Northern Ireland Peer Review of Cancer MDTs

EVIDENCE GUIDE FOR:
Gynae Specialist & Local MDTs

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A. Introduction

This evidence guide has been developed to assist individual MDTs and their Trust's management in preparing supporting evidence for peer review.

There are three types of gynaecology cancer teams: specialist MDTs (Belfast Trust); local MDTs (Western & Southern Trust) and locality (diagnostic teams; Northern & South Eastern Trust). Different sets of measures apply to each type of team.

1. The specialist team needs to cover all of the specialist measures. It does not need to complete the measures for a local team. However, the operational policy of the specialist team needs to describe how it is organised to deliver its local service as well as its specialist function.
2. Local teams should provide evidence for all of the measures listed for local teams.
3. Locality teams (Diagnostic Service) - the list of measures for locality teams is limited to six. These teams will be expected to submit an operational policy only. There is no Northern Ireland evidence guide for these teams. These teams should use the National Cancer Peer Review evidence guide entitled "Evidence guide: Gynaecology Locality (Diagnostic Service)" which is available for download via CQuINS or by visiting http://www.cancerni.net/networkservices/regionalprojects/peerreview.

All teams will receive a separate peer review visit.

The guide should be read in conjunction with the NI Peer Review Handbook and the relevant measures from the Manual of Cancer Service (the measures for all three types of gynaecology cancer teams are available to download via CQuINS or at http://www.cancerni.net/networkservices/regionalprojects/peerreview[1]).

The contents of this guide are not exhaustive and organisations should continue to tailor their policies to reflect activity of the respective team, whilst demonstrating compliance with the quality measures. Trusts and MDTs during the review process will be required to demonstrate ownership of all policies, and assure visiting Review Teams that policy is reflective of practice.

Evidence of agreement by an MDT

During the review process each MDT will need to demonstrate ownership of all its policies and assure the visiting review teams that the policies are a true reflection of how the service is provided.

[1] Please note some of the measures have been adapted for local use – where a measure has been changed it will be highlighted in the guide.

The schedule used to record compliance with each of the measures is shown in appendix 1.

Where agreement to guidelines, policies etc is required the cover sheet of the relevant document should state the date when it was agreed and its version number. Where a measure requires evidence of adoption of network guidelines or policies the minutes of the relevant NICaN regional tumour group meeting should be attached to the document as an appendix.[2] Evidence of guidelines, policies etc requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead, etc) implies that their agreement is not personal, but that they are representing the consensus opinion of that group.

Confirmation of Compliance

Compliance against certain measures will be assessed by the review team on the day of the visit through a review of selected sets of medical records as well as examining the range of patient information used by the MDT.

Three key evidence documents

Three key documents are required to evidence compliance with the measures,

- **An operational policy**
- **An annual report**
- **An annual work plan**

The later sections of this document set out the topics that need to be covered in each of the key documents so that compliance with the measures can be demonstrated in a systematic way that avoids duplication. This guide has been adapted in a few areas from the one used for the cancer peer review programme in England – these are highlighted in red in Appendix 1.

Organisations should ensure that the three key documents provide a profile that fully describes the way in which the MDT is organized and how its service is delivered; this information should give a practical insight into how the team works and its range of care which a new member of the team would find useful. The points included in the guides to the three key documents should therefore not be regarded as an exhaustive list of what should be included.

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[2] Compliance requires a copy of the minutes of NICaN regional tumour group meeting where the guidelines were agreed and must show attendance by a core member of the MDT who can agree the guidelines on behalf of the MDT. However, it would be considered good practice if teams can evidence that the guidance has also been discussed and agreed by the MDT in an MDT meeting.

Outcomes from the peer review programme.

