National Cancer Action Team

Part of the National Cancer Programme

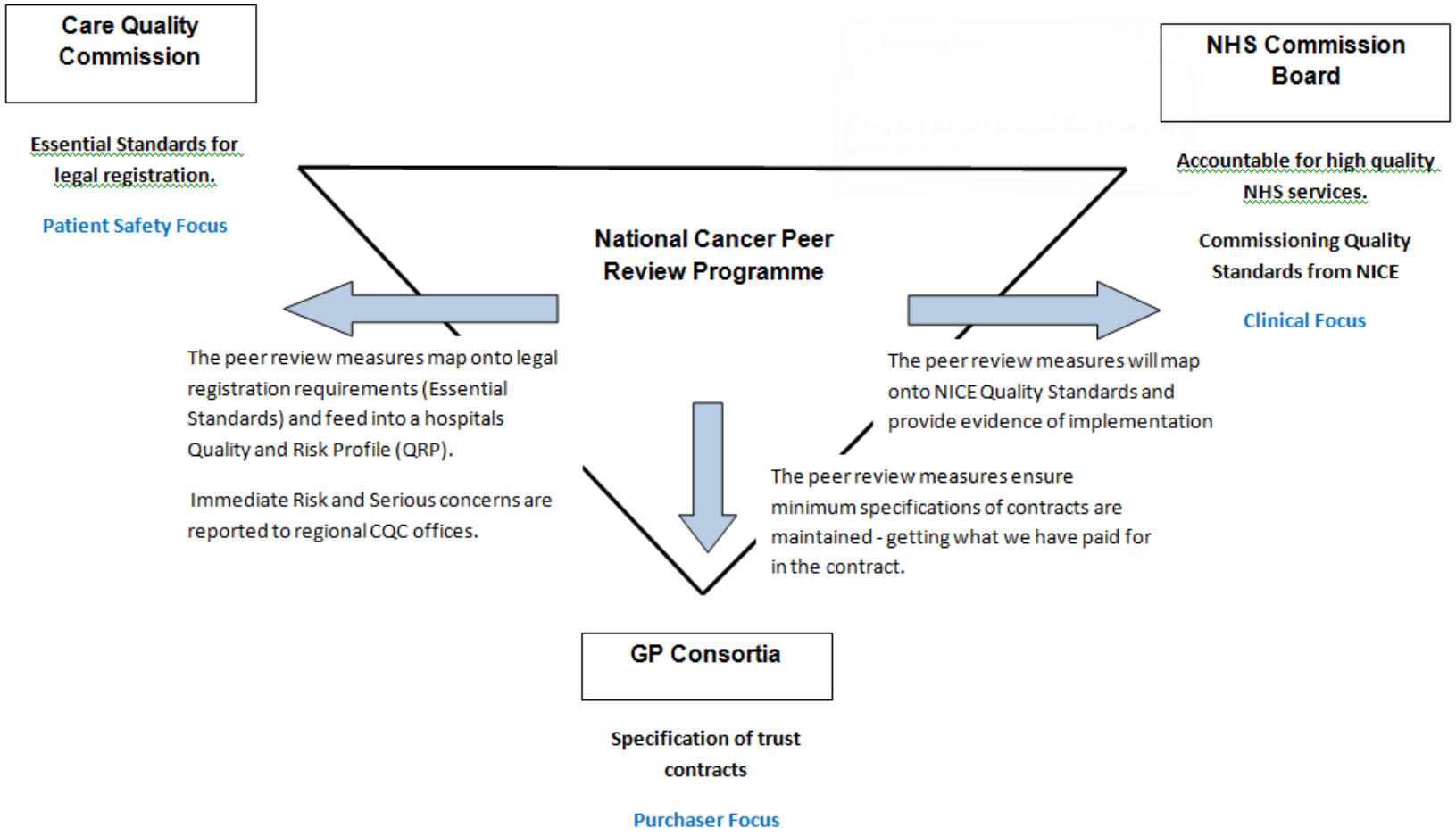
LUNG SSCRG Workshop

National Cancer Peer Review

February 2011

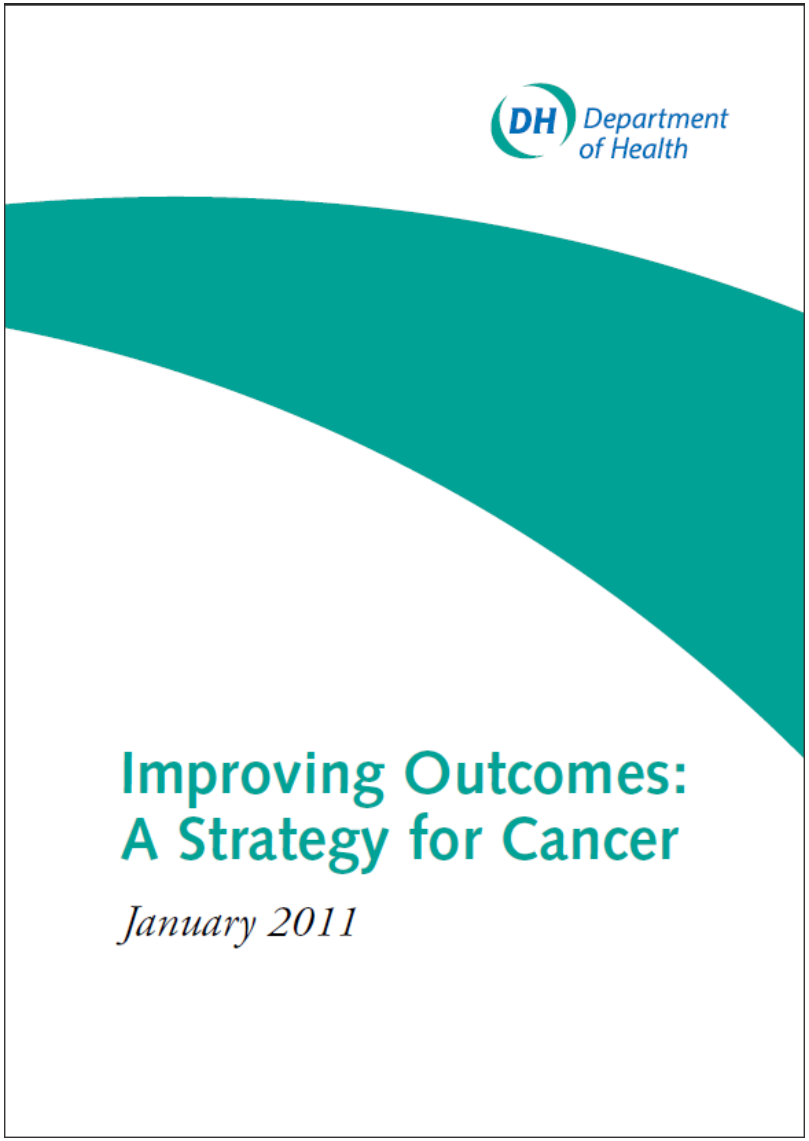
The Peer Review Process 2011 - 2012

The New Healthcare Environment



Ensuring Effective Levers

- Ensuring Peer Review outcomes are fed into the Care Quality Commission legal registration requirements
- Embedding Peer Review outcomes into the commissioning process
- Providing evidence that services are meeting the NICE Quality Standards


DH Department of Health
Improving Outcomes:
A Strategy for Cancer
January 2011

Reducing the Burden of Peer Review on the NHS

The key recommendations are:

- To further reduce the number of measures within the manual for cancer services by 10% and where possible amalgamate measures to reduce the number of IV reports required i.e. locality and MDT measures.

- To require evidence for the annual SA biennially but the team/service should instead complete a commentary in relation to the key questions each year along with the SA against compliance with the measures. The exception to this would be teams performing below 50% compliance or with unresolved immediate risks.

