

National Cancer Action Team

Part of the National Cancer Programme



National Cancer Peer Review Programme

Report 2010/2011

An overview of the findings from the
2010/2011 National Cancer Peer Review of
Cancer Services in England



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An overview of the findings from the 2010/2011 National Cancer Peer Review of Cancer Services in England

FOREWORD

From the National Cancer Director

I am very pleased to introduce this overview of the findings from the 2010/2011 round of peer review for cancer services in England, which was undertaken between April 2010 and March 2011.

This was the second round using the current peer review methodology where the annual self-assessment is central to the programme, with the Chief Executive of the service provider endorsing their report.

The internal validation process has now started to be embedded into clinical governance processes within Trusts and the external verification process has highlighted that internal reports are becoming more reliable. This will enable patients and their carers to use them to inform choice on teams and services within the programme.

The introduction of Clinical Lines of Enquiry, as a pilot for Breast and Lung services, is a first step to peer review becoming focused on clinical outcomes. An evaluation of this pilot is included in the report, but it has been received well and is already being rolled out to other tumour sites in the 2011/2012 programme which is currently under way. Peer Review provides comprehensive information about cancer services and is now moving to provide information about the outcomes achieved by these services.

The report looks at the findings on the quality of cancer services for 1163 tumour multidisciplinary teams, and 241 tumour network groups with the

accompanying Network Board measures, along with services for Radiotherapy, Children's, Cancer Research Networks, Rehabilitation and Complementary Therapy. I would once again like to express my heartfelt thanks to everyone who has contributed to the success of the programme whether as a reviewer, a member of one of the coordinating teams or as a member of the service being reviewed.

The findings outlined in this report confirm the progress which has been made since the 2004/2008 peer review round and since 2009/2010. This National Report complements the detailed network overview reports on individual services which are already in the public domain (www.cquins.nhs.uk).

The national overview focuses on compliance with specific measures but also identifies key themes nationally and by tumour type. Reports for each tumour type are included and provide a benchmarked performance of each team/service.

The full reports on individual teams in the Network Overview Reports have highlighted many of the qualitative aspects of the delivery of cancer services. The reports have commented on numerous examples of a committed and enthusiastic workforce, strong networking and team working and innovative clinical practice.

The national overview shows that some teams and services continue to achieve very high levels of compliance with the measures. When considering all

of the 1,635 Multi-Disciplinary Teams (MDTs) and Network Services (Network Board and Network Site Specific Groups [NSSGs]), 883 (54%) achieved compliance with over 90% of the measures.

However, the 2010/2011 round of peer review has again highlighted some significant challenges. Some of these will already have been addressed at a local level following the relevant visits and report. Others will need to be addressed now.

In some cases compliance could be achieved through local effort, but without the need for additional resource. In other

cases commissioners will need to consider whether it is practical for a team to achieve full compliance, or whether two or more neighbouring teams need to be merged to achieve sustainability both of workforce and throughput of patients.

In summary this report demonstrates that much has been done to improve cancer services in this country, but more remains to be done to achieve our goal of providing optimal diagnosis, treatment, care and outcomes for all cancer patients.

Professor Sir Mike Richards
National Cancer Director

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1 Executive Summary

1.1 Overview

This report presents a national overview of the findings from the National Cancer Peer Review (NCPR) programme for 2010/2011. A total of 1163 multidisciplinary teams (MDTs) were assessed in that period, covering a total of eight tumour groups (Breast, Lung, Upper GI, Urology, Gynaecology, Skin, Colorectal, and Head and Neck) along with Radiotherapy and Children's Services.

There were a number of high performing teams in 2010/2011;

- 8 teams (0.7%) achieved 100% compliance
- 830 teams (70%) achieved $\geq 80\%$ compliance

However, there were also a small number of low performing teams;

- 14 teams (1%) had compliance of 50% or under

Performance of services can be compared to previous rounds of peer review in 2004/2008 and 2009/2010. Improvement has been observed for most tumour groups, with increases in median compliance scores and reductions in variations between MDTs. 392 (34%) of MDTs scored over 90% against the peer review measures, compared with only 25% of MDTs in 2009/2010.

However, a small number of teams (around 1%) are performing poorly, with compliance scores below 50%. A high proportion of these teams also had Immediate Risks or Serious Concerns noted by reviewers. These were reported to Trust Chief Executives and should have been acted upon immediately.

Internal governance is improving and although internal assessments still remain less robust and reliable than external assessment, progress is being made. The section on external verification shows that the public can be more confident in internal assessment where it has been embedded into clinical governance.

Across the country as a whole similar issues were identified to those in 2009/2010, ie gaps in core team membership and capacity, some complex surgery being undertaken outside of specialist centres particularly in Urology and the need for strengthened pathways for Testicular, Penile and Hepato-biliary services. However, there has been progress from 2009/2010, with some networks noting an increased compliment of Clinical Nurse Specialists (CNS), oncology and thoracic surgery input.

The introduction of Clinical Lines of Enquiry has highlighted the need for some MDTs and Networks to have a greater understanding of their clinical outcomes and to address issues of data collection and submission to national audits.

Peer Review teams reported a great deal of good practice, frequently noting the dedication of the workforce. Some MDTs have made excellent progress in implementing service developments with particular mention of enhanced recovery initiatives.

1.2 Background

National quality measures for cancer services were first published in 2001. They were updated and extended to

further tumour types in 2004 and are now updated annually. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services. A first round of peer review was contracted across the country at regional level in 2001. A national programme was established in 2004.

Following the 2004/2008 round of peer review a consultation was undertaken to determine the future direction. There was strong support for the continuation of the programme, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when information became available.

In response to this the number of measures against which MDTs are assessed has been reduced by over one third. In addition Clinical Lines of Enquiry (CLE) were piloted in 2009/2010 for Breast and Lung services, based on outputs/outcomes and these are now being expanded to Colorectal, Upper GI, Gynaecology and Head and Neck services.

In addition, the burden of external inspection has been reduced by introducing three levels of assessment.

- Internal Validation (IV) - this involves self assessment by MDTs with sign-off by the provider chief executive
- External Verification (EV) - as above with desk-top review by the zonal peer review teams
- Peer Review (PR) - which involves formal assessment by an external team including relevant specialists and service users.

In recognition that some teams/services have achieved a good standard of internal quality assurance governance and in line with the cancer reform strategy to reduce the burden of inspection, the concept of Earned

Autonomy (EA) was introduced for the IV process during 2010. A team/service who had earned autonomy did not have to be subject to IV.

1.3 The 2010/2011 assessment round

In 2010/2011 peer review continued with the previously assessed tumour types (Breast, Lung, Gynaecology, Upper GI and Urology) but also included the planned expansion of the scope of the programme to Colorectal and Head and Neck services along with Radiotherapy, Children's services, Rehabilitation, Complementary Therapy and Cancer Research Networks.

1.4 Compliance with measures 2010/2011

For the tumour site MDTs reviewed the percentage of teams achieving over 75% compliance with the measures has increased from 48% of tumour MDTs in 2009/2010 to 79% of teams in 2010/2011.

In 2010/11, of the 1163 MDTs reviewed;

- 8 teams (0.7%) achieved 100% compliance (compared with 2% in 09/10)
- 392 teams (34%) achieved $\geq 90\%$ compliance (compared with 25% in 09/10)
- 830 teams (70%) achieved $\geq 80\%$ compliance (compared with 36% in 09/10)
- 931 teams (80%) achieved $\geq 75\%$ compliance (compared with 48% in 09/10)

The overall compliances for all tumour sites and services reviewed are shown below. Where a topic has been subject to both internal validation and peer review, the overall percentages are based on the combined internal validation and peer review percentages.

	No. reviewed	IV	EV	PR	EA*	% compliance (Median)	% compliance (Mean)	IR ⁽¹⁾	SC ⁽²⁾
Tumour MDTs									
Breast	155	53	1	91	13	83%	80%	12	54
Lung	163	79	2	79	7	84%	84%	5	64
Gynaecology (L)	69	59	14	8	3	88%	86%	2	23
Gynaecology (S)	41	39	8	1	1	91%	91%	1	2
Upper GI (L)	103	91	27	11	1	86%	84%	7	32
Upper GI (Oesophago-Gastric) (OG)	41	33	10	8	1	86%	83%	1	9
Upper GI (Pancreatic)	22	16	9	5	1	81%	80%	1	5
Upper GI (Pancreatic Liver Resection)	9	5	0	0	1	89%	82%	Inc in Pan-creatic report	Inc in Pan-creatic report
Urology (L)	93	82	19	7	4	89%	87%	10	35
Urology (S)	50	42	12	5	3	90%	87%	8	19
Testicular	13	2	0	11	0	68%	69%	3	6
Penile	9	5	1	3	1	78%	74%	0	1
Skin (L)	92	88	14	2	4	84%	81%	5	34
Skin (S)	43	41	8	0	3	82%	81%	3	12
Skin (Melanoma)	2	2	0	0	0	n/a	78%	0	2
Skin (Supranetwork T-cell)	5	4	0	0	1	91%	88%	0	0
Colorectal	167	167	167	n/a	n/a	89%	88%	17	92
Colorectal (Stand alone liver)	5	5	5	n/a	n/a	92%	87%	0	0
Head & Neck UAT/Thyroid	56	56	55	n/a	n/a	85%	83%	4	31
Head & Neck Thyroid only	25	25	25	n/a	n/a	77%	80%	4	11
Other Clinical Services									
Radiotherapy Services									
Radiotherapy Department Generic	53	n/a	n/a	53	n/a	65%	68%	4	22
Radiotherapy Department External Beam	53	n/a	n/a	53	n/a	88%	85%	0	7
Radiotherapy Department IMRT	51	n/a	n/a	51	n/a	90%	81%	1	7
Radiotherapy Department Brachytherapy	41	n/a	n/a	41	n/a	86%	84%	1	11
Children's Services									
Children: Principle Treatment Centre (PTC) Core	13	13	2	n/a	n/a	90%	88%	0	4
PTC, Late effects MDT	13	13	2	n/a	n/a	57%	63%	0	2
PTC, Diagnostic & Treatment MDT	32	32	7	n/a	n/a	78%	76%	0	6
Paediatric Oncology Shared Care Unit (POS-CU) Level 1 Core	61	61	23	n/a	n/a	86%	81%	2	16
Paediatric Oncology Shared Care Unit (POS-CU) Level 2 Core	13	13	3	n/a	n/a	88%	84%	2	6