The main objective of the programme is to promote the improvement in the organization of cancer services and in its quality from a patient experience perspective as well as in clinical standards. To achieve this aim each MDT that is reviewed will receive a report that covers three aspects of how it and its services are organized:-

- **The % compliance score with a commentary against the measures within the Manual of Cancer Services** which in a few instances have been modified for the N.I. review programme.
- **A commentary from the review team on the way the MDT is organized and provides its service.**
- **A set of findings that will to be included inform the work programme of the MDT to support the further development of the team and their services.**

Key issues highlighted from the English Cancer Peer Review Programme Report of gynaecology cancer services:-

As background in preparing for peer review the main compliance issues identified by the review of gynaecology services in England were as follows :-.

- Evidence of effective links to the cervical screening programme.
- Ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings
- Clear definition of limits of the roles of local and specialist MDTs
- Auditing system to ensure all suitable patients referred to the specialist team
- Clarifying whether local teams provide range of treatments for cancer or only have a diagnostic function
- Variation in workload of CNSs in different MDTs
- % of specialist level of surgery taking place outside a designated centre
- Extent of ovarian surgery occurring outside designated centre
- % of emergency ovarian cancer operations.
- Range and quality of clinical data collected locally and submitted to central system
- Do surgeons in the specialist MDT who manage gynaecological cancer spend at least 50% of their direct clinical care time on the management of cancer cases
- In-reach surgery governance arrangements

These points have formed some of the main elements of the development (work) plans of gynae-oncology teams in England.

B. Key questions for an MDT

Having produced the three key documents an MDT should be able to draw some overall conclusions from the evidence they have assembled about their compliance with the measures and about their main organisational and service issues. The following four questions provide a framework for an MDT to identify its key issues.

The four questions will highlight the main issues that are likely to arise from the review. It is useful to think about these questions at an early stage in your preparation as it will identify some of the areas you might need to focus on as a team. Moreover, the visiting review teams will organize their discussion with each gynaecology team around these four questions.

In subsequent years it is expected that a Trust's management will use these four headings to carry out the annual internal validation of each MDT prior to submission of the self-assessment.

Q1. Can you demonstrate that you have a properly constituted and functioning MDT?

This can be demonstrated through compliance to those measures that relate to MDT leadership, MDT structure (membership) and MDT meeting arrangements (including attendance). In addition, measures regarding ensuring that all new patients are reviewed by the MDT, the % time MDT core members devote to this cancer service the extent of training requirements of MDT members and responsibilities of nurse MDT Members being met also help demonstrate compliance with this question. MDT workload data and surgical workload data is also important here.

Q2. Can you demonstrate that you have effective systems for providing coordinated care to individual patients?

This can be demonstrated through compliance to those measures that relate to the existence of a coordinated and patient centred pathway of care. For example, measures relating to communication with patients, key worker and principal clinician policies, communication with GPs, gaining feedback from patients, recording of treatment planning decisions, and agreement of Network Clinical Guidelines.

Demonstration of coordinated referral pathways between specialist and local teams is also an important part of showing a well coordinated service for many tumour sites. In addition, teams may demonstrate within their evidence other aspects of service delivery not covered by the existing measures that may be relevant for inclusion here (for example, the provision of streamlined diagnostic pathways, enhanced recovery programmes or other patient support initiatives).

Q3. Can you demonstrate that your team has adequate information to help it improve service delivery?

The term information is used in its broadest sense to cover data, audit, feedback from patients and feedback from service improvement initiatives. Compliance with the measures relating to data collection (collection of agreed minimum datasets for example), participation in agreed Network Audits, submission of data to national tumour specific clinical audits, service improvement initiatives and gaining feedback from patients would also show that the team has a well developed set of accurate information to meet this question. A breakdown of the team's workload showing the use of different treatment modalities is also important to show this question has been addressed.

Q4. Can you demonstrate how you are continuously improving your service (including clinical effectiveness and the patient experience)?

This question seeks to identify the wider range of sources that the MDT has used to assess opportunities for improving its services such as the results of national or regional audits or patient surveys, recent NICE guidance, technology appraisals or advice from relevant professional bodies. From these sources and the conclusions of discussions in the network tumour group it would be expected that the work programme of the MDT would identify the specific improvement areas it intends to pursue.

Where possible the annual report should identify the improvement achieved, whether it is related to the patients experience, clinical outcome, waiting times, or other quality issues/indicators.

