT lead clinician and clinical nurse specialist as a minimum and at least one other from the MDT, e.g oncologist, radiologist, pathologist.

Service Meetings

Service lead and one other as a minimum.

Preparation:

Before meeting, panel members are e-mailed the MDT's self-assessment documentation to read as this helps with the process of the evidence review on the day.

On the day, the panel members attend and discuss compliance with the measures and assess the key documents submitted. At the end of this discussion the panel should agree which measures (if any) to alter for the assessed compliance scores (either from no to yes or yes to no), and record why this decision was made. This process should also identify any areas where they need to seek clarification with the teams/services.

The Panel Meeting with the team/service:

The purpose of the meeting is to seek clarification about how the team/service works and the patient pathway against the evidence submitted.

Any face to face review meeting can create anxiety for those being reviewed. Being reviewed and undertaking reviews when working relationships exist can create conflict on both sides and panel members need to be aware of the effects such a meeting could create and manage the outcomes sensitively.

The meeting should be chaired by any of the panel members other than the cancer services manager (who would have supported the MDT in developing their self-assessment).

Following the Panel Meeting

The panel should then discuss what the MDT's evidence means at a broader level – by moving through the questions listed within the validation report. What are the overall conclusions against each of the key questions, where are the team's/service's strengths and weaknesses (based on their assessment evidence) against each of these. The panel may also wish to record any specific feedback about each of the three evidence documents.

If any 'immediate risks' have been identified then these should be recorded and the process for addressing immediate risks should be implemented. In addition any identified good practices, significant achievements and overall conclusions / key recommendation should also be recorded.

In the event of a serious service issues or personal / professional concerns being identified, the panel should instigate action in line with the trust's corporate governance procedures (further advice as to what may constitute such a concern can be found at section 4.3).

A process for feedback to the team/service should be undertaken, to ensure that any queries are addressed and the report agreed by the chair of the validation panel prior to being agreed for submission by the organisation's CEO. The

CEO, or delegated authority, is accountable for declaring that the information provides an accurate assessment of the team/service reviewed. Information is then uploaded on to the CQuINS database.

3. Approach to Internal Validation- Desk Top Exercise and Face to Face Panel Event

Introduction

This approach to internal validation of MDTs / cross cutting groups involves an initial desk top exercise to determine if the evidence submitted meets the compliance requirements of the measures, and a panel face to face meeting with team/service members. To enhance the rigour and robustness of the face to face meetings, panel members, or their deputies, are constant throughout the internal validation cycle.

Benefits of this model include:-

- information generated from the desk top exercise provides a baseline to inform the face to face meeting;
- it enables the panel to concentrate on the broader quality issues that support fully functioning teams/services, rather than using the time to trawl through the evidence to confirm compliance;
- it promotes consistency across the teams/services being reviewed and enables the panel to gain a deeper insight into cancer service as a whole.

Cancer Management Team (CMT) Role

The CMT is responsible for organising and coordinating internal validation and acts as the point of contact for cancer peer review. The CMT undertakes a desk top exercise to review self assessment evidence and produces a table of compliance against each measure. This information is forwarded to the internal validation panel, along with highlighted comments / queries to alert them to issues that need to be clarified or explored further.

It is envisaged that additional information arising through internal quality assurance processes will be submitted as evidence e.g reports from observations of MDT meetings.

Teams/services will also receive the information generated by the CMT to enable them to provide further evidence, within a given timescale, prior to meeting the panel. In addition teams/services will also receive provisional notification of MDT members who may need to attend the panel meeting to answer specific questions.

Panel Meeting with Teams/services

The panel convenes four weeks after the self assessment and following the desk top exercise having had access to the evidence and compliance tables beforehand. After reading this information the panel will be

asked to confirm with the CMT which members of the team/service they would like to meet. Other team/service members may also attend if they wish.

The panel meeting is structured with an hour to discuss the evidence presented and identify issues that each member would like to explore. Up to an hour is allocated for the meeting and an hour to complete the validation report, ensuring that all the questions have been addressed. It is proposed that the report is completed real time by the panel on a laptop and signed by the appropriate panel members prior to conclusion of the session.

Immediate risks / serious concerns, if identified, should be recorded and the agreed process for addressing them initiated. In addition, examples of good practice / significant achievements should also be recorded.

Internal Validation Panel Membership selected from:-

- Cancer manager Clinical lead
- Trust executive lead for cancer
- Patient / carer
- Nurse representative
- AHP representative
- Network representative
- PCT commissioner representative

NB deputies will be identified and also members may fulfil more than one role.

Post Meeting Activity

Feedback on the outcome of internal validation is given to the team/service prior to submission on CQuINS. The outcome of internal validation of self assessments will feed into the trust's clinical governance reporting system and the report agreed by the chair of the validation panel prior to being agreed for submission by the organisation's CEO. The CEO, or delegated authority, is accountable for declaring that the information provides an accurate assessment of the team/service reviewed. Information is then uploaded on to the CQuINS database.

