

# CANCER RESEARCH NETWORK MEASURES

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<a href="#">1A-403</a>	Management structure and reporting arrangements of the Research Network	1*
<a href="#">1A-404</a>	The Clinical Lead of the Research Network should be a named member of the Cancer Network Board	1*

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Number	Measure	Level
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These measures are generic for each MDT cancer site in the Manual for Cancer Services and their measure is shown in fig. 1 below.

Number	Measure	Level
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Fig. 1

	1	2	3
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## TOPIC 5A-1 - FUNCTION OF THE CANCER RESEARCH NETWORKS

<b>Number</b>	<b>Measure</b>	<b>Level</b>
<a href="#"><u>5A-101</u></a>	List of responsibilities of the Clinical Lead of the Research Network	1*
<a href="#"><u>5A-102</u></a>	Annual review of the Clinical Lead of the Research Network	1*
<a href="#"><u>5A-103</u></a>	Distribution of the Research Network Annual Report	1*
<a href="#"><u>5A-104</u></a>	Annual work programme for the Research Network	1*
<a href="#"><u>5A-105</u></a>	The Research Network service level agreement	1*
<a href="#"><u>5A-106</u></a>	A single group for the Research Network and its associated Cancer Network	1*
<a href="#"><u>5A-107</u></a>	The terms of reference for the Research Network single group	1*
<a href="#"><u>5A-108</u></a>	Six monthly meeting of the single group for the Research Network	1*

## 1 INTRODUCTION

### 1.1 Aim of the Manual of Cancer Services 2004

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This revised Manual of Cancer Services is an integral part of the NHS Cancer Plan and modernisation of cancer services. It will support quality assurance of cancer services and enable quality improvement.

The Manual provides a ready mechanism by which cancer services will be able to demonstrate that they are meeting the *Standards for Better Health*<sup>1</sup>, in particular, in the domains of safety, clinical and cost effectiveness, governance and patient focus, the latter being concerned with the design of health care around decisions which respect the diverse needs, preferences and choices of patients, their carers and relatives.

The process of cancer peer review is concerned not only with the review of an organisation's compliance against a set of detailed measures, but also with the qualitative assessment of a broad set of objectives for the delivery of services which will encompass the whole system of patient care and the patient and carer experience. Cancer peer review will, therefore, provide a mechanism to enable the overall quality of cancer services to rise.

Development of this Manual of Cancer Services 2004 and the continuation of peer review visits has been supported by the service and agreed by Strategic Health Authorities following the positive evaluation of the 2001 cancer peer review visits<sup>2</sup>. The Manual has not been centrally imposed.

### 1.2 Background and Context

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The Calman-Hine Report "A Policy Framework for Commissioning Cancer Services" (1995) and subsequent evidence based "Improving Outcomes Guidance" on individual cancer sites (for example, breast, colorectal, lung and gynaecological cancers) provided the basis for establishing the national standards for cancer care. The original Manual of Cancer Services Standards published in December 2000 was used to support the peer review programme of 2001. In the revised Manual those standards are now referred to as measures, to ensure that a distinction is made with the high level standards contained within the *Standards for Better Health*, but it should be emphasised that the change of name does not result in a change in their meaning or value.

Since publication of the Calman-Hine Report, there have been a range of reports and policy documents that have had direct impact on planning for, and delivering cancer services. These subsequent publications include the NHS Cancer Plan; "Shifting the Balance of Power: Next Steps"; and "Improvement, Expansion and Reform the Next Three Years." Most recently there was the "NHS Cancer Plan: Three Years Progress Report, Maintaining the Momentum," published by the Department of Health in October 2003.

In addition to the documents listed above, since publication of the Manual of Cancer Services Standards, further Improving Outcomes Guidance has been published by NICE and new measures are included for upper GI and urology.

This Manual also sets out a number of new quality measures in relation to the commissioning of cancer services, service improvement and user involvement.

The revised Manual has therefore been drawn up to incorporate the recommendations contained within the relevant national publications and the new guidelines published by NICE. Changes have also been made as a result of feedback from the use of standards in the original Manual in peer review, and following a detailed evaluation of the first national round of peer review visits undertaken by the Controls Assurance Support Unit (CASU), based at the University of Keele.