C. The Review of Clinical Aspects of the Service

The purpose of peer review is to promote the development of MDTs so they are able to enhance their services using relevant information including that relating to aspects of clinical service quality. The table below lists a range of clinical issues/topics for audit for which gynaecological cancer teams should be aiming to collect data in order to inform their work programmes. (It is expected that these will built into data collection systems over a number of years). The issues have been identified from a range of sources :-

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- Areas of known non-compliance from previous rounds of peer review
- Improving Outcomes Guidance and other best practice guides (e.g. guidance from relevant professional bodies) and from the results of national and regional audits
- The N.I. Service Framework for Cancer Prevention, Treatment & Care.

The list will change in future years as national and international audits are published and are reflected in additional guidance from commissioners and clinical advisory groups. For some of these clinical areas agreed benchmarks are still being developed or have yet to be generally adopted.

The remit of the peer review team is to enquire about the progress made in collecting data and what changes the network group or MDT have decided to make after analyzing such information.

Ultimately, it is hoped that much of the clinical information can be extracted through the CaPPs system.[3] In the meantime, teams should consider alternative existing sources of information (e.g. results of local or regional audits or registry reports). Teams should consider the need to undertake some prospective data collection data on team workload and activity. MDTs should give consideration to how these audits could be carried out.

The table that follows shows the clinical issues/topics that the regional tumour group has agreed it would be valuable to collect data on so that it can continually review and develop its practice. Information collected on these aspects of clinical practice should be included in the MDTs annual report.

The Northern Ireland Peer Review handbook describes the limited remit that the programme fulfills with regard to the assessment of clinical issues. Its scope is limited to whether an MDT has reviewed recent clinical guidance, the extent to which it has set up data collection systems to assess its relative position and whether changes in its service are planned or have been implemented in response to regional and / or national policy documents or guidance.

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[3] It is anticipated that queries for CaPPs will be available towards the end of this calendar year.

Areas for audit	Standard / benchmark	Source	Data source
Auditing system to ensure all suitable patients referred to the specialist team	Each MDT has recording system and can show data collected	Manual of Cancer Services	CaPPs
Percentage of patients undergoing pelvic node dissection who have had 15 or more nodes removed*	Data provided by network and considered by MDT	Cancer Service Framework	CaPPs
Percentage of patients who are undergoing radical *chemoradiation* for cervical cancer completing treatment within 7 weeks of starting the course of treatment*	Data provided by network and considered by MDT.	Cancer Service Framework	CaPPs
Percentage of patients who have undergone radical surgery for gynaecological cancer who have been assessed for voiding difficulties*	Data provided for review by specialist team	Cancer Service Framework	Trust audit
Percentage patients with voiding difficulties who have received specialist physiotherapy*	Data collected by MDTs	Cancer Service Framework	Trust audit

D. The Operational Policy

This should describe the MDT's membership and how it is organised as well as describing the way its service is provided. The policy needs to set out how the patient pathway is organized from referral and initial clinics, through how diagnostics and initial treatment are provided as well as how ongoing care and follow up are delivered. The way that palliative care is linked with the MDT also needs to be described.

The policy should have a cover sheet that shows when it was formally adopted by the MDT (the minutes of the relevant meeting should be attached to the policy). The name and date when the Trust Cancer lead signed it off on behalf of the management of the Trust should also be shown. The date when the policy will be reviewed should also be shown on the cover sheet.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Introduction		Confirm locality which MDT is part of and population served	Declare cancer types team deals with. Attach team's patient pathway.
Purpose of MDT		Describe the aims & objectives of the MDT	MDTs objectives may include Implementation of IOG, working to agreed NSSG[4] guidance, undertaking service improvement, participating in audit, including agreed NSSG Audits.
Leadership Arrangements & responsibilities	08-2E-101	State name of MDT clinical lead and detail agreed responsibilities of clinical lead	
Membership Arrangements	08-2E-102	State names and professional roles of each Core Team Member ***In N Ireland core membership of the local and specialist MDT has been extended to include a representative of the S&PC team (see Appendix 2).***	State the Name of individual responsible for integrating recruitment of patients into clinical trials and person responsible for Patient / Carer issues The number of specialist nurse half day sessions devoted to the cancer service should be stated along with the number of new patients discussed by the MDT over the previous year. Details should also be given of the number of clinics attended by a CNS when patients are given their diagnosis & any not so covered; the extent to which they fulfill the key worker role should be defined as well as whether they carry out any other distinctive roles e.g. nurse run follow up clinics, endoscopy sessions etc.

