



# **Northern Ireland Peer Review of Cancer MDTs Handbook 2009/10**

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## 1. Introduction

The Northern Ireland Cancer Network (NICaN) has been funded by the Regional Medical Services Group (RMSG), to lead on the implementation of a rolling peer review programme of cancer services delivered through multidisciplinary teams (MDTs). Following an open tender process, the National Peer Review Team in England was awarded the contract for delivery of the programme. The programme will commence in 2009/10 with a review of breast, lung, gynae and colorectal MDTs.

This is the handbook for the Northern Ireland Peer Review Programme of Cancer Services that will be delivered through an assessment of MDTs. This handbook describes the method and procedures by which this review programme will be organized. The purpose of the reviews is to assess current services and identify areas of good practice and areas for the further development of services. This quality assurance system is based on the National Cancer Peer Review Programme in England.

The English Peer Review Programme was independently evaluated after its first three years of operation. As a result of this assessment it was concluded that peer review should continue but that the process should be streamlined. All teams will receive a visit in the first round of review, thereafter visits will be on a targeted basis (i.e. teams will be visited again only where there are specific reasons such as a low compliance score) All tumour services will be reviewed within a five year rolling programme. This new model is based on trusts taking on clearer responsibility for an annual quality assurance process (self assessment) of the services they deliver through their governance systems.

The Northern Ireland programme is adopting this new streamlined process to peer review its cancer services based on an annual self assessment process by each Trust. This will be supported by an initial round of review team visits to assess each MDT but with a targeted visit programme thereafter. As has happened in England the programme is being introduced on a phased basis with the MDTs for 4 tumour services being reviewed in the first year.

The revised English cancer peer review programme is based on the following key features which are being used for the Northern Ireland reviews:

- the process is clinically led with a greater emphasis on outcomes
- the reviews will take a developmental approach
- there is a stronger emphasis on the responsibility on trusts to monitor the quality of their services through their internal governance and risk management processes
- there is a continued focus on system and services within and across organisations in a cancer network to ensure co-ordination of patient care
- retaining the peer on peer review process for visits
- looking to achieve greater integration with other review systems
- retaining the patient and carer involvement in the programme both at the national level of overseeing the programme and at the local level of MDT reviews.

## 1.1 Background and Context

The Cancer Control Programme (DHSS&PS, 2006) made 55 key recommendations with the aims that:

- more lives will be saved
- patients' quality of life will be improved
- inequalities reduced
- build capacity for the future
- enable cancer care to be delivered in the best place at the right time
- achieve maximum value for money

The Service Framework for Cancer Prevention, Treatment and Care, which is due for publication in early 2010, builds on the recommendations of the Cancer Control Programme and will provide a commissioning framework for cancer services until 2013.

Peer review will provide a framework within which to implement, monitor and drive further improvement against many of the standards contained within the Service Framework for Cancer Prevention, Treatment and Care.

The Multi-disciplinary Team (MDT) and its regular meetings (MDMs) are the cornerstone of effective, safe and well-planned patient cancer care. The peer review programme will enable trusts and the Network to benchmark MDTs against a range of measures outlined in the Manual of Cancer Services (DoH, 2004 with some amendments introduced in 2008). These measures cover the membership and functioning of the multidisciplinary team and include such aspects as:

- is the membership complete
- how meetings are organized
- the extent of the development of CNS roles
- how fully the team's operational policies define how the MDT organizes its care pathways to provide responsive and well

- coordinated services
- the range of information by which the MDT is able to assess its service
- participation in audit and research
- use of patient feedback in service development

The scope of peer review is being extended; MDTs will be asked to outline their plans and priorities for responding to a range of clinical issues. These issues impact on patient care and outcomes that have been identified as areas for development through national and local audits and NICE Improving Outcomes Guidance (IOG; including further guidance produced since the original IOGs were produced). Many of these clinical issues mirror the tumour specific standards identified by MDTs in the Service Framework (e.g. access to chemotherapy and new radiotherapy services). The extent to which the peer review process examines clinical issues is limited to establishing if a team is aware of such recent clinical guidance, whether it has established data collection / analysis arrangements to assess its position against such recommendations and whether changes in the service provided by the team have been introduced in response to the guidance. Peer review does not review individual clinical practice.

It is intended that peer review will provide a range of information about how each MDT provides services to its locality. This will help those responsible for the planning, commissioning, organising, and provision of cancer services to identify good practice, identify gaps in provision and to check the appropriateness and quality of existing services within a given locality.

There has been a clear commitment to the establishment of an active and positive relationship with the Regional Quality Improvement Authority (RQIA) and information gathered from the programme will be shared with the Authority. RQIA will play an important role in assessing the quality of cancer services and peer review will work in partnership with the Authority.

## **1.2 Aims and Outcomes of The National Cancer Peer Review Programme**

The 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 programme will be:

- confirmation that cancer services are of an approved quality and are consistent across the region
- speedy identification of any major shortcomings in the quality of services so that they can be rectified
- enhance local system management processes to support governance
- identify the areas where the allocation of resources within cancer services should be redirected
- highlight how care pathways can be improved
- provide a patient perspective on the service provided
- highlight any regional issues which require a Network response

- support the development of better informed commissioning of cancer services
- published reports that provide accessible public information about the quality of cancer services and highlight areas of good practice

The programme is based on the understanding that those involved have a shared commitment to further developing cancer services. The discussion between a review team and an MDT is designed to result in a balanced and objective assessment of the current stage to which the MDT has been able to develop their service and to highlight the areas where further improvements can be made. It is therefore important that the dialogue between MDT members and reviewers is conducted in an open way with participation from staff from different disciplines so an accurate profile of the team and its services can be produced. The report should cover the way the complete patient pathway is provided from referral through diagnostic, initial treatment and follow up services as well as how complications and advanced disease are managed.