Reducing the Burden of Peer Review on the NHS

- To require the completion of IV biennially. A tumour site will be assigned either an odd or even year so like teams are verified in the same year. The responsibility for completion of the key questions transfers from the IV panel to the team/service as part of the SA process. The exception to this would be teams performing below 50% compliance or with unresolved immediate risks.

- To clarify the evidence required to support the SA and provide training and example materials for those who are responsible for the completion of the evidence.

Reducing the Burden of Peer Review on the NHS

- To withdraw Earned Autonomy (EA) as all teams/services will now be IV biennially rather than annually.

- To undertake Peer Review visits only where a team/service:
  - Falls into the risk criteria
  - Where there is considered to be an opportunity for significant learning
  - As part of a small stratified random sample to assure public confidence in SA and IV.

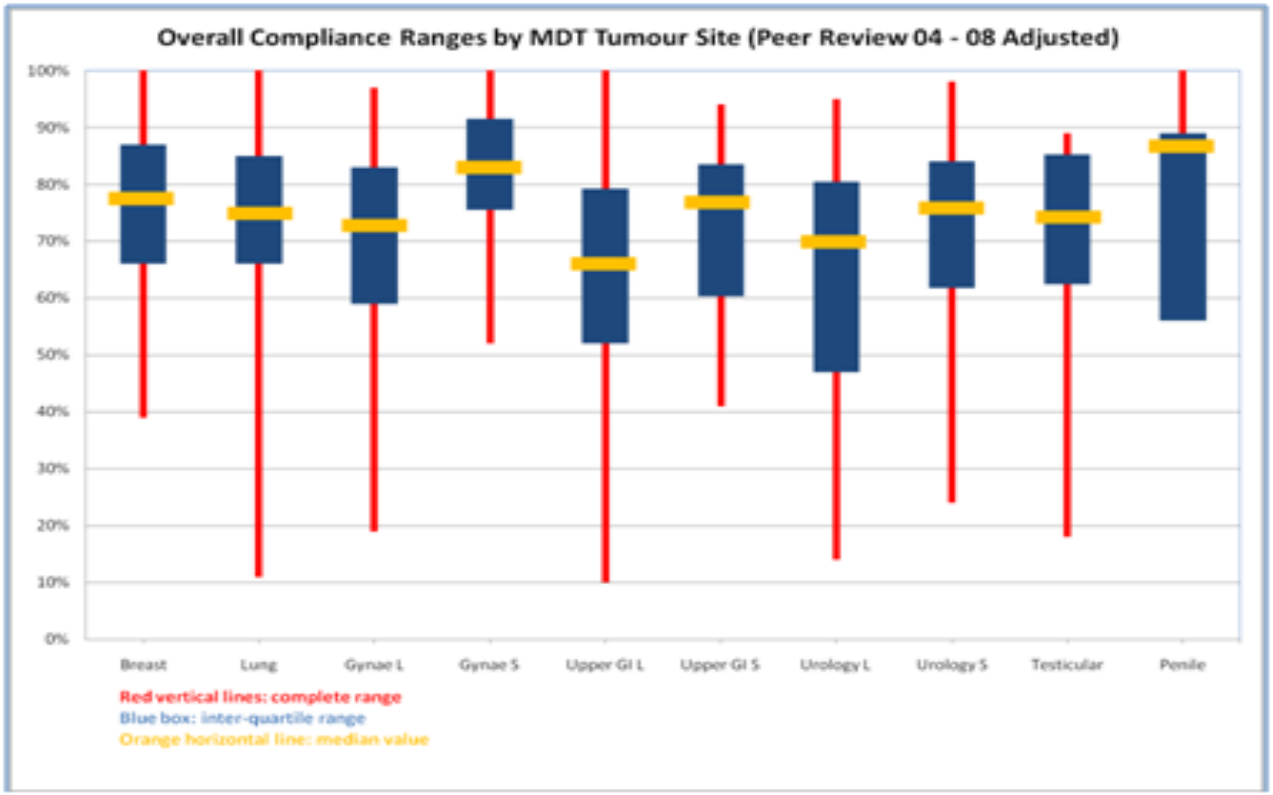
Schedule of Teams for Internal Validation

