Cancer Quality Surveillance Policy

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Key Documents Owner:	Elaine Stratford	Cancer Quality Assurance Manager
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Key Amendments

Date	Amendment	Approved by
9th March 2017	Revert to Original text in document in relation to referring to 'immediate risks' and 'serious concerns'	Cancer Board
23rd May 2019	Document approved	Cancer Board
15th July 2021	Document review date amended as per the Key Documents policy 3 year approval update.	Trust policy
6th June 2023	Document extended for 6 months whilst under review	Elaine Stratford

Introduction

The National Quality Surveillance team was established in April 2015. It is a specialised commissioning directorate within NHS England and is responsible for all specialised services and all cancer services irrespective of how they are commissioned.

The purpose of the National Quality Surveillance programme is to measure both clinical outcomes and the implementation of the service specification by the clinical service against a number of set indicators. These focus on patient experience, clinical outcomes, structure and process. The programme will support the Quality Surveillance Team (QST) in the alignment of specialist services, building a quality profile for each specialised service and to provide a National and regional reporting function. The QST will also provide a responsive and flexible review visit programme in line with regional and National priorities.

The Quality Surveillance programme introduced a new information portal in July 2016 the Quality Surveillance Information System (QSIS). This portal enables each team to submit self-declarations (SD), against a number of specified indicators. It will act as a tool for commissioners to compare and benchmark across providers. Data will also be extracted from other sources such as National audits and surveys, acute and specialist Trust dashboards, CQC visit reports and local mechanisms of gaining feedback.

Data collection will also include sources such as patient experience feedback from the friends and family test, complaints, serious untoward incidents, service reviews, and previous peer review visits.

<u>Self-declaration for cancer services</u>

The Quality Surveillance programme for cancer services will require each team to submit an annual self-declaration. This will be sent out to the clinical teams for them to populate with the required information against the set quality indicators.

Within cancer services, the majority of teams and services will have an internal validation (IV) by an approved panel within the organisation. Information following the IV panel will be transferred onto the QSIS portal by the Cancer Quality Assurance Manager (who is QSIS lead/administrator for cancer services).

All self-declarations will need to be submitted by the deadline specified by the national team.

The National Quality Surveillance team as part of the NHS business plan will be organising external visits. These are in 3 categories:

1. Comprehensive visit

   These will be based on quality indicators and will be agreed nationally with the Specialised Commissioning Programmes Of Care (POC) boards based on national priorities. This will be for all organisations providing that particular service across the country. The schedule for the first of these comprehensive visits will be given by the end of November 2016 and will continue to be provided on an annual basis.

2. Targeted visit

   The National Quality Surveillance team may also request a targeted visit for a service. This would be a planned review to specific services/team informed by annual assessment and agreed with regional specialised commissioned teams, based on local priorities.

3. Rapid response visit

   At any point a rapid response visit may be requested by the National Quality Surveillance team which will be a short notice visit to a specific service/team in response to concerns raised in relation to patient safety.

The visit cycle will predominantly be from January to July, but may extend throughout the year.

Scope of the Policy

This policy is intended to cover all cancer and palliative care MDT's and services across the Trust for which indicators have been developed by the national quality surveillance team NHS England.

Definitions

- Self-declarations (SD): Every year each team/service will complete the self-declaration demonstrating compliance against the national indicators. In addition, the team/service will be required to provide an annual report, a work programme, an operational policy and appendix containing supporting evidence.

- Internal Validation (IV): a process of internal governance by the Trust. This includes a review of the selected teams/services' self-declaration, annual report, operational policy, work programme, and appendix. This will be by a panel with membership from the Trust, Clinical Commissioning Groups (CCG's) and user representation.

- External Reviews will take the form of comprehensive, targeted or rapid response as outlined above.

- 'Dummy run': prior to an announced comprehensive visit, targeted visit or rapid response visit from the national team, there will be a review of the evidence provided by the team/service. This review will take place at least 6 weeks prior to the planned visit, however the time frame may be less

depending on the type of external visit requested. If the national team wish to undertake a rapid response visit when the Trust may have as little as 4 weeks' notice of the visit.