Paediatric Oncology Shared Care Unit (POSCU) Level 3 Core	12	12	0	n/a	n/a	92%	88%	0	1
POSCU MDT	85	85	26	n/a	n/a	82%	75%	1	20
Other Services and Functions									
Cancer research networks: Functions of the Cancer Research Networks**	31	31	0	n/a	n/a	86%	84%	0	3
Rehabilitation: Functions of the Rehabilitation Group	28	n/a	n/a	28	n/a	21%	29%	0	4
Complementary therapy: Locality Measures	127	127	127	n/a	n/a	80%	69%	3	26

* Teams and services that had Earned Autonomy may also have chosen to publish an Internal Verification report.

** Please note that the Network Measures for Cancer Research Networks (10-1A-5) were only partially completed and it is therefore not possible to give an overall national percentage for that section.

⁽¹⁾ IR = Immediate Risk

⁽²⁾ SC = Serious Concern

Across the five tumour groups assessed three times (2004/8, 2009/10 and 2010/11) a total of 771 MDTs were reviewed in 2009/2010 and 768 teams in 2010/11.

All tumour sites reviewed in 2004/2008, 2009/2010 and 2010/2011 have experienced an improvement against

the measures since 2004/2008, with the exception of testicular and penile teams which have faced particular challenges with regard to Improving Outcomes Guidance configuration and robustness of pathways.

All tumour sites with the exception of Testicular, Lung and Breast have

Changes in median performance

MDTs	2004/8 Median Values	2009/10 Median Values	2010/2011 Median Values	Change from 04/08	Change from 09/10
Breast	77%	86%	83%	+ 6%	- 3%
Lung	74%	87%	84%	+ 10%	- 3%
Gynae (L)	72%	85%	88%	+ 16%	+ 3%
Gynae (S)	83%	85%	91%	+ 8%	+ 6%
Upper GI (L)	67%	83%	86%	+ 19%	+ 3%
Upper GI (OG)	78%	81%	82%	+ 4%	+ 1%
Upper GI (Pancreatic)					
Urology (L)	70%	82%	89%	+ 19%	+7%
Urology (S)	77%	78%	90%	+13%	+ 12%
Testicular	74%	85%	68%	- 6%	- 17%
Penile	89%	67%	78%	- 11%	+ 11%

improved their median percentage since 2009/2010. However, in 2009/2010 all Lung & Breast teams were subject only to internal validation, whereas a large proportion of Lung and Breast MDTs have been subject to the more robust peer review assessment in 2010/2011. As there may be anticipated to be a fall of approximately 10% between IV and peer review assessment, Breast and Lung teams (with a reduction of 3% in compliance) are likely to have maintained improvements in service which is borne out in the narrative of the reports.

1.5 Recommendation and next steps

Each Cancer Network and NHS Trust has already received a full report on its performance during 2010/11 peer review round and these individual reports are all in the public domain, (www.cquins.nhs.uk).

This report provides a national picture against which both commissioners and providers can benchmark local performance. At a national level it is clear that considerable progress has been made over the past few years, but that some services are still not matching agreed measures.

It is important to recognise that although the peer review measures largely reflect the structure and process of core delivery, these are very largely based on Improving Outcomes Guidance (IOG) developed by the National Institute of Health and Clinical Excellence (NICE). The structure and process measures therefore reflect those aspects of care delivery most likely to impact on patient outcomes.

In parallel with the publication of this report host commissioners are being alerted to those services which were identified as scoring below 50% and / or were identified as having an Immediate Risk.

In order to reduce the burden on the service and ensure the peer review programme is sustainable a number of changes were introduced for the 2011/2012 round. However, further work is currently underway to significantly revise the programme in 2012/2013 and a national consultation is planned to take place in November 2011.

The key changes to the programme introduced to date are:

- A further reduction in the number of measures for each tumour type by 10% and the amalgamation of measures to reduce the number of IV reports required i.e. locality and MDT measures.
- The self assessment evidence is now only required every two years rather than annually.
- The IV is only required every two years rather than annually.
- Peer Review visits are only undertaken where a team/service:
 - Falls into the risk criteria (see Appendix 3)
 - Where there is considered to be an opportunity for significant learning
 - As part of a small stratified sample to assure public confidence in SA and IV.

In addition, and in recognition of the additional burden as a result of new topic being introduced, a one year self-assessment amnesty has been agreed whereby high performing teams (ie over 85% with no Immediate Risks or Serious Concerns; see Section 9 for full criteria) do not have to complete a self-assessment in 2011/2012.

A list of the teams eligible for the amnesty is available on the CQuINS website. The amnesty includes around 830 teams/services.

The Care Quality Commission (CQC) continues to be informed about the poor performing teams and trusts, with regular updates also being provided to CQC on any Immediate Risks identified through peer review. The findings of the National Cancer Peer Review process inform the Quality and Risk Profiles of CQC which are used to monitor on-going compliance with legal registration standards.

Clinical Lines of Enquiry have been extended to Gynaecology, Colorectal, Head and Neck and Upper GI services as well as the continuation of Breast and Lung. The intention is that these will be

rolled out to all tumour sites in future. This will enable Peer Review to engage in discussions with clinical teams on those elements of clinical care which will produce the best outcomes and ensure the safety, effectiveness and experience of care for patients.

In future National Cancer Peer Review will need to align with the NHS Outcomes Framework, and in relation to this it is currently engaging with NICE to ensure that the Peer Review Measures are in line with the new Quality Standards which are in the process of development.

2 Introduction

This report summarises the findings of the 2010/2011 round of the National Cancer Peer Review Programme. The findings are based on Peer Review Reports of the cycle which took place between April 2010 and March 2011. The Peer Review Reports may be either internally validated self assessment reports, external verification reports or peer review visit reports. The analysis makes clear which of these report types has been used. Findings from the previous round of National Cancer Peer Review have also been used in order to assess progress.

The report principally summarises the numerical data contained within the Cancer Quality Improvement Network System (CQulNS) which records the level of compliance by individual networks, teams and services against the measures contained within The Manual for Cancer Services.

In addition reference is made to the comments made by reviewers in their reports on aspects of the qualitative information that were gathered during the reviews.

The identification of good practice for dissemination and recommendation is a vital positive component of the peer review process. This report therefore highlights examples of good practice that have been identified by peer reviewers during this programme. The report also identifies the key messages that have emerged from the reviews and highlights some of the challenges facing Cancer Networks, providers of services for patients with cancer, and commissioners, as they strive to ensure the delivery of effective and high quality care.

The annual internally validated self assessment is now embedded in the peer review process and this is the second annual national overview report based on this new process. This move should ensure that reports are up to date and can be built into the commissioning cycle. To support this we include maps for specialist services showing the configuration of services and benchmarking of individual teams in each of the tumour site sections.

3 Background to National Cancer Peer Review Programme

3.1 National Cancer Peer Review Programme 2001

The first national cancer peer review programme was in 2001. It was organised and operated on a regional basis. The first Manual for Cancer Services which covered 'standards' for the four common cancers Breast, Lung, Colorectal and Gynaecology was published in 2001. Although this was a national programme, it was implemented with regional differences which made it difficult to compare the results across the country.

A national evaluation of the 2001 programme was undertaken by Keele University. This recommended that national consistency was addressed and a new methodology was introduced in 2004.

3.2 National Cancer Peer Review Programme 2004-2008

In 2004 the second national programme commenced. This was delivered by 6 zonal teams; North West, North East, West South, East, London and South. The programme was coordinated by a national team. A new Manual for Cancer Services, which covered 'measures' for six cancer sites (Breast, Lung, Colorectal, Gynaecology, Upper GI and Urology) and six cross cutting services (Chemotherapy, Radiotherapy, Pathology, Imaging, Specialist Palliative Care and Network Users Groups) was published to support the programme. All teams/services within a cancer network were asked to complete a self assessment once in the three year cycle, which was then followed by comprehensive peer review visits.

In the last 18 months of the programme Head and Neck, Haematology and revised Colorectal measures were published. A comprehensive review of all Head and Neck and Haematology services was completed during 2007/2008 and all Colorectal services received a second peer review visit.

A national independent evaluation of the 2004/2008 programme was undertaken and it was also included in the review of national programmes by the Office of Strategic Health Authorities. The continuation of the peer review programme was supported but changes were recommended in order to meet the annual requirements of the national regulator (Healthcare Commission); reduce the perceived burden of inspection; encompass the principles of better regulation to only review what needs to be reviewed and to become more outcomes focused.