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<sup>1</sup> *Standards for Better Health – Health Care Standards for Services under the NHS – A Consultation*. Department of Health. February 2004

<sup>2</sup> *Cancer Peer Review Evaluation* Prof Ellie Scrivens et al CASU 2002

The Manual draws on NICE evidence based “Improving Outcomes Guidance” and identifies the characteristics of service that are likely to have a significant impact on health outcomes. It is intended that those characteristics should help those involved in planning, commissioning, organising, and providing cancer services to identify gaps in provision and check the appropriateness and quality of existing services. The measures provide a ready specification for the commissioning of cancer services within a given locality.

There is a clear commitment to the establishment of an active and positive relationship between the Healthcare Commission (formerly CHI), and the National Cancer Peer Review Programme within the principles set out in the new Healthcare Concordat to help reduce the burden of regulation, including the minimisation of duplicate visits to organisations including voluntary hospices.

The details of that relationship are still being established, but it is intended that Cancer Peer Review will report to the Healthcare Commission:

- Progress on the implementation of NICE guidelines
- Co-ordination of care across organisations
- Patient experience
- Agreed remedial action within a clear timetable
- National Annual Report to the Healthcare Commission from the National Peer Review Steering Group

In the meantime the Healthcare Commission is represented on the National Cancer Peer Review Steering Group and has been an active participant in the development of the Peer Review Programme.

### 1.3 Measures within the Manual for Cancer Services 2004

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It is acknowledged that the revised quality measures continue to relate largely to secondary and tertiary services. The intention has always been to supplement the Manual with measures relating to the role of primary care in the provision of cancer services. With the development of the new GMS contract and the inclusion of indicators on cancer, it is thought that the time is not right to introduce additional primary care measures.

The measures are currently still confined to adult cancer services, except where they relate incidentally to children, for example, a radiotherapy department would normally treat adults and children.

These measures should not prevent local services from working towards more rigorous measures.

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

- Reflect new NICE guidance and revisions to existing NICE guidance.
- Allow greater influence by users of cancer services and their carers.
- Take account of possible modifications to measures following peer review visits.
- Ensure the scope of measures encompasses the broader implementation of the NHS Cancer Plan.
- Reflect *Standards for Better Health*, following consultation, and development of criteria by which compliance with these Standards will be assessed.

Over the next year, it is anticipated that measures for the following areas will be developed and incorporated into this Manual:

- Cancer Research Networks
- NICE Guidance on Improving Supportive and Palliative Care

Future measures development will address further NICE Improving Outcomes Guidance, for example, services for people with skin cancers, sarcoma and children and young people with cancer.

## 1.4 Reviewing the Measures

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Cancer peer review visits aim 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

It is anticipated that the benefits of peer review will be as follows:

### For Teams

- As an aid for self-assessment and gap analysis
- As a catalyst for change

### For PCT Commissioners

- The Manual is a ready made service specification for commissioning for quality
- The peer review visit assures quality of service provided to population
- The review helps set priorities for quality improvement

### For Trusts

- The peer review report will demonstrate that a Trust meets *Standards for Better Health*

### For Patients

- The peer review report will provide an open scrutiny of quality/CHOICE
- The outcome of the peer review process will contribute to the range of information made available to the public about local services

The peer review process consists of the following three key stages:

- Pre-assessment - to include a self-assessment of the degree of compliance against the quality measures, and the collection of additional evidence, particularly to support the implementation of Improving Outcomes Guidance.
- The peer review visit to a Cancer Network, which is likely to take place over a period of up to eight weeks, which will provide the opportunity for a more qualitative assessment.
- Agreeing remedial action against a clear timetable, implementation and follow up.

It is acknowledged that the process will continue to evolve over the three year period of the peer review programme, but it is clear that the second round of national cancer peer review will have a different set of expectations from those in the first, reflecting:-

- The extra investment made in cancer service
- The expectation of follow up action from the first set of reviews, and from major findings contained within the NHS Cancer Plan: Three Year Progress Report
- A stronger emphasis on clinical quality and the wish to seek evidence that local arrangements exist to assess this.
- The fact that Cancer Networks are now more established than many were during the first round.