[4] NSSG = Network site specific group or NICaN regional tumour group.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
	08-2E-105	State the cover arrangements as named individuals for each core member.	The cover should be named individuals except where this role is fulfilled by a senior trainee. The expectation is that the number of such individuals providing cover will be limited in number to reflect the trends of increased tumour specific sub-specialization in diagnostic and treatment services as well as continuity of input to the MDT.
	08-2E-117	State names and professional roles of each Extended Team Member	
	08-2E-104	If there is a separate “diagnostic” MDT state names and professional roles of the each diagnostic MDT Member.	The attendance both core and named cover should be recorded at each MDT and a summary sheet provided that shows for each which meetings they attended and a total % attendance for each person.
	08-2E-113; 08-2E-114; 08-2E-115	Details of core nurse members specialist study (completed or enrolled on). Detail the agreed responsibilities for Core Nurse Members	2E-113 and 114 - Compliance requires evidence that the nurse concerned has completed or is studying for a qualification that is specific to the tumour service concerned and has at least 20 credits or is at degree level. Evidence of other equivalent courses should be provided.
Diagnostic Services	08-2E-112	Provide confirmation that core Histopathological members are taking part in a general histopathology EQA that includes gynae pathology.	Attach certificate as appendix to the operational policy.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
The MDT Meeting	08-2E-105; 08-2E-108	Confirm frequency, time and duration of MDT meetings and arrangements for recording attendance Detail policy for dealing with patients that require a treatment decision before next scheduled meeting. Detail policy whereby it is intended that all new cancer patients will be reviewed by the MDT.	A complete schedule of meetings and record of attendance should be outlined as part of the annual report – refer to Section E. Outline requirements for attendance (e.g. in person, via video link) Useful to also include details of which patients are routinely discussed at MDT, how list for discussion is compiled and arrangements for identifying pts suitable for clinical trials. The operational policy should define criteria used for distinguishing different categories of patients and the extent to which they are discussed so MDT time is used to best effect. ***In N Ireland the standard is that 95% of new cases are discussed (increasing to 98% by 2012).***
	08-2E-122	Include details of the system for collating information prior to the MDM and for recording and circulating MDT decisions.	Attach samples a completed MDM meeting record - ensure that no patient details are identifiable. This should include the MDT meeting from which the case-notes provided for review have been supplied.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
	08-2E-109	Outline policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis within 48 hours (or two working days). ***Local policies prohibit use of faxing of patient information. Hence in NI this measure has been amended from a 24 hr to 48 hr standard in order to allow the information to be sent by mail.***	This should identify who in the MDT carries out this role. The intention is that the GP is informed before a patient is likely to be seen in the surgery. The information provided to the GP confirms the diagnosis and treatment option(s) discussed with the patient in clinic. Details of the audit of this (required by measure 08 2E 109) – to be included on annual report.
	08-2E-110	Outline 'key worker' policy	Compliance will be confirmed via a review of case notes on the day of the visit. Case notes must show that a named key worker has been recorded in the notes. ***NI definition of this measure indicates that key worker policy should include provision of back up arrangements to cover job shares or to cover leave or sickness absence.***
Data Collection	08-2E-129	State agreement to the NSSG minimum dataset. Attach/link to the NSSG MDS	This should confirm the data which the MDT has agreed to collect including that which the regional group has agreed should be collected relating to clinical issues for audit. Some recent examples of anonymised records should be attached as an appendix to the operational policy.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Patient and Carer Feedback & Involvement	08-2E-118	Outline arrangements for patients to be offered permanent record of consultations.	This is to show the patient has been offered / given a record of the consultation where they were given their diagnosis and treatment options were discussed. This is often a copy of the consultant's letter to the GP but may be a note provided by a CNS after she has gone through the issues and often uses less technical language.
	08-2E-121	Details of the type of information offered to patients – provide a complete set of that used by team on the day of the review but not in the uploaded evidence.	Teams should use record what information is given to the patient, and ideally when, in the patient notes (possibly in the form of a checklist). This will be reviewed as part of the case note review on the day of the visit.
Treatment (including palliative care)	08-2E-123; 08-2E-124; 08-2E-125; 08-2E-126	State agreement to Network Diagnostic Guidelines – including imaging and pathology (attach / link to the full Network guidelines)	Attach guidelines as appendix to the operational policy. Include as an appendix a copy of the minutes of NICaN regional tumour group meeting where the guidelines were agreed. Minutes must show attendance by a core member of the MDT who can agree the guidelines on behalf of the MDT. It would be considered good practice if teams can evidence that the guidance has also been discussed and agreed by the MDT.
Agreements		Use a front cover sheet which Includes Date MDT Agreed this policy Date lead Cancer Clinician Agreed this policy Date when policy is next due for review.	