It is essential that 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 will be emphasised during each of the peer review training sessions.

## **1.3 Management of the National Cancer Peer Review Programme**

The planning and implementation of the programme will be overseen by a regional Peer Review Reference Group, which will function as a sub-group of the NICaN Board. The reference group includes representation from the NICaN, RHSCB, PHA, RQIA and all five Trusts and will

provide direction to the London Zonal Team who will coordinate the delivery of the programme. The agreed Terms of Reference for the Peer Review Reference Group are included in Appendix 1.

The peer review programme in England is organised by four zonal teams, one of which covers London, Essex and Hertfordshire.

The London team will oversee the review teams meeting with each MDT in Northern Ireland. The reviewers will be clinicians mainly drawn from London hospitals. The London Zonal Team are:

- Mike Bellamy – Zonal Quality Director
- Angela Hoyes – Zonal Quality Manager
- John Bolton – Zonal Clinical Lead

The performance of the London Zonal Team in delivering the peer review programme is defined in the project plan and will be monitored by NICaN and the Peer Review Reference Group.

#### **1.4 Scope of Peer Review**

The scope of peer review has been extended. The programme will continue to review compliance with measures contained within the Manual for Cancer Services. However, it will also ask teams to describe the clinical data that they are collecting and how they are using this to inform service planning in order to improve quality and outcomes. In order to ensure that peer review is aligned to emerging cancer policy, the clinical aspects of the review will include an assessment of the work that teams are undertaking in relation to the delivery of the standards included in the Service Framework for Cancer Prevention, Treatment & Care.

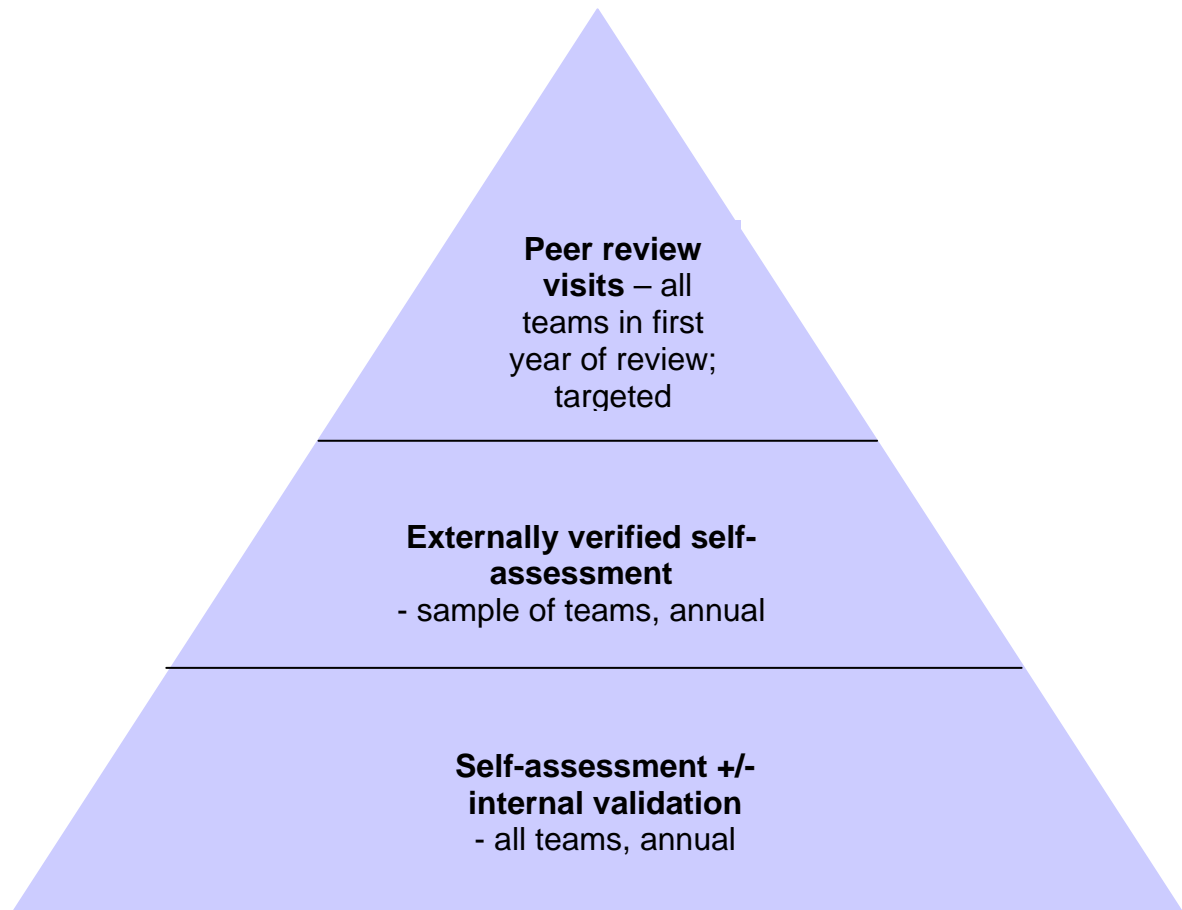
The peer review programme will commence with a review of the following

MDTs: breast; colorectal; gynae and lung. This will be the first round in a rolling programme which will see the programme extended in future years to other tumour sites and service areas for which peer review measures have been developed.