The dummy run will be undertaken by the cancer team reviewing the available documentation to identify any potential areas of concern. The MDT team, directorate, divisional and executive teams will be informed immediately of any potential immediate risks or serious concerns identified at the 'dummy run'.

Responsibility and Duties

Cancer Management Team:

The cancer management team will lead on the IV process and will facilitate external reviews.

The team consists of:

- Associate Medical Director for Cancer Services
- Cancer Manager
- Macmillan Lead Cancer Nurse
- Cancer Quality Assurance Manager
- Cancer Data Information Manager
- Assistant Cancer Data Information Manager
- Macmillan Cancer Information and Support Service Lead
- Cancer services team secretary (for IV)

Associate Medical Director for Cancer Services:

- The Associate Medical Director for Cancer Services is Chair of the Trust Cancer Board, where any outcomes or actions from the Cancer Quality Surveillance process will be noted, discussed and monitored. Minutes from the Cancer Board will be forwarded to the executive team.

- To be responsible for reviewing the teams/services self-declarations and ensuring that any necessary changes are made. Any immediate risks and serious concerns at any stage will be reviewed and escalated to the Chief Executive Officer (CEO) or nominated deputy.

- To chair all IV panels where able (however if the Associate Medical Director for Cancer Services' own team is under review an alternative chair will be identified) and will agree and submit the subsequent report to the CEO or nominated deputy.

- To take part in the 'dummy run' of the team or service to be externally reviewed within a specified timeframe, (normally 6 weeks prior to the review but dependent of the type of review requested by the national team).

- To deliver a brief presentation introducing the selected team or service at any external review.

Cancer Services Manager and Macmillan Lead Cancer Nurse:

- To have overall responsibility for leading the Quality Surveillance programme.

- To be part of the IV panel and will Chair when required.

- To take part in the 'dummy run' of the team or service to be externally reviewed approximately six weeks prior to a visit requested by the National Quality Surveillance team, but this will be dependent of the type of review that has been requested.

Cancer Quality Assurance Manager:

- In discussion with the Associate Medical Director for Cancer Services and the Macmillan Lead Cancer Nurse and Cancer Services Manager develop the programme of internal validations and co-ordinate the external reviews ensuring all the relevant stakeholders have been informed. This will include the assembly of the internal panel, making room bookings and ensuring that the relevant documents have been circulated to panel members. Relevant IT equipment and facilities for use should also be made available.
- To support the teams in completion of the self-declaration documents, annual report, operational policy, work programme and supplementary evidence in the form of appendices, providing guidance regarding format and content.
- To maintain close communication with the national team.

- To be responsible for co-ordinating the internal programme of reviews and also any external reviews.

- Once the teams/services self-declarations have been completed, they will form part of the evidence for both IV and external review (taking the place of what was formerly the self-assessment document).

- To be a member of the IV panel.

- To fulfil the role of QSIS lead/administrator for cancer services, assisting MDT members to register on the portal with appropriate permissions.

- To disseminate all IV and external reports to executive members of the Trust board and the clinical governance department.

- To present the IV and external report findings at the Trust Cancer Board.

- At the national team's request for an external review, to organise and participate in a 'dummy run' and review the evidence provided by the MDT/service approximately 6 weeks before the external visit (or sooner if a rapid response visit is requested).

- To inform the Divisional Director of Operations, Clinical Director, Directorate Manager and MDT Lead immediately of any risks identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

- To inform the following members of Trust staff immediately of any immediate risks or serious concerns identified at the IV or external review:
    - The Chief Executive Officer
    - Chief Medical Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Deputy Chief Operating Officer
    - Relevant Divisional Medical Director,
    - Relevant Divisional Directors of Nursing,
    - Relevant Divisional Director of Operations
    - MDT Lead
    - Directorate Manager
    - Matron

To send the IV panel report to:

- The IV panel for factual accuracy for return of comments/clarification within 14 working days then
- The clinical team for factual accuracy for return of comments/clarification within 14 working days
- To oversee and facilitate the process identified in appendix one.
- To facilitate the Trust CEO response to any risks identified at any external visits.
- To ensure divisional teams are aware of any risks identified in either internal or external reviews and appropriate action plans are in place.
- To enter any immediate risk or serious concern onto the risk register (DATIX) system with the ownership of the risk being with the clinical and operational team. Cancer Board will monitor and review progression of the action plan in relation to the risk register on a regular basis.
- To liaise with divisional clinical governance teams in relation to the risk register.