3.3 National Cancer Peer Review Programme 2009 to 2011

In April 2009 a new methodology for National Cancer Peer Review was introduced. The new methodology has adopted an annual self assessment process supported by a targeted visit programme. This annual process will allow more up to date information to be available to support the commissioning of cancer services and patient choice.

The peer review programme consists of three key stages:

- **Internally validated self assessments** – completion of an annual self assessment by the team/service who deliver the

service. Internal validation of the self assessment by the host organisation for that service.

- **External verified self assessments** - An external desk top review of selected internally validated self assessments by the zonal cancer peer review coordinating teams.
- **Peer review visits** - A targeted schedule of peer review visits takes place. The schedule of peer review visits is agreed with each cancer network by the end of December.

3.4 A phased introduction

As a result of national consultation on the new methodology it was agreed that the programme would have a phased introduction.

In 2009/2010 the programme included six cancer sites: Breast, Lung, Gynaecology, Upper GI and Urology and one new site, Skin.

In 2010/2011 a further six topic were included: Colorectal, Head and Neck, Radiotherapy, Children's cancer, Network Rehabilitation, Network Complementary Therapy and Cancer Research Networks

3.5 Earned Autonomy

In recognition that some teams/services have achieved a good standard of internal quality assurance governance and in line with the cancer reform strategy commitment to reduce the burden of inspection, the concept of Earned Autonomy (EA) was introduced for the IV process during 2010. A team/service which had earned autonomy did not have to be subject to IV. The criteria by which a team/service was considered for earned autonomy were:

A team/service which received a peer review visit report/external verification in the previous year indicating that the compliance against the measures was 75% or greater and having no Immediate Risks or Serious Concerns. In addition the teams /services compliance against the measures in 2010/2011 must be greater than 75% and greater than their assessment in previous year with no Immediate Risks or Serious Concerns identified within the self assessment.

202 (12%) of MDTs and Network teams were eligible for earned autonomy however only 56 of these choose to take up this option.

3.6 Clinical Lines of Enquiry (CLE)

Clinical Lines of Enquiry were introduced as a pilot in 2010/2011 for Breast and Lung Services, in order to make the reviews clinically relevant, outcomes focused and to sustain the continued support and involvement of clinical staff.

Clinical Indicators were developed by NCPR and the National Cancer Intelligence Network (NCIN) Site Specific Clinical Reference Groups (SSCRGs). It is the intention to feedback and review these Clinical Indicators at the SSCRG on an annual basis.

Further details of the 2010/2011 peer review process can be found in the National Cancer Peer Review Programme Handbook (2011) on the CQuINS website www.cquins.nhs.uk.

4 Internal Validation and External Verification

4.1 Internal Validation

The IV schedule for 2010/2011 was Breast, Lung, Gynaecology, Upper GI, Urology, Colorectal, Head & Neck, Children's Services, Cancer Research Networks and Complementary Therapy.

Where any of the above services were selected for a peer review visit IV was not mandatory. However, host organisations may have chosen to IV them if they so wished. This would be viewed as a principle of good practice.

71 (20%) teams and services voluntarily completed an IV even though they were due to be peer reviewed.

Two main models for IV were used by organisations. They were a panel review and a desk-top review.

4.2 External verification

The EV reports show a traffic light system – Red, Amber and Green rather than a percentage compliance against the measures, indicating the status of IV;

IV confirmed – Green

IV confirmed with exceptions – Amber

IV unconfirmed – Red

The IV status is calculated using three key triggers. These triggers are shown in [Appendix 3](#).

4.3 EV schedule

In 2010/2011 all Colorectal and Head and Neck teams were externally verified along with a small random sample of other topics.

4.4 Outcomes of EV

Number of teams red	167
Number of teams amber	179
Number of teams green	465

4.5 Internal Governance

The robustness of the internal governance processes is reflected in any change in percentage compliance from self-assessment to internal validation and internal validation to external verification for those teams who have not been subject to peer review, and from self-assessment to peer review compliance for the remainder of the teams.

Comparison of percentage changes on IV and PR cycles 09 – 10 and 10 – 11

	2009 – 2010	2010 - 2011	Number of Networks with a decrease in percentage difference
Self-assessment to Internal Validation*	4%	4%	9 Networks
Internal Validation to External Verification	13%	14%	7 Networks**
Self-assessment to Peer Review	20%	15%	16 Networks

*This is the change in percentage compliance from self-assessment to internal validation for those teams who were subject to External Verification.

**3 Networks [Greater Midlands Cancer Network (GMCN), North London Cancer Network (NLCN) and Peninsula Cancer Network (PCN)] had a decrease in percentage difference both from self-assessment to internal validation and internal validation to external validation. Two of these Networks (GMCN and NLCN) also had a decrease in percentage difference from self-assessment to Peer Review.

These figures indicate that the public can have increasing confidence in the internal governance processes of Trusts and Networks. Whilst Peer Review continues to be a catalyst for improvement the internal governance ensures that the quality of the service is always in place and not just completed for external review.

5 Network Overview

5.1 Network and NSSGs

The 2010/2011 reviews reflected the changing NHS environment, with the need for cost saving and the emerging structures of clinical commissioning groups having an impact on Network and Board activities. Many Networks had to operate in an environment of uncertainty either over their own future or of the NHS organisations with which they interact, affecting the links with commissioning, the funding of service developments and commissioning priorities. With the increased commissioning focus of networks there was also a reported change from performance management to commissioning support.

There was much variation in the degree of interaction with commissioners, with some NSSGs noted as unclear about their mechanism for influencing commissioning priorities and others with innovative examples of interaction, for example a Network Radiotherapy Group who organised a specific radiotherapy event for clinical teams to meet with commissioners and discuss the provision of a high class radiotherapy service for patients; a Lung NSSG who took part in a commissioning project comparing costs of local pathways to the national lung cancer pathway with a view to redesign if appropriate and also a Lung NSSG who had appointed a General Practitioner as Chair in the light of increased emphasis on prevention and early diagnosis.

The involvement of the Networks and also the constituent Trusts in the NSSGs was variable, and this was reflected in their effectiveness in ensuring consistent service development and ability to address network inequalities in diagnostic and treatment pathways. The introduction of Clinical Lines of Enquiry

for Breast and for Lung highlighted those NSSGs who took a proactive approach to monitoring outcomes and those which needed to develop in this area, and also the variance in data collection and support for that collection.

The reviews of both the Networks and the MDTs indicated that there were still gaps in some core membership of MDTs, particularly in oncology and CNS provision, which Networks must continue to address. However there are some Networks in the 2010/2011 reviews where it was noted that oncology provision had increased and that there was greater availability of thoracic surgery input to some of the Lung MDTs.

5.2 Improving Outcomes Guidance

There had been further progress in the implementation of Improving Outcomes Guidance since the 2009 to 2010 reviews, with a number of issues now resolved across the Networks.

However, there were still outstanding issues particularly in reference to Urology, for instance complex pelvic surgery outside of agreed configurations, insufficient population base, surgery across more than one site, and less than robust pathways for Penile and Testicular cancer.

Upper GI oesophageal services were generally in place, although there were two Networks (Central South Coast Cancer Network and Essex Cancer Network) in which there were complex pathways which required continued cross-network collaboration and review. The configuration of Hepato-Biliary and Pancreatic services was non-compliant and subject to review in two Networks, with a further three networks where the population base did not

meet IOG requirements, but where the configuration had NCAT agreement.

There had been progress in the implementation of Colorectal IOG compliant services; however there were still outstanding issues in at least three networks with regard to anal surgery taking place outwith agreed configuration.

Although Head and Neck IOG guidance and configuration was complete in many Networks, there was still movement towards transfer of surgery and establishment of local support groups in others.

There had been much progress in the establishment of Skin services since the 2009/2010 reviews, although there were at least three Networks where it was noted that there was a need for further development of pathways and robust support to ensure equity for patients across the network.

With regard to Gynaecology, most networks had fully implemented IOG guidance, however there was one Network in which a final decision on configuration was awaited and one network where services remained non-compliant with IOG configuration.

6 Multidisciplinary Teams Overview

6.1 Overall compliance

A total of 1163 multidisciplinary teams were reviewed as part of the 2010/2011 peer review programme. 231 received a peer review visit, 381 were externally verified and 895 completed an internally validated self assessment.

The number of multi-disciplinary teams achieving 100% compliance with the measures was 8 (ie 0.7%); the number of multi-disciplinary teams achieving over 90% compliance with the measures was 392 (ie 34%); the number of multi-disciplinary teams achieving over 80% compliance with the measures was

830 (ie 70%) and the number of multi-disciplinary teams achieving over 75% compliance with the measures was 931 (ie 80%).

The following figures and table show a comparison of compliance of teams reviewed in 2009/2010 and 2010/2011, and the overall national compliances for all teams including the additional tumour sites added for 2010/2011 ie Head & Neck and Colorectal.

A more detailed breakdown on compliance and commentary on all tumour sites can be found in the individual tumour sections.