The process of cancer peer review is concerned not only with the review of an organisation's compliance against a set of measures for each tumour service, but also with the broader assessment of each team and its service looking at the way the whole pathway of care is delivered against the aims identified in the introduction in Section 1 above with a strong emphasis on the quality of the service from a patient and carer perspective.

## 2. The Peer Review Programme

The peer review programme consists of the three key stages illustrated in the following diagram.



### 2.1 Self-assessment

All teams should complete an annual self assessment.

In most years, Trusts would be asked to undertake an **internal validation** of each team's self assessment. Internal validation is only a formal requirement of the peer review programme where an MDT is not being visited and as a consequence the responsibility for ensuring that minimum standards are being met rests more extensively with the Trust. In Northern Ireland all teams will receive a visit in the first year that they join the programme. Internal validation of self-assessments is not compulsory in the first year.

### 2.2 Internal Validation

When an MDT is not having a review visit this validation process needs to be carried out. It should be carried out as a two stage process to ensure the procedure of signing off the declaration on behalf of the CEO is reliable:

- an initial desk top review of the self assessments of each MDT carried out by the trust cancer management team to identify the key issues regarding compliance with the IOG and Measures.
- a second stage involving a face to face session between members of each MDT and a small review panel of senior Trust management

on behalf of the CEO. This meeting would discuss the key issues and any action to address non compliant aspects should be agreed and mentioned in the final set of evidence uploaded onto CQulNs.

A standard template for carrying out the internal validation process is attached as Appendix 2.

### **2.3 External Verification of Self Assessments**

In years that teams are not being visited, the zonal cancer peer review team will undertake an external check of selected internally validated self assessments. 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.

### **2.4 Peer review visits**

Site visits by the peer review team to the relevant MDTs. All teams receive a visit in the first round of review with a selective visiting programme thereafter (i.e. teams will be visited again only where there are specific reasons such as a low compliance score).

Each of the above stages of the peer review process should determine whether each measure has been met and if not whether there are clear plans to achieve compliance by a firm date in the future. If evidence is not available then the measures will be considered as not met.

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. This should be within an agreed timescale, 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 action plans is primarily a function of clinical and corporate governance systems of each Trust and of the Cancer Network and not a prime responsibility of the peer review programme. However, the zonal team will provide feedback on plans submitted in response to immediate risks or serious concerns identified during the visit process (see Section 9).

### **2.5 Future years**

Because this is the first year of review and all teams will be receiving a visit teams will be required to complete a self assessment and to undergo a visit. ***Teams will not be expected to undertake internal validation or undergo external verification.***

Your team will need to undertake their next self assessment and internal validation between April 2011 to 30<sup>th</sup> September 2011 and annually from then on. The external verification process will take place during October of each year. The external verification process checks a selection of teams on an annual basis but the process ensures that all teams undergo external verification at least once every 5 years.

### **3. Support Available for Trust Teams Undergoing Review**

A range of support tools and mechanisms will be made available to teams to assist them in their preparation for peer review.

#### **3.1 Evidence guides for each MDT**

Evidence guides will be produced for each tumour topic. These will outline the measures against which the teams will be reviewed and will identify the key pieces of evidence that teams will need to submit in order to comply with the measures.

#### **3.2 Access to Cancer Quality Improvement Network (CQuINS)**

The National Peer Review Programme has developed a national, web-based database for peer review called CQuINS. CQuINS provides access to examples of evidence submitted by English Networks. All Trust teams now have access to the site. <http://www.cquins.nhs.uk/>

Further information on CQuINS is outlined in Section 9.

#### **3.3 Shadowing opportunities**

All trusts will be given the opportunity to send at least two MDT clinical leads or Trust cancer leads to shadow reviews taking place in West London in July 2009 and in the Mount Vernon Cancer Network in September 2009.

#### **3.4 Trust Familiarisation workshops**

The zonal team will undertake half day Trust Familiarisation workshops in each Trust at the end of June 2009. The team will meet representatives from trust executive teams and from the four tumour

services that are being reviewed in order to provide them with a more detailed insight into the peer review process.

Prior to this it would be helpful if each MDT had looked at some other operational policies, annual work programmes and annual reports on CQuINS as well as at the evidence guides for these three key documents that clarify the distinctive aspects of the peer review programme in Northern Ireland.

#### **3.5 Network Support**

Each Network Site Specific Group (NSSG) or tumour group will establish a peer review preparation sub-group.

Each MDT will be encouraged to nominate at least two core members to attend, preferably to include the Chair and a clinical nurse specialist where one is available. Trusts will also be asked to nominate a representative from their local cancer management team.

These groups will be facilitated by the Network Service Improvement Lead and will:

- facilitate a shared understanding of the measures
- facilitate a shared understanding of the required evidence
- share examples of good practice
- provide a forum for peer support and shared problem solving
- identify common issues that could be picked up in the work programme of the NSSG

A clinician who has been involved in peer review within a London Network has been identified for each of the four tumour sites to be reviewed. These clinicians have

been invited to attend the first meeting of each of the peer review preparation sub-groups. The meetings will commence in June 2009.