Peer review teams will also want to be assured that Cancer Networks are progressing agreed Improving Outcomes Guidance action plans according to the milestones set out.

The relationship between NICE Improving Outcomes Guidance and the quality measures within the National Manual is explained in more detail in Appendix B.

## 2 STRUCTURE OF THE MEASURES

The general layout of the measures is illustrated in the diagram in Appendix C.

Topic 1 covers the management and organisation of the whole network.

Within Topic 1:

Section 1A covers the establishment of the network board and its functions. Its functions are:

- to establish the network management and organisational structures,
- to divide the network into geographical locations,
- to clarify and define the extent of certain services,
- to have action plans for certain service reconfigurations in line with Improving Outcomes Guidance,
- to ensure cancer leadership for its Trusts, to co-ordinate data collection,
- to ensure the provision of MDTs for the specified cancer sites and
- to co-ordinate proposals for service development.

Section 1B covers co-ordination of cancer commissioning for service developments, in the form of measures for the establishment and functioning of a PCT collective Commissioning Group for the Cancer Network.

Section 1C covers the functions of the network site-specific groups (established by the board), each of which deals with a specific cancer site.

Section 1D covers the functions of the locality groups, each of which is responsible for the management and organisation of one of the localities that have been defined and established by the board.

Similarly, Section 1E covers the functions of the following groups:

- Palliative care
- Cancer Imaging
- Chemotherapy
- Cancer Pathology
- Network Users' Group.

Each of these is established by the board and each is responsible for the co-ordination of its appropriate issues across the network.

Topics 2 and Topics 3 deal with service delivery rather than network management and organisation.

Topic 2 covers the establishment and functions of the MDTs for a particular cancer site or related group of cancers.

Topic 2E (gynaecological cancer), 2F (upper GI cancer), 2G (urological cancer) and 2I (Head and Neck) have more than one section. Each section deals with a particular subtype of MDT within that group of cancers – classed either by level of specialisation ('local', 'specialist', 'supranetwork' teams) or by a defined cancer site (for example, testicular cancer).

Topic 3 deals with services, which are not specific to a particular cancer site. They cover specialist palliative care MDTs, cancer imaging, chemotherapy, cancer pathology and radiotherapy.

Topic 3C (chemotherapy) has three sections, section 3C-1 for the clinical chemotherapy service, section 3C-2 for the oncology pharmacy service and section 3C-3 for IT chemotherapy.

Some themes, such as service improvement, patient centred care/general supportive and palliative care and data collection are addressed at various places within the Manual of Cancer Services 2004.

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

## **Levels**

Each measure has one of three levels attached to it that can be defined as follows:

### **Level 1\***

These measures are fundamental to the delivery of a satisfactory service and are underpinned by the following:

- Structurally essential – e.g. the rest of a cancer network's structure depends on its having an overall controlling body relating to statutory organisations (the Board)

Or

- Logically essential – e.g. an MDT actually meeting is essential to its making timely, corporate multidisciplinary decisions on patients

Or

- Critical to an authoritative external agenda – IOG implementation, NHS Cancer Plan, DH milestones, HSCs etc

Or

- Strong and multiple expert support via working parties and consultations

### **Levels 1 and 2**

Levels 1 and 2 reflect progressive development in the quality of the service.

The difference between these two levels is one of degree rather than essence.

### **Manual of Cancer Services On-line**

To assist cancer networks to navigate round the 2004 measures - and to help individuals focus on the measures of interest to them – an on-line version of the Manual of Cancer Services has been developed.

The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

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

## Appendix A

### Reviewing the quality of cancer services

#### 1 Introduction

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The 2001 peer review visits reinforced the value of peer review as an integral part of quality management of cancer services. In particular, peer review:

- Encouraged changes to practice and structures.
- Enabled serious problems to be immediately identified and acted upon.
- Facilitated the sharing of good practice between professionals and organisations.

It has therefore been agreed by the Department of Health, Strategic Health Authorities and the National Cancer Taskforce that the peer review programme should continue as the vehicle for monitoring the quality of cancer services within the context of the NHS Cancer Plan. It has also been agreed that there is a need for national co-ordination and consistency in the peer review process and, therefore, new quality measures and reporting arrangements have been put in place.