Fig 1: Median comparison 04-08, 09-10 and 10-11

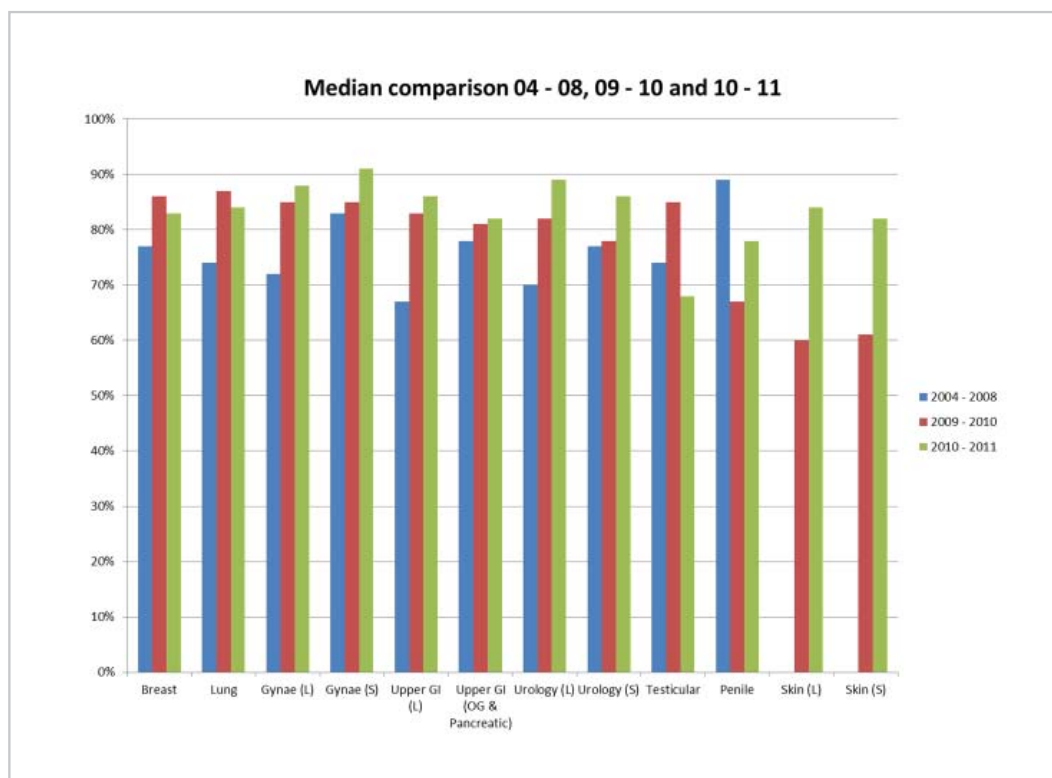
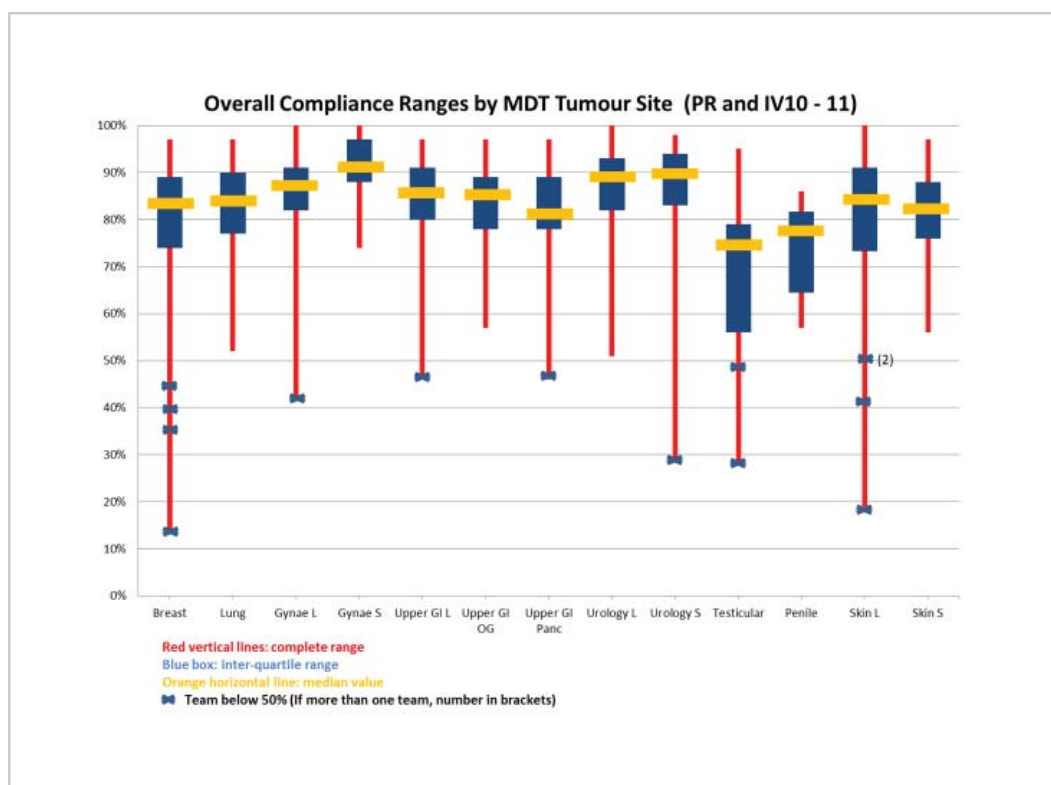
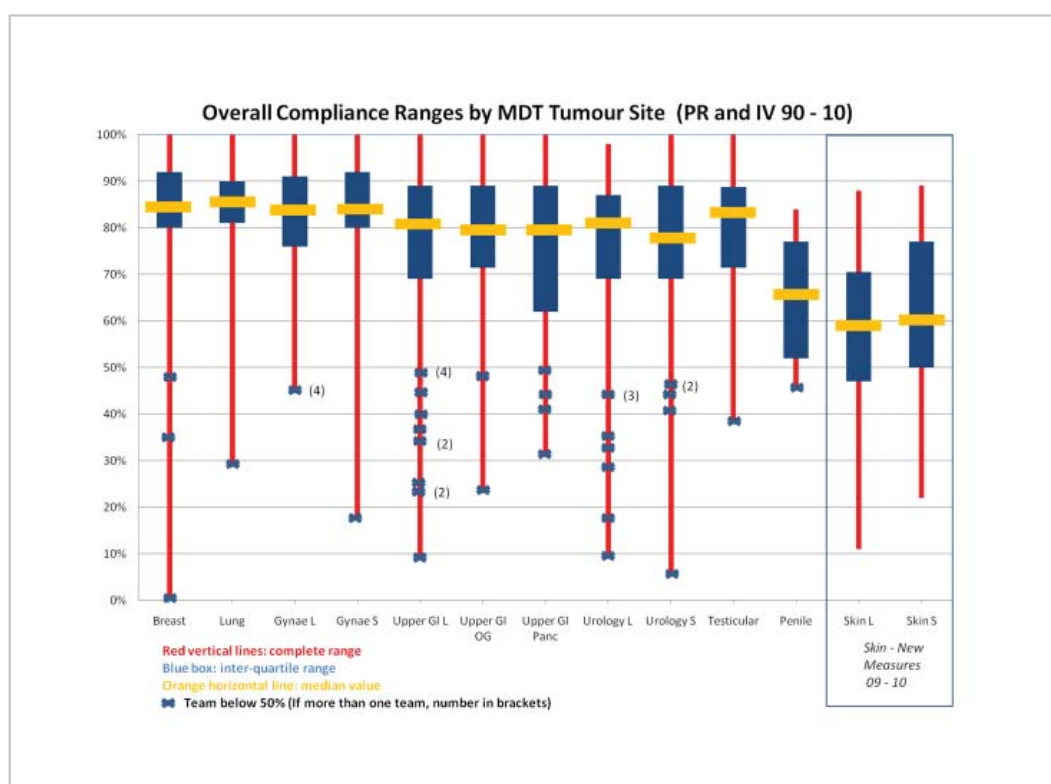


Fig 2: Overall compliance ranges per tumour site 2010 – 2011 ***Fig 3: Overall compliance ranges per tumour site Peer Review 2009 - 2010 ***

*NB These includes both IV and PR compliances. For those teams with a compliance of under 50%, the specific type of assessment may be found in Section 6.2

Table 3: Comparison of Overall National Compliances (Mean) 2004 – 2008, 2009 – 2010 and 2010 - 2011

MDTs	2004/8 - Overall National Percentage	2009/10 - Overall National Percentage	2010/2011 - Overall National Percentage
Breast	76%	85%	80%
Lung	73%	84%	84%
Gynae (L)	69%	80%	86%
Gynae (S)	82%	83%	91%
Upper GI (L)	64%	76%	84%
Upper GI (OG)	72% (NB OG & Pancreatic combined)	77%	83%
Upper GI (Pancreatic)		76%	80%
Urology (L)	63%	76%	87%
Urology (S)	73%	75%	87%
Testicular	69%	78%	69%
Penile	78%	65%	74%
Skin (L)	n/a	58%	81%
Skin (S)	n/a	61%	81%
Skin (Melanoma)	n/a	75%	78%
Skin (Supranetwork T-cell)	n/a	75%	88%

Table 4: Comparison of Teams 2004 – 2008, 2009 – 2010 and 2010 - 2011

	Number of teams			Total reduction in teams	Change in number of teams
Measure	2004 - 2008	2009 - 2010	2010 - 2011	04 - 08 to 10 - 11	09 - 10 to 10 - 11
Breast	174	157	155	-19	-2
Lung	175	163	163	-12	0
Gynae (L)	99	75	69	-30	-6
Gynae (S)	44	42	41	-3	-1
UGI (L)	129	103	103	-26	0
UGI (S) OG	74 (OG and Pancreatic)	41	41	-11 (OG and Pancreatic)	0
UGI Pancreatic		25	22		-3
UGI (Pancreatic put forward as liver resection)	17	7	9	-8	+2
Urology (L)	129	89	93	-36	+4
Urology (S)	74	51	50	-24	-1
Supranetwork Testicular	16	10	13	-3	+3
Supranetwork Penile	10	8	9	-1	+1
TOTALS	941	771	768	-173	-3