In addition, each Trust lead has been linked to a colleague in a London Trust who has had experience of preparing for peer review.

## 4. The Annual Self Assessment

Peer review is based on self assessment.

### 4.1 What Will Be Self Assessed?

MDTs will be required to complete a self-assessment against the peer review measures for their team. Evidence guides have been produced for each tumour topic. The evidence guides set out the relevant key questions and cover the information requirements for the main documents that teams/services are required to submit as part of their self assessment.

### 4.2 How to Self Assess

A set of four key questions have been developed which will assist teams and Trust management to make an overall assessment of their service from an organizational, and to some extent a clinical quality, standpoint. The key questions also provide a broad set of objectives for the delivery of a quality and safe service in relation to patient, carer and patient perspective.

#### ***MDT Key Questions***

Can you:

- demonstrate that you have a properly constituted and functioning MDT;
- demonstrate the extent to which you have effective systems for providing coordinated care to individual patients;
- demonstrate the extent to which your team/service has adequate information to help it assess its services and improve service quality;
- demonstrate how you are seeking to continually improve your services (including both clinical effectiveness and the patient's experience).

Teams are expected to submit 3 key pieces of evidence in support of their self-assessment.

#### ***The Operational Policy Document***

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 (Jan-Dec, 2009)***

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 by the MDT and MDT attendance by the core team); national audits; local audits; patient feedback; trial recruitment; work programme update.

#### ***Annual Work Programme (Jan – Dec, 2010)***

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 year

- the audit programme, patient feedback, trial recruitment and actions from previous reviews.

Evidence of guidelines, policies etc. require written evidence unless otherwise specified.

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.

### **4.3 When Will a Team/Service Need to Self Assess?**

The process of preparing for a peer review visit is an important part of an MDT assessing with its Trust management the key issues about their services and working out how to address areas of non compliance with the Measures and other requirements such as those from NICE or the Services Framework. It is common for a range of developments to be identified for implementation during this preparation phase. Peer review is a developmental process and so it is expected that MDTs at whatever stage of their team or service development will have identified the scope for making further improvements.

After the familiarisation workshops in June the MDTs, with support from their Trust management, should create a peer review project plan that identifies the key tasks that need to be undertaken in order to meet the measures and the dates by which they will be completed. This might include for example, reorganizing work plans so the core membership covers all the required disciplines or that an MDT introduces a system for recording attendance. These plans and the progress being made in implementing them would be the basis for the preparation support visit that the zonal

team will make in the third week of November.

Each MDT being reviewed, with support from their Trust management, should from October through to the end of January 2010 complete their set of evidence. Self-assessments and supporting evidence will need to be uploaded on to CQuINS by the middle of February.

The scope to altering compliance is limited by this stage as peer review expects to see that any systems have been established and running for at least three months before the visit.

The CEO of the Trust has to confirm that the final set of information has been signed off by them and this has to be uploaded by the end of March 2010. At the review it is expected that the Trust will have an overall view of each of their MDTs against the four key questions identified in section 3.2. above.

## 5. Internal validation

### 5.1 What will be subject to Internal Validation

All self assessments will need to be internally validated with the exception of those teams/services who have undertaken a self assessment in preparation for a peer review visit. However it may be considered to be good practice for self assessments to be internally validated for these teams / services as well.

### 5.2 Responsibility for Internal Validation

Responsibility for internal validation for teams rests with the Trust.

The National Cancer Peer Review Programme requires Trusts to organise and coordinate their own system for internal validation, culminating in a report that is an accurate assessment of the team/service and is agreed at CEO level.

### 5.3 The Purpose of Internal Validation

The purpose of internal validation is as follows:

- 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.

### 5.4 The Process of Internal Validation

Internal validation should be completed as a two stage process as outlined in paragraph 2.2.

Those responsible for internal validation should ensure that the process 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 chief executive 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 proforma (see Appendix 2); completed electronically on CQuINS.

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 proforma is completed and suitable for publication;
- feedback to the teams/services;

- ensure that the final self assessment has the agreement of the chief executive;
- upload onto CQuINS by end of September each year.

## **5.5 Categorisation of Issues**

The validation proforma asks for identification of concerns (See Section 9 of this handbook).

## **5.6 When will internal validation take place?**

Internally validated self assessments will need to be uploaded on to CQuINS by the end of September each year.

## 6. External Verification

### 6.1 What is External Verification?

An external check of validated self assessments led by the zonal cancer peer review team. *This stage does not apply to MDTs in the first year of review when all MDTs will receive a peer review visit.*

The process of external verification will include the following steps:

- desk top review of internally validated self assessments
- a request for further information if required
- obtaining advice from specialist clinicians or user reviewers where necessary
- feedback to the MDT and Trust.

### 6.2 Responsibility for External Verification

External verification will be led by the London Zonal team. The zonal team will also have access to expert clinical advisors during this stage, whose role is to clarify or advise on any clinical or other issues arising from the zonal review of the validated assessments.

External verification reports will then be completed using the national proforma and agreed by the zonal quality director and clinical lead.

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 cancer

peer review zonal team and clinical advisors. In the event of a resolution not being reached at zonal level a peer review visit to the team / service may be carried out in order to clarify the position.

### 6.3 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.

### 6.4 When Does External Verification Take Place?

In future years external verification will take place during the month of October.