2011/12 (INTRODUCTION YEAR)	2012/13 (EVEN YEARS)	2013/14 (ODD YEARS)
Acute Oncology	Breast	Acute Oncology
Chemotherapy	**Lung**	Chemotherapy
Teenage and Young Adults	Colorectal	Teenagers and Young Adults
Sarcoma	Upper GI	Sarcoma
Brain and CNS	Head and Neck	Brain and CNS
Gynaecology	Skin	Gynaecology
Urology	Cancer Research Network	Urology
Network Service User Partnership Group	Radiotherapy	Network Service User Partnership Group
	Rehabilitation	Children's
	Complementary Therapy	Cancer of Unknown Primary
	Psychology	
	Specialist Palliative Care	
	Haematology	

Peer Review Results

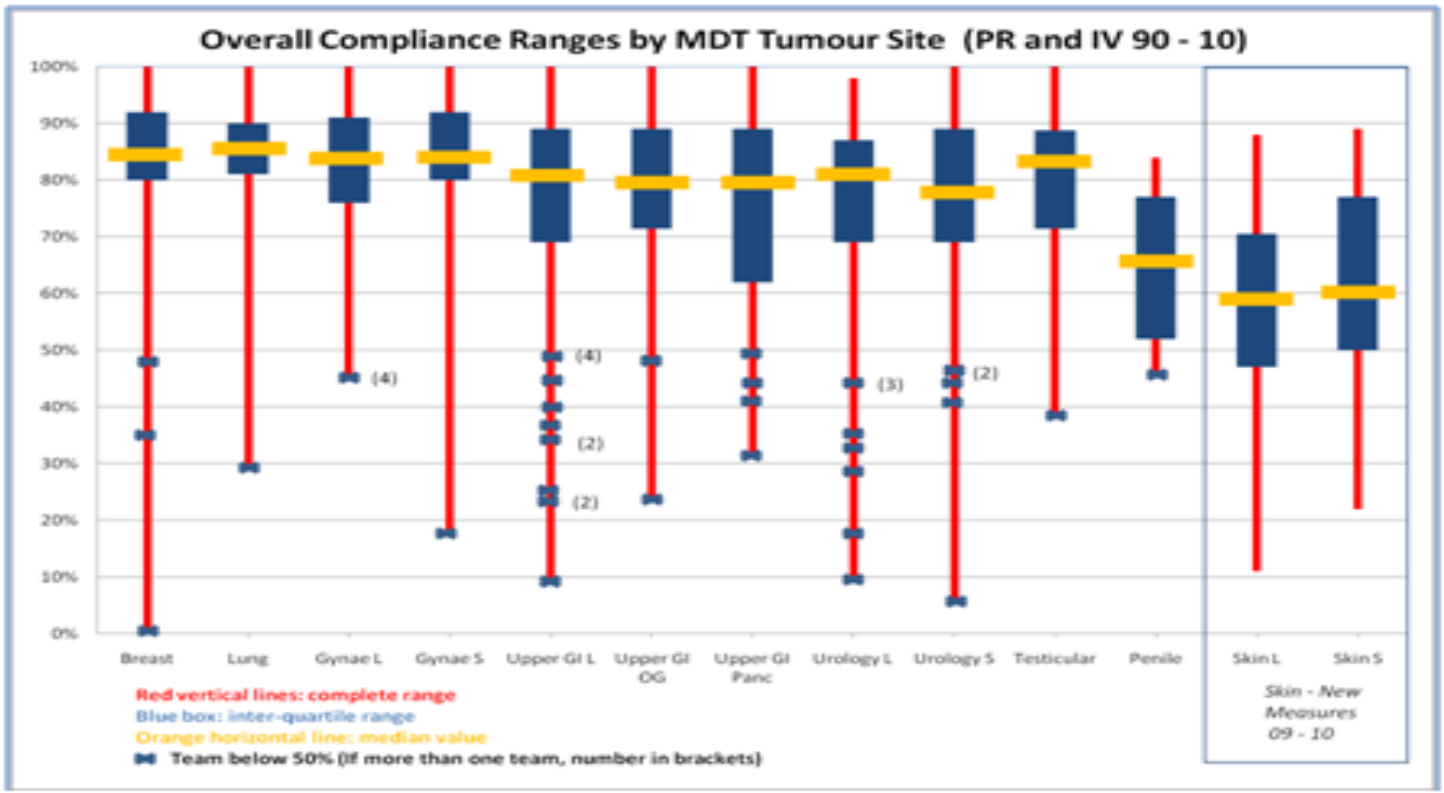
Overall compliance by MDT Tumour Site 04/08 Adjusted