The Cancer Data Information Manager and Assistant Cancer Data Information Manager:

- To be a member of the IV panel.
- To provide the specific cancer data information as required by Quality Surveillance indicators and to participate in the 'dummy run' of the team or service to be externally reviewed when available.

The MDT Coordinators:

- To use the Somerset Cancer Register live in the MDT meeting to assist in the collection of the specific cancer data information as required.
- To provide any specific information as requested by the cancer quality assurance manager.

Cancer Services Quality Improvement Nurse

- To be part of the "dummy run" of the team or service to be externally reviewed when available.
- To assist in the identification of patient representatives to form the IV panel when required.

Cancer Services Team Secretary:

- To provide administrative support to the cancer services team throughout the Quality Surveillance programme.

MDT Clinical leads:

- To ensure that the team/service has completed the self-declaration, annual report, operational policy, and work programme and that supporting evidence is available in the form of an appendix. These must be completed in the time frames that are specified either by the Trust or the national team.
- To facilitate the engagement of the clinical team in the Quality Surveillance programme.

- To be available for all internal and external validations of their team/service.

- To receive feedback from the IV panel or the national team and to inform the MDT team/service of the outcomes and take appropriate action as required.

- Following notification of any immediate risks or serious concerns the MDT lead working within the operational team is required to respond to cancer services within timeframes specified by the national team. (Responses are required within 10 working days for an immediate risk and 20 working days for serious concerns.)

- To attend the Trust Cancer Board at the request of the Chair.

- To take part in the 'dummy run' prior to any visits from the national team.

- To ensure an operational meeting is held yearly to discuss the Cancer Quality Surveillance programme and relevant evidence documents.

Chief Executive Officer:

- The CEO (or deputy) is responsible for the final approval of the self-declaration produced by the clinical team and ratified by the IV Panel to confirm that it is an accurate assessment of the selected team/services.

- The CEO (or deputy) will approve the self-declarations (following process as outlines in appendix one).

- Following an external visit from the national team, the CEO (or deputy) will be required to attend the High Level Feedback session.

- Following any external visits from the national team, it is the responsibility of the Trust's CEO (or deputy) to formally respond to the Quality Surveillance Team Director, within ten working days of notification of an immediate risk being identified and 20 working days after a serious concern being identified.

- Final approval of reports following internal validations.

Trust senior executives (Chief Medical Officer, Chief Nursing Officer and Chief and Deputy Operating Officer):

- To attend the high level feedback on the day following internal and external reviews.

- The Chief and deputy-chief operating officer will act as the QST leads for the organisation providing final sign off of self-declarations on the QSIS portal and acting as a point of contact for the organisation for communication with the Quality Surveillance team.

The Divisional Medical Directors, the Divisional Directors of Nursing, the Divisional Directors of Operations and Clinical Directors:

- To attend the high level feedback on the day of internal and external reviews when available.

Matrons:

- To participate in the 'dummy run' prior to any external reviews from the National Quality Surveillance Team.

- To attend the high level feedback session following internal or external reviews.

- To assist the MDT Lead and Directorate Manager to produce an action plan following notification of any risks and identified.

Directorate Managers:

- To take part in the 'dummy run' prior to any reviews from the national team

- To attend high level feedback sessions following IV and external reviews by the national team.

- To work with the MDT Clinical Lead to respond with an action plan following notification of any risks identified within timeframes specified by the national team. These are: within 10 working days for any immediate risks and 20 working days for any serious concerns.

- Any action plans developed will be monitored within the Division, and by Cancer Board and will be submitted to the national team as part of their annual assessment process.