#### 2 New national peer review structure

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A National Peer Review Steering Group has been established to oversee the peer review process and ensure consistency of approach. The group will also oversee the development of national guidance on peer review, the development of a national training programme for peer reviewers and the on-going evaluation of the review programme.

A national peer review co-ordinating team has been formed and will ensure consistency in both the interpretation of quality measures and implementation of the peer review process in each Zone.

Zonal peer review co-ordinating teams will work with cancer networks to continue towards the achievement of high quality consistent cancer services. Within each of the zones a reference group has been established. These groups are responsible for ensuring local ownership and implementation of the cancer peer review programme, for supporting consistency of interpretation of the national cancer quality measures, for maintaining an overview of remedial action agreed following peer review visits and for taking appropriate action if progress is not satisfactory. The groups also have responsibility for identifying strategic issues identified through the peer review visiting process. Core members of the zonal reference group include:

- Cancer lead from each constituent Strategic Health Authority
- One representative from each constituent cancer network
- One Tier 1 specialised services commissioning representative
- Zonal peer review co-ordinating team.

#### 3 Reviewers

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Peer review visits will be undertaken by a multi-disciplinary group of service users, clinicians and managers with appropriate skills and training. As far as possible “peers” will be people who are trained and working in the same discipline as the people they are reviewing. This has the advantage that the reviewers have a very good understanding of the services they are reviewing, will bring this understanding to the review process, and will take relevant learning from it. Reviewers should not come from the same network as the Trust / Network they are visiting. It is recommended that visiting teams should normally have a mix of experienced and new reviewers, but where this is not possible arrangements will still be made for the visits to take place.

## 4 Protocols for Reviews

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The national co-ordinating cancer peer review team are required to establish common protocols and a set of guidelines for peer review visits to ensure a consistent approach.

A national core training programme has been developed with the aim of familiarising reviewers with the quality measures and the philosophy that underpins the peer review process, and with equipping them with the skills to be a reviewer. In support of the consistent approach to peer review, it will be mandatory that all reviewers attend the training programme.

## 5 Self-Assessment

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Self-assessment is a critical part of a Trust's preparation for a peer review visit and provides essential information for reviewers. Networks and Trusts will be required to complete the self-assessment forms and submit them to the zonal peer review co-ordinating teams at least three months before the date of the visit.

It is intended that the majority of the work in checking a Network's, Trust's or MDT's compliance with the measures will have been completed prior to a peer review visit taking place.

A national database has been developed (CQuINS) with the intention of supporting the self-assessment process, providing information for visiting teams and reducing the amount of paperwork.

## 6 Scope of Visits

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Peer review visits will review compliance with the national cancer measures.

The focus of the visit will be on the pursuit of any issues that emerge from the self-assessment as well as a more qualitative assessment of cancer service provision and the co-ordination of patient care across the cancer network.

As far as possible, peer review visits will look at the whole system of care for patients and the whole of the patient and carer experience. Visit reports will therefore identify issues that are not directly covered by the quality measures but are very closely related or important precursors of achievement of the quality measures, and focus on the qualitative aspects of cancer service delivery.

## 7 Information for visiting team

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In addition to the self-assessment exercise the zonal peer review co-ordinating team will also undertake a pre-visit to a network to conduct an initial assessment of compliance, to identify any specific issues which the review team may wish to focus on and to agree the additional information that the network will be asked to produce for the visiting team.

This is likely to include:

- Network / Trust self-assessment plus the Quality Manager's assessment of evidence
- Key items of evidence, in particular, the operational policy for each MDT.
- Short background report giving an overview of the organisation of cancer services and the Trust / Network context
- Data on the number of newly diagnosed patients seen each year by each MDT, populations served and comparative data where possible.
- Data on cancer registrations
- Reports of screening QA visits (for relevant MDTs)
- Report of the most recent cancer peer review visit.
- Most recent relevant CHI / Healthcare Commission visit report.

A national template for the collection and presentation of information for visiting teams will be prepared.







































