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Northern Ireland Peer Review of Cancer MDTs

EVIDENCE GUIDE FOR:
Breast 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. The guide should be read in conjunction with the NI Peer Review Handbook and the measures from the Manual of Cancer Service (these are available to download 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.

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.

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[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.

[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.

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.

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 breast cancer services

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

- 12% of MDTs did not have the full core membership
- 9% of MDTs had below the minimum of at least 100 new cases per annum and over 80% of these low overall compliance scores.
- Only 52% of MDTs had 2 named personnel in the core team from each professional group (dedicated pathologist, oncologist and radiologists have been difficult to establish)
- Only 40% were compliant with the MDT attendance requirement for histopathologists and ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings was still a problem
- Only 50% of teams had core members who all devoted at least half their sessions to breast cancer services.
- There were wide variation in workload of Clinical Nurse Specialists (CNSs) in different MDTs
- Auditing of sentinel node biopsies and of axillary node clearance was not consistently established
- 59% of networks had agreed guidelines for early breast cancer follow up
- 45% of networks had compared the pathways for symptomatic and screening services
- The range and quality of clinical data collected locally and submitted to central system varied widely.

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 breast-oncology 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 from the local breast cancer team for services provided elsewhere and describing how follow up is organized is also an important part of showing a well coordinated service. 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 breast 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
% patients undergoing sentinel node assessment for region & by MDT	25%	Cancer Service Framework	CaPPs (MDM module)
% node positive patients undergoing axillary node clearance in total and by MDT*		Analysis carried out and information provided for discussion at network group	
% of patients with invasive breast cancer with ER and / or PR positive disease receiving adjuvant hormone therapy	90%	Cancer Service Framework	CaPPs (MDM module)
Each surgeon involved in the NHS BSP should maintain a surgical caseload of at least 10 screen-detected cancers per year, averaged over a three year period.			
Breast cancer surgery should only be performed by surgeons with a specialist interest in breast disease	At least 30 surgically treated cases per annum	*(Surgical guidelines for the management of breast cancer (2009))*	Manual audit
Mastectomy v Breast Conservation Surgery (BCS) rates by MDT*	Mastectomy should not exceed 40%	Cancer Service Framework	CaPPs
% patients receiving radiotherapy post conservation surgery*	90%	Cancer Service Framework	CaPPs
Clear arrangements for patients being offered access to immediate reconstruction surgery	Number of cases referred for this treatment by MDT	National Mastectomy & Breast Reconstruction Audit	Operational policy
No & % mastectomy patients undergoing reconstruction by Trust	Number of cases by MDT	National Mastectomy & Breast Reconstruction Audit	CaPPs

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. State whether or not the MDT offers triple assessment (TA). Identify the number of TA clinics held weekly and their overall capacity/ number of patients that can be diagnosed. 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	08-2B-101	State name of MDT clinical lead and detail agreed responsibilities of clinical lead	
Membership Arrangements	08-2B-102 08-2B-112	State names and professional roles of each Core Team Member The core clinical members of the team spend at least 50% of their contracted sessions working in the breast cancer services.	State the Name of individual responsible for integrating recruitment of patients into clinical trials and person responsible for Patient / Carer issues This should be demonstrated by the operational policy having an appendix which has the weekly sessional timetables of the consultants and CNSs.

[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
	08-2B-113	Outline role of Clinical Nurse Specialist.	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.
	08-2B-106	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-specialisation in diagnostic and treatment services as well as continuity of input to the MDT.
	08-2B-119	State names and professional roles of each Extended Team Member	
	08-2B-104	If there is a separate “diagnostic” MDT state names and professional roles of the each diagnostic MDT Member.	

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
	08-2B-115; 08-2B-116; 08-2B-117 SEE APPENDIX 1	Details of core nurse members specialist study (completed or enrolled on). Detail the agreed responsibilities for Core Nurse Members	Compliance requires evidence that the nurse concerned has completed or is studying for a qualification that is ideally 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	08-2B-114	Provide confirmation that core Histopathological members are taking part in a general histopathology EQA that includes breast pathology.	Attach certificate as appendix to the operational policy.
The MDT Meeting	08-2B-105; 08-2B-109 SEE APPENDIX 1	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. ***In NI 82-2B-109 requires that 95% of new cases are discussed (increasing to 98% by 2012).***	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.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
	08-2B-124	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.
	08-2B-110	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 2B 110) – to be included on annual report.
	08-2B-111	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.***