Appendix 7

Reviewer Person Specifications

Team Member Reviewer Person Specification

Experience (not applicable to patient / carer reviewers).

At least two years working in the role they will be undertaking during the visit.

Working at a senior / expert level within the context of

cancer services (as clinician [including non-medical clinician], manager, commissioner).

Skills

Communication	<ul style="list-style-type: none"> • Presents own viewpoint clearly and concisely • Actively listens to others • Reflects back own understanding others' contribution • Tactful and sensitive to others' verbal / nonverbal reactions • Accurately records and reports on findings • Diplomatic • Confidential
Team orientation	<ul style="list-style-type: none"> • Actively seeks views from other team members • Demonstrates respect for others' viewpoints • Adapts own behaviour to suit situation • Demonstrates ability to work within a multi-disciplinary team
Analysis & problem solving	<ul style="list-style-type: none"> • Bases judgement on an unbiased logical approach • Asks probing questions • Searches for evidence on which to base judgements • Carefully uses observation as a source of evidence
Task oriented	<ul style="list-style-type: none"> • Prepares fully • Focuses on achieving an outcome • Takes personal responsibility for delivering results • Completes required tasks
Resilience	<ul style="list-style-type: none"> • Maintains and projects enthusiasm despite pressure • Can adapt to a variety of situations
Organisational awareness	<ul style="list-style-type: none"> • Able to identify the essentials • Considers individual events within the context of the wider system

Knowledge, understanding and commitment to:

- Principles of the cancer peer review programme
- Principles and implementation of Improving Outcomes Guidance

- Multi-disciplinary approaches to care
- Patient / carer and carer involvement in service delivery and service improvement
- Modernisation of cancer services and implementation of the National Cancer Plan

Peer Reviewers will undergo mandatory training and should be able to commit to undertaking peer review visits over the period of the national programme (2009 – 2013).

User/Patient Reviewer person specification

The following person specification for user/patient reviewers is proposed.

Experience

It is essential that user/patient reviewers should have first hand experience of cancer services (this includes experience as a carer of a patient with cancer)

Essential Skills

<p>Good Listener and Communicator</p>	<ul style="list-style-type: none"> • Ability and confidence to present own viewpoint clearly and concisely to both the reviewers and the MDT during the review • Ability to listen to others' viewpoint without interruption, both during the morning preparation, the review and report writing sessions • Ability to understand and utilise others' contribution • Tactful in communication and awareness to others' verbal / nonverbal reactions
<p>Good at working in teams</p>	<ul style="list-style-type: none"> • Ability and confidence to ask for advice, guidance and the views of other team members where necessary • Ability to demonstrate respect for others' points of view • Able to adapt own approach/style to suit situation during the review day – between the different sessions of the day (the morning preparation, the review and report writing sessions) • Able to demonstrate an ability to work within a team • Ability and confidence to raise any concerns with the review team and ask for help if needed
<p>Ability to prepare for review</p>	<ul style="list-style-type: none"> • Able to assimilate relatively large amounts of information both at the review and in preparation prior to the review • Ability and confidence to ask probing questions sensitively during the review day • Able to use the evidence available to base judgements at the review to ask questions and contribute to the writing of the report • Ability to maintain and project enthusiasm during the review day (approximately 6 hours plus travel time)

Knowledge, understanding and reasonable commitment to:

- Principles of the cancer peer review programme.
- The purpose of peer review and the contribution that user/carer team members can make.

In addition, nominees for peer review should be:

- Able to commit to and be available for an agreed number of days for training and peer review in a given (1 year) period (provided good health allows)

- Willing and able to support (buddy) new user/carer team members as individuals become experienced.

Appendix 8

Appeals and Complaints Policy

Appeals and complaints policy

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.

Appeals

The circumstances where an appeal will be considered are where reviewers have concluded that a network/trust give cause for serious concern or immediate risk or the reviewers have concluded that the network /trust 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 a sub-group of the Executive Group of National Cancer Peer Review. The membership of the sub-group will be determined on a case by case basis by the Chair of the Executive Group, but may include a representative from Care Quality Commission and a patient/carer representative. No member of the 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 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 Executive Group for National Cancer Peer Review will be the final with no further stage of appeal. Whenever 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 the sub-group will be provided by members of the National Coordinating Team for NCPR.

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 Programme Director for NCPR.

In general, any complaints that cannot be resolved with the quality director will be referred to the National Programme Director for National Cancer Peer Review, who in turn will refer the matter to the Executive Group for National Cancer Peer Review.