- To attend the Cancer Board at the request of the Chair to update on the progress of actions in response to immediate risks or serious concerns.

Representative from Clinical Commissioning Groups:

- A representative from the Clinical Commissioning Groups and will be invited to take part in the Trust's IV as a member of the IV panel.

Table 1: Evidence for Quality Surveillance Review (annual)

Operational Policy	Annual Report	Work Programme
Describing how the team functions and how care is delivered across the patient pathway Outlining policies/processes that govern safe/high quality care Agreement to and demonstration of the clinical guidelines and treatment protocols for the team.	Summary assessment of achievements and challenges Demonstration that the team is using available information (including data) to assess its own service MDT Workload & Activity Data (activity by modality, surgical workload by surgeon, numbers discussed at MDT, MDT attendance) -National Audits -Local Audits -Patient Feedback -Trial Recruitment -Work Programme Update -Information relating to Clinical Lines of Enquiry	How the team is planning to address weaknesses and further develop its service. Outline of the team's plans for service improvement and development over the coming year -Audit Programme -Patient feedback -Trial Recruitment -Actions from previous reviews

Demonstration of agreement

Where agreement of strategic clinical network guidelines, policies, etc. is required, this should be stated clearly on the cover sheet of the relevant evidence documents, including agreement dates and versions. Similarly evidence of Trust guidelines, policies and all three core evidence documents require agreement of the MDT/service lead and the Associate Medical Director for Cancer Services dated and signed on the cover sheet. The agreement by a person representing the group or MDT (chair or lead ,etc.) implies that their agreement is not personal; they are representing the consensus opinion of the MDT.

Time scales for Self –Declaration

The Cancer quality assurance manager will produce an annual Trust Quality Surveillance programme timetable, once they have received notice from the national team of any planned external visits.

It is expected that the national team will inform the Trust by the end of November their timetable of comprehensive external visits for the forthcoming year ahead. In relation to other external visits from the national team, depending on the nature of the visit, the timeframe will be indicated by the national team on request of the visit.

All internal validations must be completed in time for the QSIS portal to be populated with self-declarations based on national indicators as specified by the national team.

Policy Detail

Self- Declaration process

Each team/service MDT Lead clinician will be expected to complete an annual self-declaration. The self-declaration from the QSIS portal will be downloaded and sent to the MDT Lead clinician to complete. Team members are also encouraged to register onto the QSIS portal on a 'read only' basis in order to familiarise themselves with the indicators set by the National Quality Surveillance Team.

Table 2: Key dates for Self -Declaration

Key Dates for teams/services to complete their self-declaration and supporting evidence for internal validation	
Self-declaration and supporting evidence documents from teams/services to be commenced by:	**1st December in the year**
Self-declaration and supporting evidence documents from teams/services to be completed by:	**By date specified by cancer services team**
Internal Validation to be completed by:	**End of 2nd week in June in the year**

Internal Validation

The Purpose of Internal Validation

NHS England stipulates that for all specialised commissioned services and all cancer services, however commissioned, an annual self-declaration is required. It is then for individual organisations to decide their governance processes to provide assurance of compliance to the national quality indicators. These are available on the QSIS portal.

WAHNHST have agreed that each team/service will have an internal validation on an annual basis unless there is a plan for an external visit from the National Quality Surveillance Team. This is to provide a robust clinical governance framework.

The only exception to this is if there are no national indicators for the team or service. This will then be discussed with the operational and clinical team.

By following this process, both clarity and assurances will be provided to the organisation in relation to the information provided from MDT/services against the nationally set indicators.

Process for IV

An IV panel will be selected from the following staff members:

- Trust Cancer Management team
- Patient/Carer Representative
- Nurse Representative
- Clinical Commissioning Groups Representative
- An expert colleague if required

The Internal Validation will be undertaken in one of two ways

- The IV panel will review all the submitted required documents with any points of clarification discussed with the MDT lead via telephone.