E. The Annual Report

This provides information about the workload of the MDT, the changes it has introduced in the way the pathway is organized and any significant staffing issues that have arisen along with any other substantial changes introduced. Information about action on any national, regional or Trust audits should be included as well as from patient feedback. This report needs to cover the most recent 12 months for which the MDT has been able to collect the relevant data and other information (i.e. January to December 2009)

The annual report should have a cover sheet that shows when it was formally adopted by the MDT (the minutes of the relevant meeting should be attached). The name and date when the Trust Cancer lead signed it off on behalf of the management of the Trust should also be shown.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Introduction			Define period report relates to (i.e. state year covered) Include short narrative giving a summary assessment of the teams achievements and challenges faced over the previous year.
Workload of MDT /Cases Discussed			It would be helpful to include details of the number of new cases discussed by the MDT over the previous year, although this is not a specific requirement. Include details of the number of patients treated (over the previous year) by treatment type.
Team Attendance at Network NSSG Meetings	08-2E-103	Include details of the team's attendance over (at least) the last years NSSG Meetings.	Provide the minutes of at least the last three meetings as an appendix to the annual report
MDT Meeting Attendance	08-2E-104; 08-2E-105; 08-2E-106; 08-2E-107	Include a breakdown of attendance by named core team member and by specialism for MDT meetings over the previous year.	Please provide this as a schedule that shows the dates of meetings and the attendance at each named individual as well as a total figure for each person and a % attendance for each individual. The attendance by the named cover for each core member should be shown separately.
Work programme			Include summary (if relevant) of progress against work programme for the previous year or of other achievements against identified team priorities

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Meetings to discuss Operational Policies	08-2E-107	Include details of meetings of the MDT over the previous year, used to discuss, review, agree and record at least some operational policies.	Attach minutes of such meetings to the annual report
Training	08-2E-116	Advanced Communication skills training	Please note the measures differ for each team in terms of core team members who should have attended the training. Please provide detail for relevant team members regardless of when training was undertaken and include the dates where firm bookings have been made for others to attend. ***The NI definition of this measure states that attendance at any of the following training courses will meet the requirements of peer review: Wilkinson; Fallowfield and Maguire.***
Data Collection	08-2E-129 08-2E-130	Need to identify that the NSSG agreed minimum dataset, and the collection policy, are being followed by the MDT.	