All tumour sites reviewed in 2010 - 2011

Fig 4

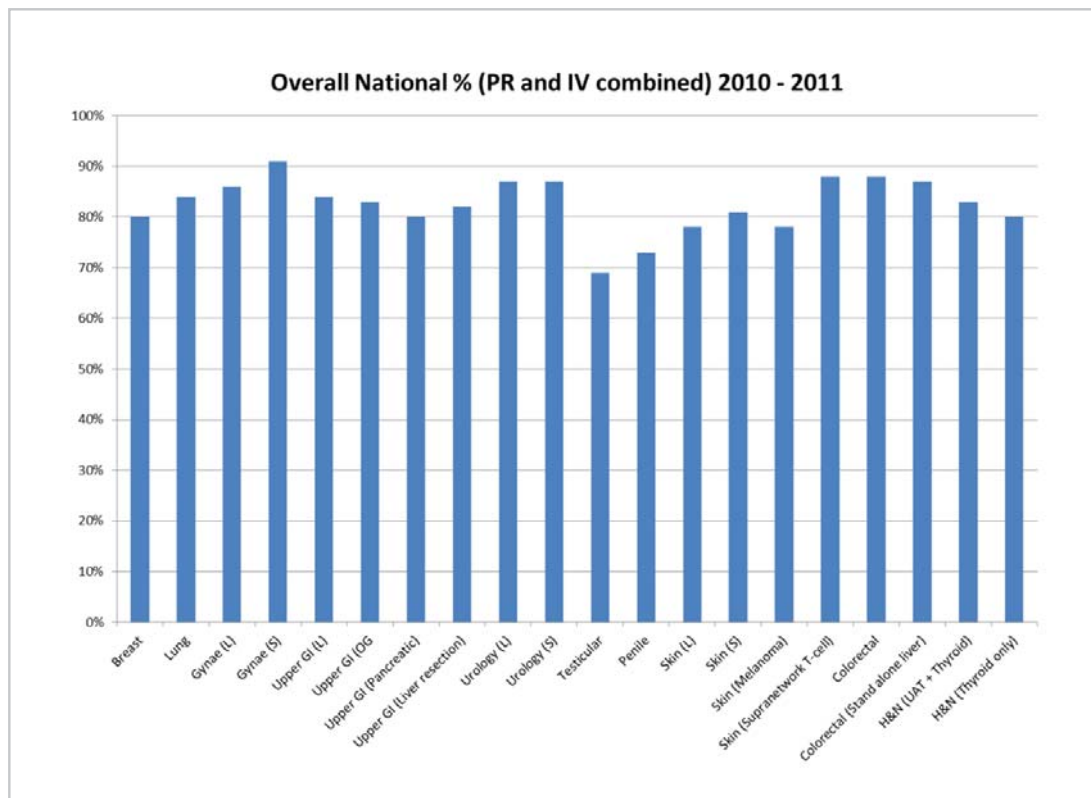
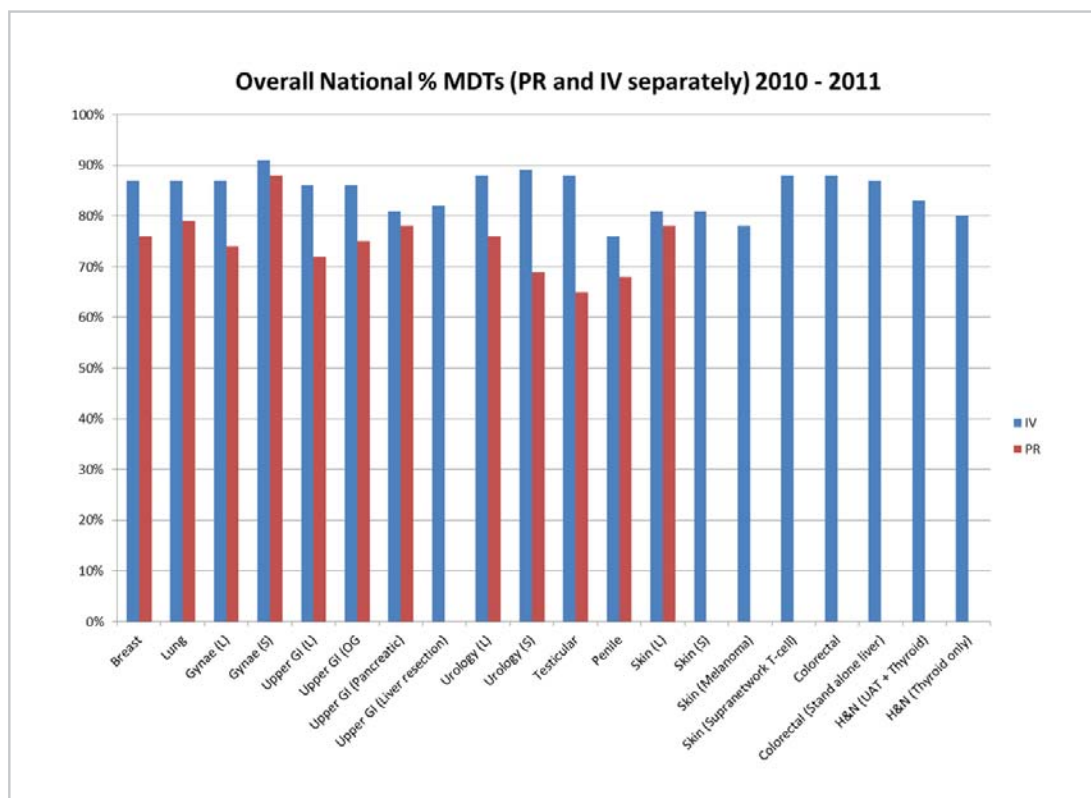


Fig 5



6.2 Clinical Teams with compliance of 50% or under

14 tumour specific MDTs had compliances of 50% or under. This equates to 1% of those teams, compared to 5% of teams with 50% or under in 2009/2010. Of those 43 teams identified as having compliances of 50% or under in 2009/2010, only 3 of those teams still had under 50% compliance (highlighted in purple below) in 2010/2011. One of these teams also had under 50% compliance in 2004/2008 (Royal Liverpool & Broadgreen Supranetwork Testicular).

The Care Quality Commission has been notified of all teams whose compliance falls below 50%, and communication from the National Cancer Director has now been sent to the Network Medical Director and the Chief Executive of the Trust concerned requesting remedial action.

Although there were also teams and services with 50% or under compliance in Radiotherapy and Children's services, these are not included in the above list as it was the first year in which those measures had been reviewed.

Tumour specific MDTs with 50% or under compliance 2010 /2011

Network	Team	% compliance	Tumour site	PR/IV
AngCN - Anglia	MDT - Hinchingsbrooke	40%	Breast	PR
AngCN - Anglia	MDT - Bedford	50%	Skin (Local)	IV
CSCCN - Central South Coast	MDT - IoW	19%	Skin (Local)	IV
ECN - Essex	MDT - Basildon & Thurrock	46%	Breast	PR
ECN - Essex	MDT - Southend	29%	Urology (Specialist)	PR
EMCN - East Midlands	MDT - Lincoln Boston (Pilgrim)	37%	Breast	PR
EMCN - East Midlands	MDT - Nottingham University Hospitals NHS Trust	49%	Urology Testicular	PR
GMCCN - Greater Manchester & Cheshire	MDT - Pennine Acute	46%	UGI Pancreatic	IV
GMCN - Greater Midlands	MDT - Mid Staffordshire NHS Foundation Trust	14%	Breast	PR
GMCN - Greater Midlands	MDT - Mid Staffordshire NHS Foundation Trust	42%	Gynaecology (Local)	PR
HYCCN - Humber & Yorkshire Coast	MDT - Scarborough And North East Yorkshire Health Care	41%	Skin (Local)	IV
MCCN - Merseyside & Cheshire	MDT - Royal Liverpool & Broadgreen	28%	Urology Testicular	PR
NWLCN - North West London	MDT - Ealing Hospital	46%	UGI (Local)	PR
YCN - Yorkshire	MDT - York	50%	Skin (Local)	IV

6.3 Good Practice

Throughout the 2010/2011 round of peer review, reviewers found examples of good practice in almost every team and organisation that was reviewed. In particular peer review teams frequently noted the dedication of the workforce. Some MDTs had made excellent progress in implementing service developments with particular mention of enhanced recovery initiatives. Many teams had built on the comments from previous reviews to achieve good practice in those areas in 2010/2011. In addition a number of MDTs were commended on their mechanisms for review of outcomes data to improve services.

Further details of those good practices can be found in the individual peer review reports and on the CQuINS database, but they include many examples of excellent leadership and clinical engagement.

Three key areas of good practice identified in relation to the Internal Validation process were where the Internal Validation panel included one or more of the following:

- Trust Executive Director
- Commissioner
- Patient/Carer (Users)

The inclusion of these members improved focus and status of the panel.

In relation to quantitative findings, this report shows that 883 (54%) of the 1,635 MDTs and Network Services achieved over 90% compliance with the measures.

6.4 Immediate Risk and Serious Concerns

A key feature of National Cancer Peer Review Programme is the identification of any Immediate Risks (IRs) and Serious Concerns (SCs). Peer review is unlike other quality assurance programmes in the NHS, in that if an Immediate Risk is identified the service is asked for it to be resolved within two weeks. The majority of the Immediate Risks identified have now been resolved. 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.

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.