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

Appendix 9

Inclusion of Peer Review Data in the Care Quality Commission Quality and Risk Profiles

Mapping cancer measures to essential standards

The data from the National Cancer Peer Review programme is now being included in the Care Quality Commission's Quality and Risk Profiles (QRPs) for individual organisations. The measures for Breast, Lung, Upper GI, Gynaecology and Urology MDTs have been mapped to the CQC essential standards. The mapping of the individual measures against the essential standards can be found on the CQuINS website www.cquins.nhs.uk but in summary relate to the six following outcomes:

- 1- Respecting and involving people who use services
- 4- Care and welfare of people who use services
- 6- Co-operating with other providers
- 13- Staffing
- 14- Supporting Workers
- 16- Assessing and monitoring the quality of service provision

Weighting the compliance for internal validation assessment

In order to reflect the level of confidence in the assessment against the measures a weighting system has been adopted.

Where the assessment against the measures is based on a peer

review visit assessment then the weighting is 1.

Where the assessment against the measure is based on Internal Validation (IV) then the weighting is based on the accuracy of the IV assessment as reflected by the external verification (EV) assessments made at that hospital site.

The methodology adopted reflects that the EV assessments (RAG rating) check the level of confidence in the IV assessment.

External Verification

The external verification checks the compliance against the measures made by the IV team against that of the peer review team. The difference between the two compliances is identified as being either:

- IV confirmed (Green) = where the difference in compliance is between 0 and 20%
- IV confirmed with exceptions (Amber) = where the difference in compliance is between 20% and 30%
- IV unconfirmed (Red) = where the difference in compliance is over 30%

Calculation of the weighting

In order to establish the level of confidence in the IV assessments at a hospital site the mean score for the EV assessments can be used.

Where a weighting for each EV assessment would be:

- 1 = IV confirmed (Green), as the compliance difference with EV may be as little as 0%
- 0.7 = IV confirmed with exceptions (Amber), as the compliance difference with EV may be as little as 20%
- 0.7 = IV unconfirmed (Red), as the compliance difference with EV may be as little as 30%

The mean is calculated by adding the individual EV weightings together and dividing by the number of EVs completed at the hospital site. For example:

- Where two EVs were completed;
- IV confirmed with exceptions (Amber) = 0.7
- IV unconfirmed (Red) = 0.7

Then the weighting would be $(0.7 + 0.7) / 2 = 0.75$

This weight is then applied to each measure that has been mapped to the CQC essential standards for the hospital site unless a team has received a peer review visit.

In the above example a compliant measure would be 0.75 and a non-compliant measure would be 0.

Collating the overall peer review measures compliance against the CQC essential standards for a hospital site.

The final stage of the process is to collate the compliance against each of the measures for all of the tumour sites at a particular hospital site.

An illustration of this is shown below.

Hospital (Site)	Outcome 1	Outcome 4	Outcome 6	Outcome 13	Outcome 14	Outcome 16	Total by all outcomes by tumour site
MDT Breast	/3	/11	/2	/6	/5	/10	/37
MDT Lung	/3	/9	/1	/6	/3	/10	/32
MDT Gynae (L)	/3	/10	/2	/5	/3	/11	/34
MDT UGI (L)	/3	/12	/2	/6	/3	/10	/36
MDT Urology (L)	/4	/18	/5	/6	/3	/10	/46
Total by outcome by all tumour sites	/16	/60	/12	/29	/17	/51	Total for all tumours and all outcomes /185

The reason for collating all the tumour types together is to enable the denominator to be sufficiently robust for trends to be identified. This is collated by hospital rather than by trust in order to prevent the masking of an individual poor performing site.

If you require further details regarding a particular hospital then contact:

sue.knights@ncpr.org.uk or
ruth.bridgeman@ncpr.org.uk

Appendix 10

Identification of Good Practice/ Significant Achievements

At all levels of the programme review teams have the opportunity to identify good practice / significant achievements in any of the settings under scrutiny. The good practice / significant achievements:

- should be directly linked to the cancer services being examined;
- could be of an innovative nature but it also could be common practice that is undertaken very well.

Those undertaking internal validation, external verification and during review visits should ensure that there is robust evidence for the identification of good practice / significant achievements. Good practice / significant achievements should be commented on in the summary of any of the reports.

The identification of good practice / significant achievements for later dissemination and recommendation is an important positive component of the review process.

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.

1. 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.

2. Good practice may have:

- contributed to the delivery of safe, high quality patient centred services;
- successfully integrated services through constraining / complex circumstances;
- facilitated improved compliance with the national Manual of 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.

3. Areas of good practice will be agreed by the validation and verification panels or the visiting team when they are drawing their conclusions. Areas identified as ‘good practice’ will be identified within the reports.

¹ Sarah W Fraser. (2002) Accelerating the Spread of Good Practice - A Workbook for Healthcare. Kingsham Press