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
National/ Local Audit	08-2E-131; 08-2E-132 See the list of areas for audit in Section C.	Include details of the audit projects the MDT had participated in over the previous year, indicating which ones are agreed NSSG audits. Give date when results of NSSG audit where presented by this MDT to the NSSG (If this has happened).	Include update on the team's participation in any established national audit programme. The Network agreed audit(s) should cover some of the clinical audit issues listed in section C. The analysis of this information is planned to be the network's approved audit project. It is useful to also provide a summary of the outcomes of completed audit projects and what changes to service delivery have taken place or are planned as a result. 08-2E-131 – It is understood that the Network does not have a budget for audit and that local capacity for doing audits has been reduced. Evidence of applications made for ad hoc funding to the Registers or the Guidelines and Audit Implementation Network (GAIN) should be listed. To be evidenced through submission of the minutes of the tumour working group's meetings at the review. The attendance at these meetings will demonstrate that a discussion had taken place with all relevant constituent members present.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Audit of timeliness of diagnosis notification to GPs	08-2E-109	Include the results of the audit of the policy whereby after a patient is given a diagnosis of cancer, the patients GP is informed of the diagnosis within 48 hours or two working days.	This needs to show that for a sample period (minimum of one month or 10 patients) that GPs have received the communication within the time limit set.
Patient and Carer Feedback & Involvement	08-2E-119; 08-2E-120	Include details of the work that this MDT has undertaken to gain feedback from its patients. Include details of the outcome of this work and what changes have taken place to service delivery as a result.	The evidence of compliance is that the MDT has assessed feedback or has firm plans for doing so i.e. the team has decided on how they are going to obtain patient and/ or carer views. The mechanism for getting feedback can be from:- • a survey – the minimum number is 20 responses, • from a regular feedback from a patient forum/ support group • from a general survey of the Trust's patients • from the results of a regional or network level group • from a national /regional cancer charity's survey. If the survey has not taken place the PR team would expect to see a survey that has been agreed and is ready to be sent out.
Research	08-2E-133; 08-2E-134	Include details of recruitment into each of the agreed NSSG clinical trials and remedial actions agreed with NSSG arising from the MDTs recruitment results.	List of trials to be provided with number entered into each. Any feedback from the research network or equivalent body on how uptake could be improved should be included.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Agreements		Confirm date when MDT Agreed this report	

F. Annual Work Programme

This should set out the range of issues which the MDT intends to address in the coming year. This should identify any planned substantial changes to the MDT's membership or in how its meetings are organized as well any proposals to streamline the pathway of care. The plan should also identify audit topics with an explanation for their selection, how patient feedback is to be organized as well as trial entry improved. The plan should include a prioritized list of developments for the service with an explanation of the expected impact that each will achieve.

The annual work plan should have a cover sheet that shows when it was formally adopted by the MDT (the minutes of the relevant meeting should be attached). The name and date when the Trust Cancer lead signed it off on behalf of the management of the Trust should also be shown.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Each area of the work programme should include dates for implementation and a named lead.			
Service Improvement & Development		Outline the MDTs agreed service improvement action plan e.g. to streamline the patients pathway.	Include details of how the team is planning to address any weaknesses in service delivery and/or the constitution & function of the MDT It is important that the service improvement aspects of this work programme are aligned with the relevant national and local service improvement priorities
Patient and Carer Feedback & Involvement	08-2E-120		Include details of planned work and also of any changes to be introduced as a result of previous surveys/ patient feedback.
Audit	08-2E-131 08-2E-132		Include details of the MDTs Audit programme (to include national, NSSG agreed or local audits that the group intends to participate in. Include details of planned actions in relation to any relevant National Audit programmes or outstanding actions from previous NSSG agreed or local audits.
Research	08-2E-134	Outline of any agreed actions arising from MDTs recruitment results.	Also list any new trials that are expected to start in the coming year
Actions from Previous Peer Review Assessments		Not applicable in first year of review.	If applicable, include any agreed actions arising from previous peer review, external verification or validation of self – assessment.
Agreements		Confirm date when work programme was agreed by MDT.	

G. Demonstrating compliance with the measures

As a way of checking that the three evidence documents have information that will establish that the team is compliant with each of the Measures a schedule attached as Appendix 1 should be completed and then uploaded with three key documents.

H. Uploading evidence onto the Peer Review database –CQuINs

Each Trust has a member of staff designated to approve staff who an MDT has identified will be responsible for uploading information onto CQuINs. Other staff can have read only access which is useful as examples of the three key documents produced by other gynaecological teams can be viewed.