In the table below the green shading shows tumour sites where the percentage of teams with Immediate Risks or Serious Concerns had decreased since 2009/2010, the red shading indicates where the percentage of teams with Immediate Risks or Serious Concerns had increased since 2009/2010 and lack of shading that the percentage had remained constant. Testicular was the only tumour site where both the percentage of Immediate Risks and the percentage of Serious Concerns had increased over this time period, with Testicular teams facing particular challenges with regard to robustness of pathways.

Tumour site	No. of teams assessed in 10/11	IR 9/10	IR 10/11	SC 9/10	SC 10/11
Breast	155	20 (13% of teams)	12 (8%)	47 (30% of teams)	54 (35%)
Lung	163	8 (5% of teams)	5 (3%)	62 (38% of teams)	64 (39%)
Gynaecological (L)	69	7 (9% of teams)	2 (3%)	22 (29% of teams)	23 (33%)
Gynaecological (S)	41	3 (7% of teams)	1 (2%)	11 (26% of teams)	2 (5%)
Upper GI (L)	103	12 (12% of teams)	7 (7%)	38 (37% of teams)	32 (31%)
Upper GI (S) (Oesophago-gastric)	41	5 (12% of teams)	1 (2%)	15 (37% of teams)	9 (22%)
Upper GI (S) (Pancreatic)	22	2 (8% of teams)	1 (5%)	5 (20% of teams)	5 (23%)
Urology (L)	93	9 (10% of teams)	10 (11%)	39 (44% of teams)	35 (38%)
Urology (S)	50	7 (14% of teams)	8 (16%)	24 (47% of teams)	19 (38%)
Urology – Testicular	13	1 (10% of teams)	3 (23%)	1 (10% of teams)	6 (46%)
Urology – Penile	9	1 (12% of teams)	0 (0%)	6 (75% of teams)	1 (11%)
Skin (L)	92	22 (95% of teams)	5 (5%)	57 (60% of teams)	34 (37%)
Skin (S)	43	6 (14% of teams)	3 (7%)	31 (70% of teams)	12 (28%)
Skin (Melanoma)	2	0 (0% of teams)	0 (0%)	2 (100% of teams)	2 (100%)
Skin (Supranetwork T-Cell Lymphoma)	5	0 (0% of teams)	0 (0%)	2 (40% of teams)	0 (0%)

In addition the immediate risks and serious concerns for those tumours introduced in 2010/2011 are as follows:

Tumour site	Number of teams assessed in 10/11	Number of teams IR	% teams IR	Number of teams SC	% teams SC
Colorectal	167	17	10%	92	54%
Colorectal Liver	5	0	0%	0	0%
Head & Neck UAT/Thyroid	56	4	7%	31	55%
Head & Neck Thyroid only	25	4	16%	11	44%

The majority of Immediate Risks and Serious Concerns were resolved in the appropriate timescales, or had on-going action plans in place to address the issues. However there were around 7 MDTs where there were still issues which had not been satisfactorily resolved, some of these involving complex discussion on IOG configurations.

Across the country as a whole similar issues were identified to those in 2009/2010, ie gaps in core team membership and capacity, some complex surgery being undertaken outside of

specialist centres particularly in Urology and the need for strengthened pathways for Testicular, Penile and Hepato-biliary services. However, there had been progress from 2009/2010, with some networks noting an increased compliment of CNS, oncology and thoracic surgery input. The introduction of Clinical Lines of Enquiry highlighted the need for some MDTs and Networks to have a greater understanding of their clinical outcomes and to address issues of data collection and submission to national audits.

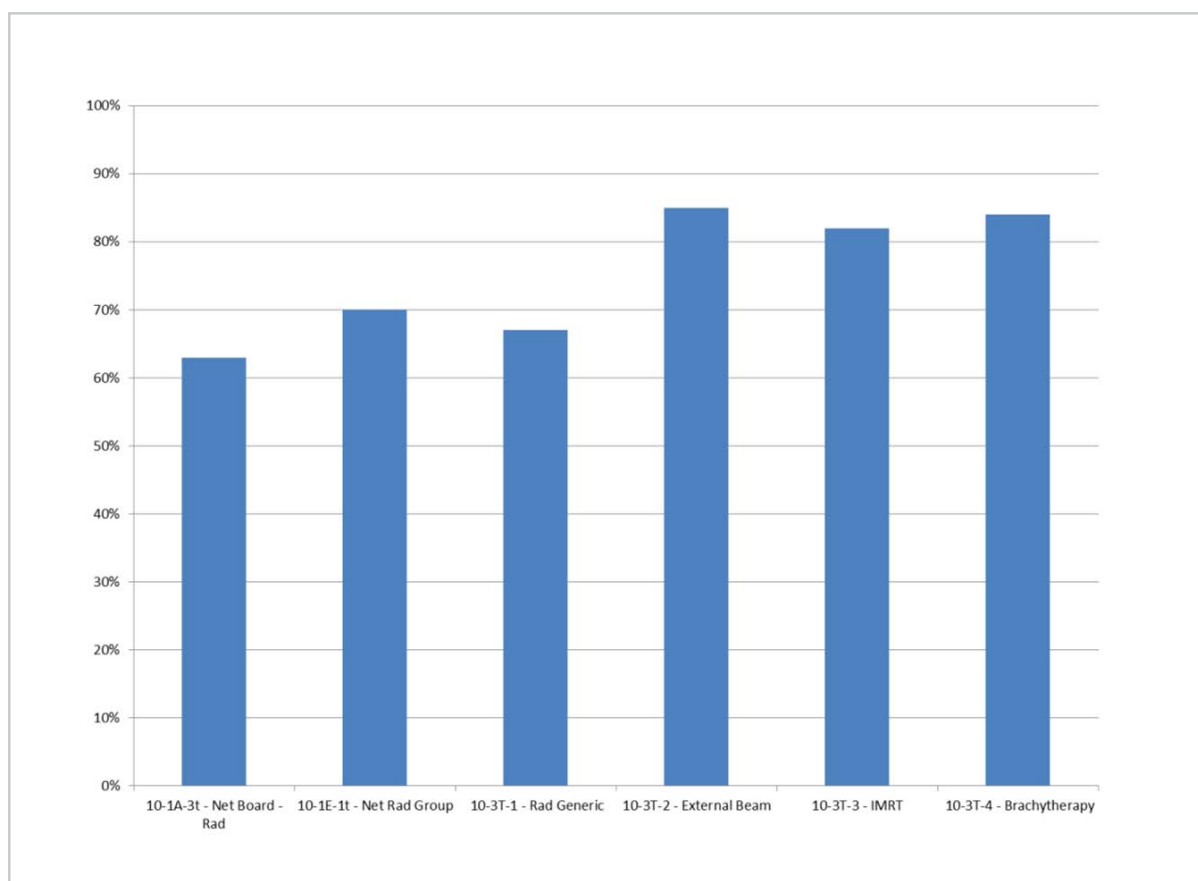
7 Other Teams and Services Overview

7.1 Radiotherapy Services

All radiotherapy services were subject to a full peer review in 2010 – 2011 following the introduction of new

measures, ie 53 Core Radiotherapy services; 53 External Beam Radiation services; 51 Intensity Modulated Radiotherapy Treatment (IMRT) services and 41 Brachytherapy services.

Overall percentage compliance



Immediate Risks and Serious Concerns

Measure series	Number of services IR	% services IR	Number of services SC	% services SC
Board & Network Group	1	4%	8	29%
Radiotherapy Generic: 10-3T-1	4	8%	22	42%
Radiotherapy External Beam: 10-3T-2	0	0%	7	13%
Radiotherapy IMRT: 10-3T-3	1	2%	7	14%
Radiotherapy Brachytherapy: 10-3T-4	1	2%	11	27%

The Immediate Risks and Serious Concerns for radiotherapy related to patient safety issues (for instance robustness of checking procedures; lack of standard protocols, prescriptions and dose measurement; working practices off protocol and limited number of patient identifiers); inadequate quality management system (for example ISO:9000); lack of planning or funding for equipment replacement programmes and staffing (medical physics; radiographers; oncologists;). To a lesser extent there were also Serious Concerns over waiting times (11 weeks in one instance) and inequity of provision across Networks with more than one centre.

There were also particular concerns related to the specific modalities. In the provision of External Beam Radiation Therapy (EBRT) there were concerns

with regard to the timeliness of Thermo Luminescent Dosimeter (TLD) results and the audit and consistency of Clinical Target Volume (CTV) to Planning Target Volume (PTV). For Intensity Modulated Radiotherapy Treatment (IMRT) there were Serious Concerns related to inequity of provision for patients across a network; delays in implementation of IMRT; robustness of risk assessment and staffing levels and education/training. With regard to Brachytherapy all the serious concerns related to low numbers of patient throughput for intrauterine insertions and prostate interstitial implants.

Further detail can be found in the separate Radiotherapy Section of the Report.

7.2 Children's Services

All Children's Services were subject to Internal Validation during 2010/2011 following the introduction of the Children's Measures.

For the Children's Cancer Networks serious concerns related to lack of a lead nurse and issues of nurse training; poor progress in developing

the Children's Cancer Network with uncertainty with regard to the number of POSCUs and governance arrangements for the pathway.

Further detail can be found in the separate Children's Services Section of the Report.