## 7. Peer Review Visit

### 7.1 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 as well as identifying a broader set of issues concerned with the delivery of a quality and safe service in relation to patient care and the patient experience. In addition the visit will provide a further external check on the robustness of internal quality assurance processes.

### 7.2 Who is Responsible for Peer Review?

The London zonal team will utilize its database of clinicians who have been trained and carried out reviews for their own tumour service across the five London networks and two adjoining ones – Mount Vernon and Essex. Visiting teams will be made up of clinicians from a range of disciplines depending on the tumour service being reviewed and include managers who are also trained and experienced reviewers.

The patient / carer members of the review teams will be drawn from Northern Ireland. Patient reviewers will receive training or order to enable them to play a full role in the assessment of evidence and in the discussion with each MDT. Training will take place by January 2010. Patient and carer members of the review teams will generally review services other than the one covering the tumour for which they have been treated. They usually will have completed their treatment at least two years previously.

Reviewers have a collective responsibility for gathering, verifying and sharing information that enables them to reach robust conclusions about compliance with the measures and about the quality of particular cancer services. While undertaking a review, reviewers are acting on behalf of the National Cancer Peer Review Programme and are not expected to pursue any individual or organisational interests.

### 7.3 The Peer Review Visit Process

Figure 1 (overleaf) provides an overview of the peer review visit process and timetable for 2009/10.

#### 7.3.1 Submission of Self Assessments

The deadline for the latest draft submission of self assessment and supporting evidence is 12<sup>th</sup> February 2010 for the four services being reviewed. The success of the visit will be dependent on the ability of teams/services to meet this deadline.

#### 7.3.2 Pre Visits

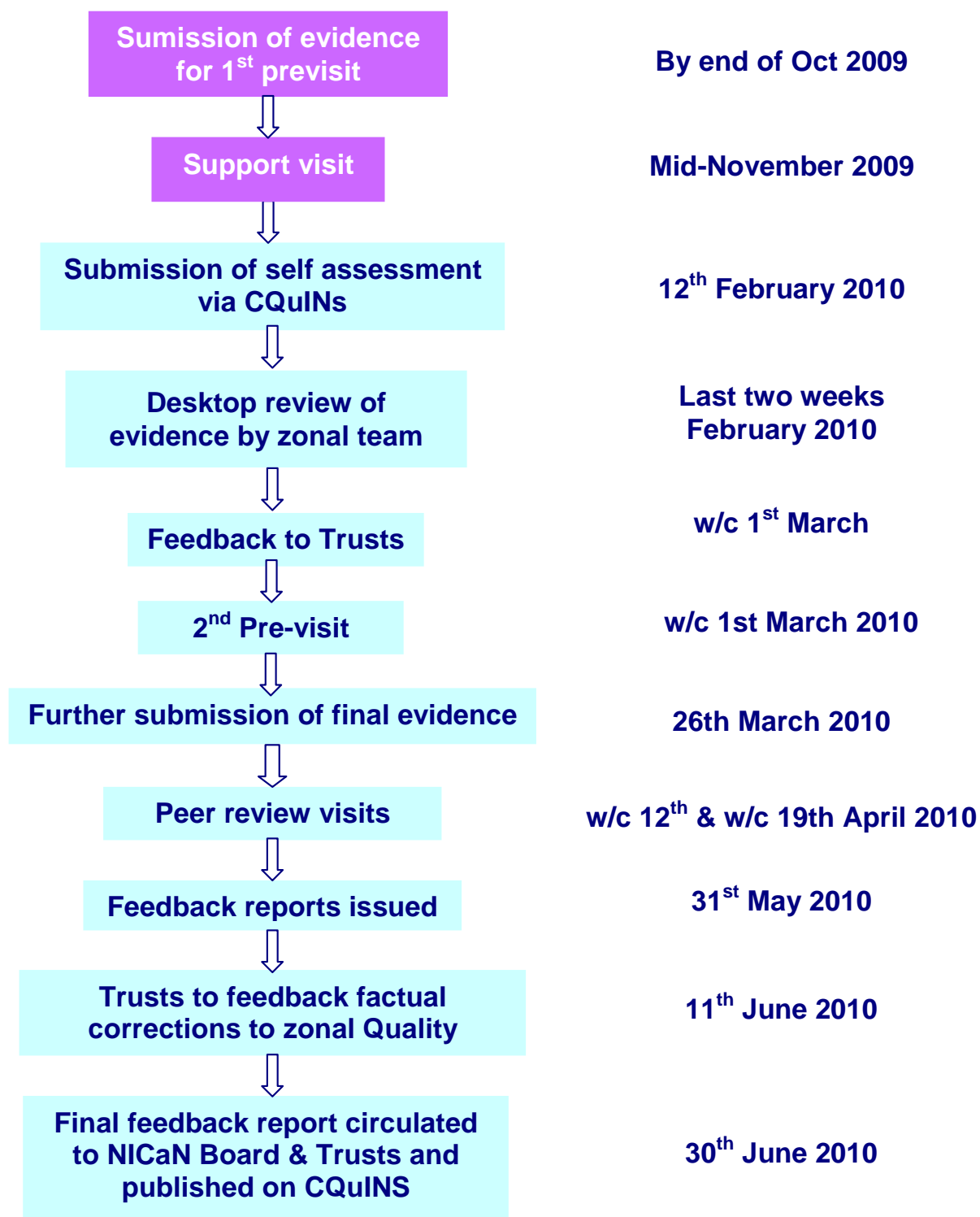
Following the external desk top review of the self-assessment documentation each trust will receive a second pre-visit during the first week March 2010.