Fig: Overall compliance ranges per tumour site Peer Review 04 - 08 Adjusted



Overall compliance per MDT tumour site 2009/2010

Fig: Overall compliance ranges per tumour site 2009 – 2010



Measures under 50% 2009 – 2010

- 08-2C-116: Attendance at national advanced communication skills training programme (8%)

- 08-2C-107: Core member (or cover) present for 2/3rds of meeting (41%)

Immediate Risks and Serious Concerns

Main issues related to immediate risk and serious concerns

- Lack of core membership or attendance
  - Thoracic Surgery
  - Histopathology
  - Oncology
  - CNS
  - Radiology
- Delay in histopathology turnaround times
- CNS capacity – attendance at clinics for breaking of bad news compromised

Preliminary comparison 2009-2010 and 2010 - 2011

- Initial comparison shows that the overall percentages are similar; this is encouraging as a number of the teams presenting challenges or risk have now been subject to the robust Peer Review process
- The one team with under 50% compliance (29%) in the previous round now has a compliance of 65% at Peer Review

Lung Clinical Lines of Enquiry

Lung Clinical Lines of Enquiry

- The % of expected cases on whom data is recorded
- The % Histological Confirmation Rate
- The % Having active treatment
- The % undergoing surgical resection (all cases excluding mesothelioma)
- % small cell receiving chemotherapy

Preliminary feedback Lung CLEs (1)

- The focus of discussion moved from structure and process to more clinically relevant issues
- Many lung teams have used the figures as the basis for audits on their practice to understand why they are outliers
- A number of teams surprised at their % of small cell cancer patients receiving chemotherapy

Preliminary feedback Lung CLEs (2)

- Highlighted issues with completeness of data collection, the process for clinical validation and whether outcomes are regularly reviewed and acted upon by the MDT
- Driven the impetus for clinical teams to work with the Trusts to address the infrastructures to support data collection

Quotes from Reports (3)

- ‘The percentage of small cell lung cancer cases receiving chemotherapy was only 60%. The MDT were surprised at this figure and whilst they reported this may in part be due to the number of cases they see with poor performance status felt that they needed to review this more closely.’

Quotes from Reports (4)

- ‘The Review Team questioned the histological confirmation rate and wondered whether a group of patients, perhaps in-patients who present with poor performance status, are not being picked up and discussed with the MDT. Reviewers were encouraged that the Lead Clinician has agreed to audit this’

Quotes from Reports (5)

- ‘The team have recognised that the LUCADA data demonstrated they were an outlier against national data in several areas and have audited this with the support of ECRIC which confirmed the reliability of the data. They recognise the potential issues and work is in progress to further understand and address the issues.’

Round Table discussion questions

- What have been the benefits of peer review to your network/MDT?
- In what ways could it be improved to maximise the benefits?
- Has the introduction of Clinical Lines of Enquiry been effective in focusing clinical discussions?
- What improvements might be made to the Clinical Lines of Enquiry or to their use?
- Are their specific examples where reflection on/discussion of the CLEs have led to improvements?