Overall Percentage Compliance

Measure series	Number of teams or services assessed	Overall national percentage
Children's Cancer Network & the Co-ordinating Group (CCNCG): 09-7A-1	13	81%
Principle Treatment Centre (PTC) Core: 09-7B-1	13	88%
PTC, Late effects MDT: 09-7B-2	13	63%
PTC, Diagnostic & Treatment MDT: 09-7B-3/4/5/6	32	76%
Paediatric Oncology Shared Care Unit (POSCU) Level 1 Core: 09-7C-1	61	82%
POSCU Level 2 Core: 09-7C-2	13	84%
POSCU Level 3 Core: 09-7C-3	12	88%
POSCU MDT: 09-7C-4	85	75%
The Children's Cancer Network Commissioning Function: 09-8A-1	7 (2 did not assess)	58%

Immediate Risks and Serious Concerns

Measure series	Number of teams IR	% teams IR	Number of teams SC	% teams SC
CCNCG: 09-7A-1	0	0%	4	29%
PTC Core: 09-7B-1	0	0%	4	31%
PTC, Late Effects MDT: 09-7B-2	0	0%	3	8%
PTC, Diagnostic & Treatment MDT: 09-7B-3/4/5/6	0	0%	6	19%
POSCU Level 1 Core: 09-7C-1	2	2%	16	27%
POSCU Level 2 Core: 09-7C-2	2	15%	6	46%
POSCU Level 3 Core: 09-7C-3	0	0%	1	8%
POSCU MDT: 09-7C-4	1	1%	20	15%
The Children's Cancer Network Commissioning Functions: 09-8A-1	1	0%	1	14%

7.3 Cancer Research Networks

All 31 Cancer Research Networks were subject to Internal Validation during 2010/2011. Generic Network Board, NSSG and MDT measures for the Cancer Research Networks were integrated within the suite of measures for each tumour site and were therefore included in the relevant internal validation or peer review compliance.

The Serious Concerns related to lack of engagement from the service network; lack of support for the Research Network Manager and poor engagement from a haematology oncology team.

Overall Percentage Compliance

Measure series	Number of teams or services assessed	Overall national percentage
Functions of the Cancer Research Networks: 10-5A-1	31	84%

NB Please note that the Network Measures for Cancer Research Networks (10-1A-5) were only partially completed and it is therefore not possible to give an overall national percentage for that section.

Immediate Risks and Serious Concerns

Measure series	Number of teams IR	% teams IR	Number of teams SC	% teams SC
Functions of the Cancer Research Networks: 10-5A-1	0	0%	3	10%

7.4 Rehabilitation

All 28 rehabilitation services were subject to a full peer review in 2010/2011 following the introduction of new measures.

Overall Percentage Compliance

Measure series	Number of teams or services assessed	Overall national percentage
Network Board – Rehabilitation: 08-1A-3v	28	75%
Functions of the Network Rehabilitation Group: 08-1E-1v	28	29%

Immediate Risks and Serious Concerns

Measure series	Number of teams IR	% teams IR	Number of teams SC	% teams SC
Functions of the Network Rehabilitation Board & Network Groups: 08-1A-3v/08-1E-1v	0	0%	4	14

Three out of the four Serious Concerns related to the lack of continuing funding for the Network AHP lead, with the fourth serious concern centred on the lack of engagement of the network board in addressing the rehabilitation portion of the Supportive and Palliative Care IOG.

7.5 Complementary Therapy (Safeguarding Practice)

All Complementary Therapy measures internal validation during 2010/2011 following the introduction of the new measures. All internal validation assessments were also subject to external verification.

Overall Percentage Compliance

Measure series	Number of teams or services assessed	Overall national percentage
Network Board - Complementary Therapy: 09-1A-3w	28	88%
Locality Measures - Complementary Therapy: 09-1D-1w	127	69%

Immediate Risks and Serious Concerns

Measure series	Number of teams IR	% teams IR	Number of teams SC	% teams SC
Network Board - Complementary Therapy: 09-1A-3w	0	0%	0	0%
Locality Measures - Complementary Therapy: 09-1D-1w	3	2%	26	20%

The Immediate Risks related to complementary therapists who are not registered with the recognised professional body or practicing on NHS premises but without the required clearance (for example CRB check).

The Serious Concerns related to the lack of a list available of practitioners that are endorsed; lack of evidence that

practitioners who were endorsed, or who were cited in patient information but working on non-NHS premises, met the relevant criteria. In a number of instances no evidence was provided, and therefore there was no reassurance that a locality was taking steps to safeguard patients treated by complementary therapy practitioners.

8 Individual Tumour Site Reports

Tumour Site	Link to Report
Breast	Breast Report
Lung	Lung Report
Gynaecology	Gynaecology Report
Upper GI	Upper GI Report
Urology	Urology Report
Skin	Skin Report
Colorectal	Colorectal Report
Head & Neck	Head & Neck Report
Radiotherapy	Radiotherapy Report
Children's Services	Children's Services Report

9 Future of Peer Review

The 2011/2012 round of National Cancer Peer Review is currently underway. The schedule for the current programme is shown below:

Peer Review Cycle 2011/2012			
Self-Assessment	Internal Validation	External Verification	Peer Review Visit
Breast			
Lung			
Colorectal			Targeted Visits
Gynae	Yes		
UGI			
Urology	Yes		
Head and Neck			Targeted Visits
Skin			
Brain and CNS		All	
Sarcoma		All	
Complementary Therapy			
Rehabilitation			
Psychology			
Cancer Research Networks			
Radiotherapy			
Chemotherapy	Yes	All	
Acute Oncology	Yes	All	
Children's Cancer			Comprehensive visits
Teenage and Young Adult	Yes	All	
Patient Partnership	Yes	All	

2011/2012 sees the introduction of Brain and CNS, Sarcoma, Acute Oncology, Chemotherapy, Teenage and Young Adult, Psychological Support services and measures for Patient Partnership Groups.

In order to reduce the burden on the service and ensure the peer review programme is sustainable a number

of changes were introduced for the 2011/2012 round. However, further work is currently underway to significantly revise the programme in 2012/2013 and a national consultation is planned to take place in November 2011.

The key changes to the programme introduced to date are:

- A further reduction in the number of measures for each tumour type by 10% and the amalgamation of measures to reduce the number of IV reports required i.e. locality and MDT measures.
- Self assessment is now only required every two years rather than annually. Teams/services are instead asked to complete a commentary in relation to the key themes; structure and function, coordination of care, patient experience and clinical outcomes.
- Internal Validation is only required every two years rather than annually.
- Peer Review visits are only undertaken where a team/service:
 - Falls into the risk criteria (see Appendix 3)
 - Where there is considered to be an opportunity for significant learning
 - As part of a small stratified sample to assure public confidence in SA and IV.

In addition and in recognition that the additional burden as a result of new topic being introduced, a one year self-assessment amnesty has been agreed whereby high performing teams do not have to complete a self-assessment in 2011/2012.

To be eligible for the self-assessment amnesty a team must not be subject to internal validation or have been identified for a peer review visit during April 2011 and March 2012 and meet the following criteria:

- Peer review visit 2010/11: Teams with 85% or over with no Immediate Risks (IRs) or Serious Concerns (SCs)
- IV with EV 2010/11: Teams with IV score of 85% or over with a green overall EV

- IV only 2010/11: Teams with IV score of 85% or over with no IRs or SCs

A list of the teams eligible for the amnesty is available on the CQuINS website. The amnesty includes 826 teams.

The Care Quality Commission (CQC) continues to be informed about the poor performing teams and trusts, with regular updates also being provided to CQC on any Immediate Risks identified through Peer Review. The mapping of the Cancer Peer Review Measures to CQC Outcomes has been extended to include all new topics and the findings of the National Cancer Peer Review process is informing the Quality and Risk Profiles of CQC which are used to monitor on-going compliance with legal registration standards.

Clinical Lines of Enquiry have been extended to Gynaecology, Colorectal, Head and Neck and Upper GI services as well as the continuation of Breast and Lung. The intention is that these will be rolled out to all tumour sites in future. This will enable Peer Review to engage in discussions with clinical teams on those elements of clinical care which will produce the best outcomes and ensure the safety, effectiveness and experience of care for patients.

In future National Cancer Peer Review will need to align with the NHS Outcomes Framework, and in relation to this it is currently engaging with the National Institute for Health and Clinical Excellence (NICE) to ensure that the Peer Review Measures are in line with the new Quality Standards which are in the process of development.

Appendix 1: The three key stages

The peer review programme consists of the three key stages. See Figure 1:

Internally validated self assessments

Completion of an annual self assessment by the team/service who deliver the particular cancer service. Internal validation of the self assessment should be undertaken by the host organisation or coordinating body for that service. It is not mandatory to internally validate a service which is subject to a peer review visit but would be seen as good practice.

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.

Earned Autonomy in relation to IV

In recognition that some teams/services have achieved a good standard of internal quality assurance governance and in line with the cancer reform strategy to reduce the burden of inspection, the concept of 'Earned Autonomy' was introduced for the IV process in 2010.

A team/service who have earned autonomy do not have to be subject to IV. The criteria by which a team/service can be considered for earned autonomy are shown below:

In relation to Peer Review

1. The team/service must have received a peer review visit report in the previous year indicating that the compliance against the measures was 75% or greater and have no immediate risks or serious concerns.
2. The teams/services compliance against the measures in the previous year and the current year must be greater than 75%; and
3. The teams/services compliance against the measures should be no less than the previous year and there should be no immediate risks or serious concerns identified within the self assessment.

In relation to External verification

1. The team/service must have received an External Verification (EV) report in the previous year indicating that the IV report was 'confirmed' i.e. Green; and
2. The teams/services compliance against the measures in the previous year and the current year must be greater than 75%; and
3. The teams/services compliance against the measures should be no less than the previous year and there should be no immediate risks or serious concerns identified within the self assessment.

Teams are still required to complete a self assessment and upload the key documents each year to demonstrate their compliance with the measures and continued improvement.

The host organisation or a cancer network may choose to complete an IV report even if the team/service has earned autonomy status if it so wishes.

External verified self assessments

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

zonal cancer peer review coordinating teams. This check takes the form of a desktop exercise. This process will ensure that every team/service will be externally verified at least once every five years.

The purpose of external verification is to:

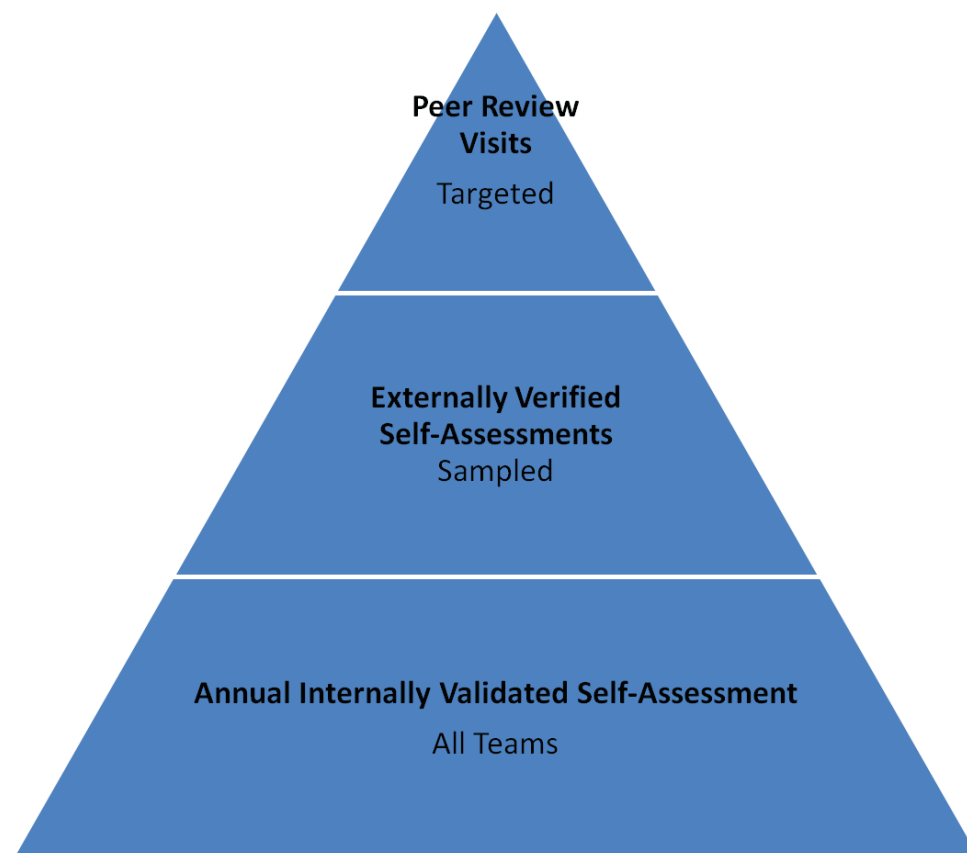
- verify that self assessments are accurate and have been completed in a similar manner across organisations;
- ensure that a robust process of self assessment and internal validation has taken place;
- confirm self assessed performance against the measures and any associated issues relating to IOG implementation;

- support identification of teams or services who will receive an external peer review visit in accordance with the selection criteria.

Peer review visits

Each year a targeted schedule of peer review visits takes place. The schedule of peer review visits is agreed with each cancer network by the end of December. The teams/services selected for a peer review visit are informed by the 31st December each year. Each visiting cycle commences in May and is completed by the following March.

Figure 1



Appendix 2 The IV status key triggers

The IV status is calculated using three key triggers. These triggers 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 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 resolve 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.

- 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. The threshold percentages have been set for the 2009/10 cycle as:

- For the IV to be confirmed – **Green**, the difference in measures compliance between the IV and EV will be less than or equal to 20%
- For the IV to be confirmed with exceptions – **Amber**, the difference in measures compliance between the IV and EV will be between 20 and 30%
- For the IV to be unconfirmed – **Red**, the difference in measures compliance between the IV and EV will be greater than 30%

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**

Appendix 3 Criteria 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.

Appendix 4: Clinical Lines of Enquiry Pilot

A pilot of Clinical Lines of Enquiry (CLE) was introduced in Lung and Breast during 2010/2011.

An online evaluation of the CLEs was completed by 286 respondents. Of those 286 respondents, 75.5% were an MDT/NSSG Team Member; 15.7% were

The results of the survey were as follows;

from a Trust Cancer Management team and 8.7% were from Network Cancer Management teams. Approximately 50% were completing the survey in relation to Breast CLEs, and 50% in relation to Lung CLEs.

Question	Yes	No
Do the clinical lines of enquiry add value to the cancer peer review process?	77.4%	22.6%
Were the clinical lines of enquiry useful to the MDT/Network in stimulating reflection on clinical outcomes and data collection?	72.2%	27.8%
Were any changes in practice of data collection introduced as a result of this process?	43.2%	56.8%
Do you agree that the metrics reflect the key clinical priorities within your disease type?	70.3%	29.7%

Breast Clinical Lines of Enquiry

Discussion on the CLEs indicated that there was variation in the degree to which NSSGs collected, collated and reflected on data to evaluate outcomes and to highlight inequalities in the constituent trusts. With regard to the indicators themselves, there was variation both within and between networks as to the availability of HER2 receptor status results at MDT discussion prior to treatment decisions, and also with regard to the availability of digital mammography which led to some inequity of service within networks. Variation in length of stay, the availability of immediate reconstruction and its take up rate, and the ratio of mastectomy to breast conserving surgery, led to networks undertaking further audit to investigate these variations. In three networks the ratio of mastectomy to

breast conserving surgery was noted as likely to have been influenced by patient choice due to the travel distance involved to access radiotherapy.

Over 40% of respondents to the online survey indicated that they had introduced changes in clinical practice as a result of consideration of the CLE data, for example in resolving challenges in the introduction of a fast-track breast reconstruction pathway and reconstruction of breast becoming part of the discussion with the patient when offering Mastectomy. In some instances where the national data was found to be erroneous the discussions also prompted improvements in data capture and improved submission to registries and national audits.

Metric	Data source
Percentage of women offered access to immediate reconstruction surgery by MDT or by referral onto another team and rate of uptake	The <i>National Mastectomy and Breast Reconstruction Audit 2</i> Report (2009)
Ratio of mastectomy to Breast Conserving Surgery (BCS)	NATCANSAT
Each surgeon managing at least 30 new cases per year	NATCANSAT
Average length of stay for breast cancer with any surgical procedure	NATCANSAT
The one-, two- and five-year survival rates	NCIN e-atlas / Registry
Local data	
Proportion of women tested for HER2 prior to commencement of drug treatment (if undergoing resectional surgery and receiving adjuvant or neo-adjuvant chemotherapy)	Local data
Availability of Screening and estimated impact on workload	Local data
Availability of Digital mammography	Local data

Lung Clinical Lines of Enquiry

Discussion on the CLEs indicated that there were still challenges with data capture and accurate submission to LUCADA in Networks, although this was shown to be improving over time with the introduction of electronic data management in the MDTs, for example with the Somerset system. Some MDTs and Networks had taken ownership of the data and had used it to reflect on both data collection and practice, taking into account the case-mix of the MDT, but a minority had had no discussion on its implications prior to review.

With regard to the indicators themselves, there was variation between Trusts in a number of Networks, in particular with respect to chemotherapy rates for small cell lung cancer, percentage of cases receiving active treatment and resection rates. In Networks where this was the case the NSSGs were encouraged to investigate the reason for these apparent discrepancies, which in some instances was linked to lack of accuracy and completeness of data, but in others the variability was able, on further investigation, to be attributable to specific factors, for example the availability of oncology support, delays in referral pathways to oncologists; obstacles to

accessing treatment for patients not suitable for surgery, an increase in PET scanning leading to fewer patients deemed suitable for surgery, possible late presentation and lack of thoracic surgical input to the MDT. In some cases the lack of a CNS at diagnosis was attributed to capacity, clinics running in parallel or inappropriate use of the CNS for data entry impacting on their ability to be present at the breaking of significant news and one instance where further investigation highlighted that the CNS was not always made aware of the appropriate appointments in advance. A number of further audits were instigated by MDTs and NSSGs to investigate variations in the indicators.

Over 40% of respondents to the online survey indicated that they had introduced changes in clinical practice as a result of consideration of the CLE data, for example three MDTs had now secured the presence of a thoracic surgeon following the indications of low resection rates; a trust which was encouraged to work towards the implementation of inpatient chemotherapy; numerous audits to investigate variations in practice and a number of MDTs who had instigated improvements in data capture.

Metric	Data Source
The % of expected cases on whom data is recorded	National Lung Cancer Audit (LUCADA) 2009
The % Histological Confirmation Rate	National Lung Cancer Audit (LUCADA) 2009
The % having active treatment	National Lung Cancer Audit (LUCADA) 2009
The percentage undergoing surgical resection (all cases excluding Mesothelioma)*	National Lung Cancer Audit (LUCADA) 2009
The % small cell receiving chemotherapy	National Lung Cancer Audit (LUCADA) 2009

**In 2010-11 the percentage undergoing surgical resection (all cases excluding Mesothelioma) was mistakenly asked for, this should have also excluded cases of confirmed Small Cell Lung Cancer. This was rectified for the 2011 – 2012 reviews.*