APPENDIX 1 - COMPLIANCE CHECK LIST

Please read carefully the complete set of compliance criteria including footnotes and ensure the evidence you produce covers all the aspects specified.

The compliance assessment sheet is self populating and will be completed through the CQuINS upload process in February 2010

In early March 2010 the peer review central team will provide feedback on this compliance assessment of the MDT and issues will be discussed at the pre-visit. The set of evidence will usually be modified and the final upload onto CQUiNs made by the end of March 2010.

Five of the measures outlined in Manual of Cancer Services have been adapted for local use. These measures are highlighted in red; the revised criteria for these measures are outlined in the guidance tables in Sections D & E in *bold italics*.

Key

SA = Self assessment	OP = Operational policy
IV = internal validation	AR = Annual report
EV = external validation	WP = Work programme
PR = peer review visit	APP = Appendices

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-101	Single named lead clinician with agreed responsibilities																
08-2E-102	*Named core team members – see Appendix 2*																
08-2E-103	Team attendance at NSSG meetings																
08-2E-104	Meet fortnightly and record core attendance and protocols for referral to next scheduled meeting																
08-2E-105	MDT agreed cover arrangements for core member																
08-2E-106	Core member (or cover) present for 2/3 of meetings																
08-2E-107	Annual meeting to discuss operational policy																

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-108	*Policy for all new patients to be reviewed by MDT*																
08-2E-109	*Policy for communication of diagnosis to GPs and completed audit of timeliness of diagnosis notification*																
08-2E-110	*Operational policy for named key worker and its implementation*																
08-2E-111	Operational policy for low risk endometrial cancer treated by the stand alone diagnostic team members																
08-2E-112	Core histopathology member taking part in histo-pathology EQA																

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-114	Agreed responsibility for core nurse members																
08-2E-115	Agreed list of additional responsibilities for one core nurse member																
08-2E-116	*Attendance at national advanced communication skills training*																
08-2E-117	Extended membership of MDT																
08-2E-118	Patient permanent consultation record																
08-2E-119	Patient experience exercise																

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-121	Provision of written patient information																
08-2E-122	Agree and record individual patient treatment plans																
08-2E-123	MDT/network agreed guidelines for endometrial cancer																
08-2E-124	MDT/network agreed guidelines for ovarian cancer																
08-2E-125	MDT/network agreed guidelines for cervical cancer																
08-2E-126	MDT/network agreed guidelines for vaginal and vulval cancer																
08-2E-127	MDT/network agreed guidelines for gynaecology chemotherapy																

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-128	MDT/network agreed guidelines for gynaecology cancer follow up																
08-2E-129	MDT/network agreed collection of minimum data set																
08-2E-130	MDT/NSSG agreed policy for the collection of specific portions of MDS and/or in an electronically retrievable form																
08-2E-131	MDT/NSSG agreed participation in network audit																
08-2E-132	MDT annually review or present results from participation in audit to NSSG																
08-2E-133	The MDT should produce a written response to the NSSGs approved list of clinical trials																

Code	Measure	Compliant?				Self-Assessment Evidence								Internal Comments		Zonal Team Comments	
		SA	IV	EV	PR	OP	Page	AR	Page	WP	Page	APP	Page	Self-Assessment Comments	Internal Validation Comments	External Verification	Peer Review
08-2E-134	The remedial action rising from the MDTs recruitment results, agreed with the NSSG and implemented																

Appendix 2. Definition of MDT Core membership

Gynaecological cancer: Local MDM

Core members

- Gynaecologist / colposcopist
- Imaging specialist
- Histopathologist
- Clinical Oncologist
- Medical Oncologist
- Gynae nurse specialist
- MDT co-coordinator/secretary
- S&PC

Gynaecological cancer: Specialist MDM

Core members

Two surgical gynaecological oncologists

- Medical Oncologist
- Clinical Oncologist
- Imaging specialist
- Histopathologist / Cytopathologist
- Nurse specialist
- MDT co-coordinator/secretary
- Member of S&PC team