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

- enable the zonal teams to review the self assessment with a representative from the trust cancer management team
- engage in dialogue with Trusts on key findings from the self-assessment and a review of all other supporting evidence
- provide a forum to discuss points of clarification with regard to compliance

- provide initial feedback on the extent to which the service is currently meeting the quality measures
- agree the logistical arrangements for the visit to the network.

**Figure 1. An overview of the peer review visit process & timetable for 2009/10**



Pre-visits will take place during the first week of March 2010.

Only changes to self assessments arising from the discussion at the pre visit meeting will be permitted and these will have to be submitted not later than 26th March 2010.

The confirmed self assessment documentation will be available to the peer review visiting team at this stage and no further changes will be accepted after this date.

### **7.3.3 Information Available for Reviewers**

Two weeks before their visit, visiting teams will be able to access, via the CQuINS web-site, the following information:

#### **Contextual Information**

The peer review visit team will be provided with appropriate contextual information for the Network. This will include:

- information about cancer epidemiology in Northern Ireland;
- a summary of the standards included in the Service Framework for Cancer Prevention, Treatment and Care
- Information about PfA standards that relate to cancer
- cancer screening programme statistics
- an overview of achievement against access standards by trust and MDT
- an overview of palliative care services
- information about numbers and caseload for clinical nurse specialists by trust & tumour type.
- information about trust services (e.g. catchment area; number of acute hospitals; range of service provision)

#### **Self Assessment Documentation**

- compliance against the measures
- supporting evidence

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

#### **Case notes**

Reviewers will expect each MDT to make a minimum of 10 sets of case notes available for viewing on the day of the visit. Where an MDT provides treatments over a number of hospital sites the team should provide a minimum of 5 sets of notes from each site (i.e. if treatment is provided on 3 sites, the team will require 15 set of notes).

The notes should be selected from a patient list for an MDT meeting that took place not more than 3 months prior to the date of the peer review visit. A copy of the MDT list for the selected meeting should be made available along with the notes.

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

#### **7.3.4 Visits**

The visit itself will be designed around a sessional structure with the norm being two one day visits to each Trust within a cancer network. In general visits will be timetabled to run reviews of up to two individual teams/services concurrently in the morning. The majority of sessions will mirror the example below.

## MDT review module

Activity	Approx. Time
Review team to review evidence in preparation for meeting	2 hrs
Meeting with the MDT	Up to 1.5 hrs - usually starting at midday
Review team write up draft report	2 hrs

The peer review team will undertake a short feedback session at the end of each visit day (normally commencing at 4.00pm for 30 minutes). The following individuals should attend the feedback session:

- Trust Chief Executive and / or Medical Director
- Local cancer management teams
- Chairs / clinical leads of the reviewed teams
- A representative from NICaN Board.

The purpose of the feedback meeting is to:

- Provide an overview of the key findings of the review team
- identify any areas of good practice
- highlight any areas of concern (see Section 8).

### **7.3.5 Preparation of Visit Reports**

The draft reports produced on the day of the visit will be reviewed for consistency, accuracy and clarity by the zonal team and an executive summary produced and signed off by the Quality Director. These final draft reports will be sent to the Trust and Network within four weeks of the last Trust being visited.

The Trust and the Network are invited to comment on any points where the factual accuracy of the draft report can be improved. Comments should be submitted in writing to the zonal team within two weeks of receipt of the draft report. Experience from previous rounds of peer review shows that the vast majority of comments can be addressed simply by re-checking the evidence provided prior to the review as well as from the notes made by reviewers at the meeting with the MDT or in their comments on compliance. Any issues that remain unresolved will be forwarded by the Quality Director to the Peer Review Reference Group who will assess the relevant information and decide if any amendments are required or if the report can be finalized and made publically available on the CQuINS website.

## **8. 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 clinical and corporate governance systems of the Trust and Network and is not the prime responsibility of the peer review zonal team.

### **8.1 Following Peer Review Visit**

An individual peer review report for each team will be available on the public section of the CQuINS web-site by the end of June 2010. This will:

- provide external feedback to the teams/services
- will confirm the level of compliance with the measures
- provide a commentary on the services provided by the team and how they are organised and a set of issues identified whereby the MDT can provide a improved service in relation to patient care and the patient experience.

### **8.2 Annual Cancer Peer Review Reports**

Following the completion of every peer review cycle, the zonal team will write an overarching report for the Northern Ireland Network compiled using information from each stage of the peer review process. These reports will include an executive summary prepared by the Zonal Quality Director. The reports will appear in the public section of the CQuINS web-site.

The identification of good practice for wider dissemination is an important part of the review programme and will be highlighted in this report.

NICaN will notified the following organisations that the report is available on the CQuINS web-site:

Trust Chief Executives  
NICaN Board  
RHSCB cancer lead(s)  
Specialised commissioning group within RHSCB  
RQIA  
Chief Medical Officer  
Chairs of LCGs  
Patient & Client Council

Following the outcomes of the peer review process, the cancer network and its constituent organisations will 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. Identification of concerns

Concerns can emerge either during any stage of the review process (e.g. self assessment, internal validation, external verification or visit).