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Data Collection	08-2B-130 SEE APPENDIX 1	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.
Patient and Carer Feedback & Involvement	08-2B-120	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.
	08-2B-123	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)	08-2B-125; 08-2B-126; 08-2B-127; 08-2B-128 08-2B-129	State agreement to Network Clinical Guidelines (attach or link to the full Network guidelines)	Evidence should demonstrate that the MDT members have been involved in drawing these up and have formally reviewed and adopted these by the minutes of the relevant MDT meeting being attached to the annual report.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Treatment continued			Teams should outline clearly the arrangements for patients being offered access to immediate reconstruction surgery.
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	08-2B-136		Include details of the number of new cases discussed by the MDT over the previous year by referral source (red flag, screening, consultant upgrade; incidental finding).Include details of the number of patients treated (over previous year) by each of the different treatment modalities ***Breast teams should discuss 100 new patients per annum.***
Team Attendance at Network NSSG Meetings	08-2B-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	08-2B-104; 08-2B-105; 08-2B-106; 08-2B-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	08-2B-108	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	08-2B-118	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	08-2B-130 08-2B-131	Need to identify that the NSSG agreed minimum dataset, and the collection policy, are being followed by the MDT.	
National/ Local Audit	08-2B-132; 08-2B-133 See the list of areas for audit issues listed 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. All breast units should participate in ongoing national audits such as the NHS Breast Screening Programme audits, the BCCOM audit and the Sloane Project. The Network agreed audit(s) should cover some of the clinical audit issues listed in section C.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
National / Local			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. 08-2B-132 – 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.
Audit of timeliness of diagnosis notification to GPs	08-2B-110	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.

Category	Link to Measure	Guidance for Compliance*(please refer to full details of the measure)	Additional Guidance
Patient and Carer Feedback & Involvement	08-2B-121; 08-2B-122	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	08-2B-134; 08-2B-135	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.
Agreement		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 for 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	08-2B-121 08-2B-122		Include details of planned work and also of any changes to be introduced as a result of previous surveys/ patient feedback.
Audit	08-2B-132 08-2B-133		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	08-2B-135	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 breast 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.

Four 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 see 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
08-2B-101	Single named lead clinician																
08-2B-102	Named core team members																
08-2B-103	Team attendance at NSSG meetings																
08-2B-104	If separate pre-diagnostic MDT membership named																
08-2B-105	Meet weekly and record core attendance and protocols for referral before next scheduled meeting																
08-2B-106	MDT agreed cover arrangements for core member																

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
08-2B-107	Core members (or cover) present for 2/3 of meetings																
08-2B-108	Annual meeting to discuss operational policy																
08-2B-109	*Policy for all new patients to be reviewed by MDT*																
08-2B-110	*Policy for communication of diagnosis to GP*																
08-2B-111	*Operational policy for named key worker*																
08-2B-112	Core MDT clinical consultants spends 50% time on breast cancer																

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
08-2B-113	Core MDT nurse spends 50% time on breast cancer																
08-2B-114	Core histopathology member taking part in histo-pathology EQA																
08-2B-115	Core nurse member completed specialist study																
08-2B-116	Agreed responsibility for core nurse members																
08-2B-117	Agreed list of additional responsibilities for one core nurse member																
08-2B-118	*Attendance on the national advanced communication skills training programme*																

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
08-2B-119	Extended membership of MDT																
08-2B-120	Patient permanent consultation record																
08-2B-121	Patient experience exercise																
08-2B-122	Presentation and discussion of patient experience exercise																
08-2B-123	Provision of written patient information																
08-2B-124	Agree & record individual patient treatment plans																
08-2B-125	NSSG agreed clinical guidelines																
08-2B-126	NSSG agreed referral guidelines																

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
08-2B-127	NSSG agreed diagnosis assessment imaging guidelines																
08-2B-128	NSSG agreed diagnosis assessment pathology guidelines																
08-2B-129	MDT/Network agreed guidelines for early breast cancer follow up																
08-2B-130	MDT/Network agreed collection of minimum dataset																
08-2B-131	MDT/NSSG agreed policy for the electronic collection of specific portions of MDS																

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
08-2B-132	MDT/NSSG agreed participation in network audit																
08-2B-133	MDT present results from participation in audit to NSSG																
08-2B-134	MDT/NSSG agreed list of approved trials																
08-2B-135	MDT/NSSG remedial action from MDTs recruitment results																
N8-2B-136	Workload of at least 100 new patients/year																