OR

- The IV panel will convene; review the submitted documents prior to meeting with representatives of the MDT and operational team to discuss any points of clarification. The representatives will be informed of the date of the IV by the Cancer Quality Assurance Manager a minimum of 6 weeks in advance to facilitate attendance

The IV Process will ensure

- The on-going quality assurance of cancer teams and services across the Trust
- Accountability for the Self-declaration is confirmed by agreement of CEO of the organisation.
- There is Commissioner and Patient/Carer involvement within the process
- The information from the self-declaration and the outcome of the internal validation is transferred onto the National Quality Surveillance (QSIS) web based portal within the timeframes specified by the national quality surveillance team.

The IV Self-declaration

The IV Self-declaration will be completed in real time by the panel and agreed by the panel members prior to the conclusion of the session.

Any risks identified

The MDT clinical team/service may identify following the IV process, three categories of concern relating to their team/service which are

- Immediate Risk
- Serious Concern
- Concern

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. Any immediate risk will be identified to the MDT/service lead and the CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is required within 10 working days. Following IV the response will form part of the Internal Validation SD and will be agreed by the CEO or deputy.

Serious Concern

A “Serious Concern” is an issue, which although not an immediate risk to patients or staff could seriously compromise the quality or outcome of patient care and requires urgent action to resolve. Any serious concern will be identified to the MDT/service lead and CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is expected within 20 working days. Following Internal Validation the response will form part of the national teams annual review process and will be agreed by the CEO or deputy.

Concern

A “concern” is an issue that is affecting the quality of the service. It does not require immediate action but can be addressed through the work programme of the MDT/service.

Following Internal Validation or external review, the CEO and senior members of the executive team will be notified of any immediate risk, serious concerns and concerns by the Cancer Quality Assurance Manager. The outcomes will be noted, discussed and monitored by the Trust Cancer Board.

External Visits
The Process

See Appendix 1 -Quick reference guide for External Peer Review visit.

Notification of Visits

It is anticipated that the National Quality Surveillance Team will provide the Organisation with sufficient notification of dates for planned comprehensive visits. The Cancer quality assurance manager will then notify individual teams/services of those dates if they have been selected for review.

Prior to External visits

For any external reviews the Cancer Quality Assurance Manager will organise a 'dummy run'. This is a review of the evidence provided by the MDT clinical team /service approximately 6 weeks before a planned comprehensive visit by the national team, but this could be a much shorter timeframe as dictated by the nature of the visit ie.targeted or rapid response.

This 'dummy run' will involve the cancer team, the relevant MDT lead and Clinical Nurse Specialist, Directorate Manager and Matron. The Divisional Director of Operations, and Clinical Director, will be informed immediately of any areas of concern identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

Appendix One – Quality Surveillance – The process

Individual teams/services are made aware of the yearly timetable for their internal/external visit as soon as the cancer management team are aware

Team/service are sent PDF copy of self-declarations from QSIS portal. This must be returned to Cancer Quality Assurance Manager within 2 weeks of the date that the internal review is set for with a copy of annual report, operational policy and work programme.
For external visits, national timeframes will need to be strictly adhered to (this will depend on the type of visit requested)

Cancer Quality Assurance Manager and Macmillan Chemotherapy and Radiotherapy Project Nurse (as QSIS lead/administrators) enter information provided onto the QSIS portal. This information will form part of the review process.

Following the review the outcome of the review including any immediate risks and serious concerns identified are fed back to the MDT lead, executive team and senior members of the operational team.

Following IV the updated SD is generated including comments from the IV team. This is sent to the IV panel for factual accuracy check for response within 7 working days. This is then sent to the MDT/Service lead to disseminate to the team for factual accuracy. For return to the cancer management team within 7 working days.

Once any changes or amendments have been agreed the QSIS portal will be updated by the QSIS lead/administrators.

If any immediate risk and serious concerns are identified a response with an action plan is required within the nationally agreed timeframes i.e. immediate risk within 10 working days and serious concern within 20 working days. These action plans will be agreed at cancer board and monitored by both cancer board and the operational executive group

The agreed action plans will be added to the QSIS portal by the QSIS lead/administrators. The self-declarations will then be reviewed by the Associate Medical Director for Cancer Services. Any changes will be made on the portal by the QSIS lead/administrators

Once all the self-declarations have been approved by the Associate Medical Director for Cancer Services, the QSIS lead/administrators will send the self-declarations for approval.