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 3 categories of concern;

- Immediate Risk
- Serious Concern
- Concern

All require remedial action to be taken, however timescales and management will vary.

### 9.1 Immediate Risk

An “Immediate Risk” is an issue that is likely to result in harm to the patient or staff or have a direct impact on patient outcome and requires immediate action. If identified through the self assessment or internal validation it is expected that this will be addressed through the organisation’s risk management process and details of actions included on the validation proforma.

If the issue is identified at the time of an external verification or peer review visit, the zonal team will notify the organisation on the day of the visit. This will be followed up within a week of the visit by a formal letter from the zonal Quality Director to the Trust Chief Executive, outlining the immediate risk and inviting the organisation to respond with a plan as to how that risk will be resolved within a two week time scale. The issue will also be brought to the attention of the

Network, RHSCB and RQIA.

A written response identifying actions being taken to resolve the issue should be provided in writing by the CEO of the Trust within 2 weeks. There may be occasions when the action required to fully resolve a problem cannot be achieved immediately, e.g. if recruitment to a post is required, however it is expected that interim solutions will be found to minimise the risk. The zonal team will liaise with the Trust, and if necessary NICaN Board, should it be felt that the planned action is insufficient to substantially mitigate the risk to patients.

The responsibility for deciding what action to take if an immediate risk remains unresolved lies with the Trust and the Commissioners.

### 9.2 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 outcome of patient care and requires urgent action to resolve. If identified through the self assessment or validation it is expected that this will be addressed through the organisation’s risk management process and details of actions included in the validation proforma.

If the issue is identified at the time of external verification or a peer review visit, the zonal team will notify the organisation immediately. This will be followed up within a week of the visit by a formal letter from the zonal Quality Director to the Trust Chief Executive outlining the “serious concern” and inviting a written response from the organisation within 4 weeks. It is recognised that in some instances resolution will require longer term solutions in which case it is

acceptable for the organisation to submit an action plan with specific timescales for addressing the issue. The zonal team will liaise with the Trust and other organizations to assess whether the risks have been substantially reduced and if not alert the other organizations as for immediate risks.

### **9.3 Concern**

A concern is an issue that is affecting the delivery or quality of the service but does not require immediate action but needs to be addressed through the work programme of the MDT in conjunction with the management of the Trust.

## 10 Use of Cancer Quality Improvement Network System (CQuINS)

### 10.1 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 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.

### 10.2 Principles for Uploading Documents as Evidence

Evidence should be uploaded on to CQuINS six weeks before the visit. Revisions to the evidence submitted can be made following a pre visit or pre-assessment by the zonal coordinating team, but such revisions must be uploaded no later than two weeks before the start of the network review.

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.

Microsoft Office (MS Word.doc, MS Excel.xls, MS PowerPoint.ppt) can be uploaded if required.

Scanned documents should not normally be uploaded.

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

- most documents should not be more than 1Mb in size though it is recognised that on some occasions it will be appropriate to upload larger documents;
- documents of more than 4Mb should not be uploaded except in very exceptional circumstances;
- should a scanned document need to be uploaded it should be saved in Jpeg (.jpg) format at 80% quality. A scanned sheet of A4 will generally occupy no more than 500Kb while remaining perfectly legible.

The address for the CQuINS web-site is [www.cquins.nhs.uk](http://www.cquins.nhs.uk) and this will provide open access to the public web-site.

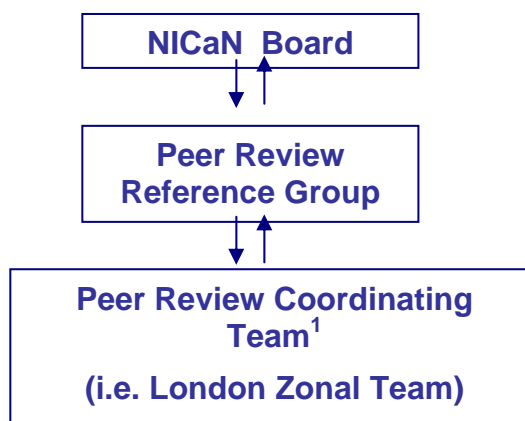
The CQuINS database is on the closed section of the web-site and can be accessed via the above web address by registered users only.

## APPENDIX 1. Project Structure & Terms of Reference

### Overview of project structure

The planning and implementation of the programme of peer review of cancer MDTs will be overseen by the Peer Review Reference Group. This document outlines the agreed terms of reference for the Peer Review reference Group.

The Peer Review Reference Group will function as a sub-group of the NICaN Board. The Reference Group will agree the measures for review and ensure that quality assurance, controls and performance management processes are appropriately planned and implemented. The Reference Group will provide direction to the Coordinating Team<sup>1</sup>.



### 1. Purpose of the Reference Group

The Reference Group for the Peer Review of Cancer has been established to plan and support the implementation of a Programme of Peer Review of Cancer MDTs for Northern Ireland.

### 2. Aims and objectives

- To establish and maintain ownership and effective communication with local stakeholders within the Network
- To agree MDT peer review measures;

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<sup>1</sup> The peer review programme in England is organised by four zonal teams, one of which covers London, Essex and Mount Vernon. The London team will provide coordination for Northern Ireland.

- To promote consistency of implementation of the agreed cancer measures and identify any issues of interpretation, seeking advice when required from the Zonal Coordinating Team.
- To agree and implement quality assurance, controls and performance management arrangements to support the programme;
- To maintain an overview of implementation of agreed actions following visits and to provide support to trusts where required; and
- To receive reports on the progress of the peer review programme within the network and agree with the zonal coordinating teams any actions required.
- To provide local knowledge and guidance to assist the process of selection of teams/services to be visited.
- To receive and note peer review visit reports. Providing an overview of consistency, identifying any strategic issues and bringing them to the attention of the NICaN Board.
- To support collaborative working and sharing of good practice across all agencies within the zone.

### 3. Membership

The group will be Chaired by Dr. Dermot Hughes, Medical Director, NICaN.

<b>Constituent</b>	<b>Name</b>	<b>Job Title</b>
NICaN Clinical Lead	<b>Dr Dermot Hughes</b>	Medical Director
	<b>Cara Anderson</b>	Network Director
Regional Board	<b>Hugh Mullen</b>	Director of Performance Management & Service Improvement
	<b>Beth Malloy</b>	Programme Director, Cancer
Public Health Agency	<b>Dr Adrian Mairs</b>	Director of Public Health
NI Cancer Registry	<b>Dr. Anna Gavin</b>	Director
RQIA	<b>Teresa Nixon</b>	Director of Quality Assurance
Trusts	<b>Jim McGuigan Sarah Williamson Sally Campalani</b>	Belfast
	<b>Anne Kyle Margaret O'Hagan Patricia McClelland</b>	Northern
	<b>Stephen Kirk Wilma Boyd Carson</b>	South Eastern
	<b>Rory Convery Alison Porter</b>	Southern
	<b>Michael Reilly Elizabeth England Fiona Beattie</b>	Western
Public / patient representative	<b>Nicola Porter</b>	NICaN PPI Forum Lead
Peer review coordinating team	<b>Mr Mike Bellamy</b>	Quality Director, London Zonal team
	<b>Ms Angela Hoyes</b>	Quality Manager, London Zonal team
	<b>Mr John Bolton</b>	Clinical Lead, London Zonal team

#### **4. The Role of the Chair**

The Chair of the Project Board is accountable for the delivery of the project. Specific responsibilities of this role include:

- Chairing Project Board meetings;
- Ensuring Terms of Reference are drafted and approved;
- Signing off the Project Initiation Document and Project Plans;
- Ensuring that the Reference oversees the implementation of the peer review of MDTs
- Ensuring that the Project continues to be viable;
- Chairing occasional meetings of the Coordinating Team;
- Recommending action to the NICaN Board if the project tolerance is exceeded.

#### **5. Meeting arrangements and frequency**

The group will aim to meet every six weeks, usually on a Tuesday afternoon (dates to be circulated in advance). Papers will be circulated no less than five working days prior to the meeting.

The Chair will be Dr. Dermot Hughes.

A quorum will be not less than 50% of all members as listed above. and must include the Chair or Vice Chair.

The meetings will be managed and the corporate records held by the NICaN Team.

#### **6. Reporting and accountability**

The Group will be a sub-committee of the NICaN Board. The Group will report on progress on the peer review of cancer MDTs at each Board meeting.

#### **7. Review arrangements**

The group has been established with a specific focused remit and is likely to be time limited to the period of the peer review of MDTs implementation timescale. The Terms of Reference will be reviewed at the end of the first peer review programme.

## Appendix 2: Proforma for Internal Validation of Self-Assessment

<b>MDT/Cross Cutting Group:</b>		
<b>Date Self Assessment Completed:</b>	<b>% Compliance at</b>	
	<b>Self Assessment</b> % (% SA'd)	<b>Internal Validation</b> % (% IV'd)
<b>Key Questions</b> <i>Provide comments and details of strengths and areas for development</i>		
<b>Does the self assessment demonstrate that this is a properly constituted and functioning MDT?</b> <i>(Consider leadership, membership, attendance, operational policies, workload etc...)</i>		
<b>Does the self assessment demonstrate that the team has effective systems for providing coordinated care to individual patients?</b> <i>(Consider patient pathways, communication, clinical guidelines etc...)</i>		
<b>Does the self assessment demonstrate that the team has adequate information to help it improve service delivery?</b> <i>(Consider data collection, audit activity, how feedback from patients is obtained etc...)</i>		
<b>Does the self assessment demonstrate that the team is continuously improving its service (including both clinical effectiveness and the patient experience)?</b> <i>(Consider outcomes from audit activity and patient feedback, include any recent achievements/developments etc...)</i>		
<b>Key Evidence Submitted</b> <i>Provide comments and details of strengths and areas for development</i>		
<b>Operational Policy:</b>		
<b>Annual Report:</b>		

<b>Work Programme:</b>
<b>Overall Conclusions</b>
<b>Good Practice/Significant Achievements:</b>
<p><b>Concerns:</b>  <i>Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the zonal team.</i></p> <p>Immediate risks:</p>
<b>Serious Concerns:</b>
<b>Concerns</b>
<b>General Comments:</b>
<b>Summary of validation process:</b>

*Provide details of the method used to validate the Self Assessment together with names of panel members if appropriate*

**Organisational Statement**

I *(insert name of validation chair)*

on behalf of *(insert name of organisation)*

agree this is an honest and accurate assessment of the *(insert name of team)*

..... MDT/Service.

Agreed by Chief Executive

Date