The QST lead (or nominated deputy) will be notified that the self-declarations have been sent for approval and will review all the self-declarations and approve them. If any amendments are required at this stage they will be sent back to the QSIS lead/administrator to make the required changes.

Appendix Two- Quick Reference Guide: The External Quality Surveillance Team Visit

The Quality Surveillance Team Visit

Documentation
Two weeks before the visit from the Quality Surveillance Team, the visiting reviewers will be able to access, via the QSIS web based portal, the Trust teams/services self-declaration which will have been added, the operational policy, annual report, work programme and appendices which will be uploaded.

They will look for

- Compliance against the indicators
- Supporting evidence

One hard copy of the self-declaration and other submitted documents must be made available by the team/service under review

Timing
The visit will be designed around a sessional structure, as shown in the example below:

Activity	Approximate Time
Review team to review evidence in preparation for meeting	1.5 hours
Meeting with service	2 hours
Review team to write report	1 hour
Review team to give high level feedback to team/service lead	0.5 hour

Logistics

- A minimum of two rooms should be booked in the Trust for the visit, ensuring the room sizes are appropriate for the size of the MDT/Service being reviewed.

- Security passes, car parking and catering arrangements should be arranged ahead of the visit, and the Reviewers advised of the details

- Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, and members of the Cancer management team to be available to meet the Quality Surveillance team at the start of the visit (if required).

- The Clinical Lead and all core members of the teams/services being reviewed should be available during the Quality Surveillance Team visit

- Members of Cancer Commissioning Services based in the Clinical Commissioning Groups will be made aware of the date of External Peer Review Visit and invited to attend if required.

The Cancer Quality Assurance Manager will assist and facilitate with this process.

Visit Reports

The Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, MDT lead, senior members of the operational team and an executive of the organisation will receive high level feedback at the end of the day of any immediate risk and serious concerns identified.

The Cancer Quality Assurance Manager will inform via email the executive team, divisional and directorate teams and MDT lead of high level feedback of any immediate risks and serious concerns identified.

Draft reports will be written by the reviewers. The Trust will be given the opportunity to comment on the factual accuracy of the report before it is published.

Any comments relating to the draft report should be submitted in writing to the regional team within 10 working days of receipt of the draft. Any queries will be resolved locally with the regional team in the first instance. Any unresolved queries will be referred by the regional team to the national co-ordinating team.

The report will be received by the Cancer management team and notification sent to the operational team and senior members of the executive team for action within the Trust. Outcomes will be noted, discussed and monitored by the Trust Cancer Board.

EQUALITY IMPACT ASSESSMENT

To be completed by the Treatment pathway owner and submitted to the appropriate committee for consideration and approval.

		Yes/No
1.	Does the treatment pathway affect one group less or more favourably than another on the basis of:	
	Race	**no**
	Ethnic origins (including gypsies and travellers)	**no**
	Nationality	**no**
	Gender	**no**
	Culture	**no**
	Religion or belief	**no**
	Sexual Orientation	**no**
	Age	**no**
2.	Is there any evidence that some groups are affected differently?	**no**
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	**n/a**
4.	Is the impact of the policy/guidance likely to be negative? If so can the impact be avoided?	**n/a**
5.	What alternatives are there to achieving the policy/guidance without the impact?	**n/a**
6.	Can we reduce the impact by taking different action?	**n/a**
7.	Other comments	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

FINANCIAL IMPACT STATEMENT

To be completed by the Treatment pathway owner and submitted to the appropriate committee for consideration and approval.

		Yes/No
1.	Does the implementation of this document require any additional Capital resources	**no**
2.	Does the implementation of this document require additional revenue	**no**
3.	Does the implementation of this document require additional manpower	**no**
4.	Does the implementation of this document release any manpower costs through a change in practice	**no**
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	**no**
6.	Other comments	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval