



**Northern Ireland Peer Review of Cancer
MDTs**

**EVIDENCE GUIDE FOR:
COLORECTAL CANCER 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 MDT meeting should be attached to the document as an appendix. 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 at Network Groups.

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**

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 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 Appendix 1 with the revised definition being in the relevant schedule –policy or annual report or work plan.

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 inform the work programme for the MDT and its service.**

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

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

- Ensuring that clinical decisions are made with all core clinical inputs being present at MDT meetings - 17% of MDTs did not have a complete core membership; 9% of MDTs lacked a histopathologist or their alternate attending 50% of meetings.
- 25% of teams had not established a key worker role
- Colorectal teams had the highest level of inappropriate use of CNSs who were carrying out administrative duties
- That there were problems of general surgeons operating on emergency colorectal admissions without then handing them over to a core member of the colorectal MDT; as a consequence a proportion of cancer cases were not being considered at an MDT meeting.

- Variable access to laparoscopic surgery including TEMs.
- Access to stenting services.
- Range and quality of clinical data collected locally and submitted to central system.

These issues have formed some of the main elements of the development / work plans of colorectal 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 colorectal cancer 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 all new patients are reviewed by the MDT, % time MDT core members devote to this cancer type, training requirements of MDT members and responsibilities of nurse MDT Members also help demonstrate this. 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 to measures relating to data collection (collection of agreed minimum datasets for example), participation in agreed Network Audits, service improvement initiatives and gaining feedback from patients would also show that the team has a well developed set of accurate information about the team's workload 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 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 colorectal cancer teams should be aiming to collect data in order to inform their work programmes. (It is expected that these will be built into data collection systems over a number of years). The issues have been identified from a range of sources :-

- 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.² 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.

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.

² It is anticipated that queries for CaPPs will be available towards the end of this calendar year.

| Areas for audit | Standard / benchmark | Source | Definition | Data source |
|---|--|--|---|--------------------|
| Number of new cases of confirmed cancer per annum per MDT per annum | All MDTs should see 60 or more new cases per annum | Improving outcomes Guidance | Number of new confirmed cases per annum per Trust | CaPPs |
| All elective radical surgery performed by surgeon who is member of an MDT and who undertakes 20 or more curative resections per annum | 20 or more curative resections per surgeon | Improving Outcomes Guidance/ Cancer Service Framework | Number of resections (colon; rectisigmoid & rectal) per surgeon Number of elective procedures carried out by a surgeon who is not a member of an MDT | Manual audit |
| Number of cases discussed for first time after surgery has occurred. | | | % cases where date of surgery precedes date of MDT discussion | CaPPs |
| Rate of laparoscopic surgery | | | Total number laps performed expressed as % of overall number of surgeries | CaPPs |
| Audit of emergency surgery performed especially by other surgeons than the core MDT members* | All patients undergoing emergency surgery should be referred to an MDT for subsequent management | | Number & % of resections (colon; rectisigmoid & rectal) undertaken as emergency procedures by Trust | Manual audit |

| Areas for audit | Standard / benchmark | Source | Definition | Data source |
|--|---|-----------------------------|--|--------------------|
| Percentage of colorectal cancer <i>surgical specimens</i> reported using the Association of Coloproctology/Royal College of Pathologists proforma. | 70% October 2011 90% October 2012 | Cancer Service Framework | | CaPPs |
| Percentage of Association of Coloproctology/Royal College of Pathologists reports discussed at the MDM within 10 days of surgery. | 70% Oct 2011 90% Oct 2012 | Cancer Service Framework | | CaPPs |
| Percentage of operations where the mesorectum has been removed intact for tumours in the middle and lower thirds of the rectum Percentage of operations where the mesorectal fascia has been removed intact for tumours in the upper third of the rectum. | Establish baseline | Cancer Service Framework | | CaPPs (MDM module) |
| % of surgical cases having pre. or post operative radiotherapy by stage | Analysis carried out and information provided for discussion at network group | Improving Outcomes Guidance | Pre-op refers to rectal only Post-op refers to colon, rectisigmoid and rectal | 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. | <p>Declare cancer types team deals with and lists modes of treatments provided by the team.</p> <p>Attach team's patient pathway.</p> |
| Purpose of MDT | 08-2D-205 | <p>Describe the aims & objectives of the MDT</p> <p>If you are not the specialist team for anal cancer, name the anal team to which patients are referred.</p> | MDTs objectives may include Implementation of IOG, working to agreed NSSG guidance, undertaking service improvement, participating in audit, including agreed NSSG Audits. |
| Leadership Arrangements & responsibilities | 08-2D-201 | State name of MDT clinical lead and detail agreed responsibilities of clinical lead | |
| Membership Arrangements | 08-2D-202 08-2D- 203 08-2D-204 08-2D- 221 08-2D- 222 | State names and professional roles of each Core Team Member. | <p>State the Name of individual responsible for integrating recruitment of patients into clinical trials and person responsible for Patient / Carer issues.</p> <p>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 when patients are given their diagnosis & any not so covered; the extent to which they fulfill the key worker role as well as whether they carry out any other distinctive roles e.g. nurse run follow up clinics, endoscopy sessions etc.</p> |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|---------------------|---------------------------------------|--|--|
| | | | <i>In Northern Ireland MDT core membership has been extended to include a member of the palliative care team.</i> |
| | 08-2D-208 | State the cover arrangements as named individuals for each core member. | |
| | 08-2D-224 | State names and professional roles of each Extended Team Member | |
| | 08-2D-244 | There should be no more than two clinical oncologists providing radiotherapy for patients with anal cancer. The clinical oncologist(s) should be a core member of the MDT specialising in anal cancer. | |
| | 08-2D-220; 08-2D-221; 08-2D-222 | Details of core nurse members specialist study (completed or enrolled on). Detail the agreed responsibilities for Core Nurse Members | 2D 220 - 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 | 08-2D-216 | 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. |
| | 08-2D-235 | State agreement to Network investigation protocol for colorectal cancer | Attach the Network guidelines 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 | 08-2D-207; 08-2D-213 | <p>Confirm frequency, time and duration of MDT meetings and arrangements for recording attendance</p> <p>Detail policy for dealing with patients that require a treatment decision before next scheduled meeting.</p> <p>Detail policy whereby it is intended that all new cancer patients will be reviewed by the MDT.</p> | <p>Please refer to annual report for full compliance – where a summary of attendance should be given.</p> <p>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 extent to which they are discussed so MDT time is used to best effect.</p> <p>The policy should describe the arrangements that are in place to ensure that patients who present as emergencies are referred into the colorectal MDT for their ongoing management and care as soon as possible after surgery has taken place.</p> <p><i>In N Ireland 82-2D-213 requires that 95% of new cases are discussed (increasing to 98% by 2012).</i></p> |
| | 08-2D-229 | <p>Include details of the system used for recording MDT decisions and for circulating these.</p> <p>Attach record of a meeting - ensure that no patient details are identifiable</p> | <p>Compliance requires samples of decision sheets for individual patients as well as for an MDT meeting that shows the way that information is collected prior to the meeting and how decisions are recorded.</p> |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|-----------------|-----------------|---|--|
| | 08-2D-214 | <p>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).</p> <p><i>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.</i></p> | <p>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 08-2D-214) – to be included on annual report.</p> |
| | 08-2D-215 | Outline 'key worker' policy | <p>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.</p> <p><i>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.</i></p> |
| Data Collection | 08-2D-236 | <p>State agreement to the NSSG minimum dataset.</p> <p>Attach/link to the NSSG MDS</p> | <p>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.</p> <p>Some recent examples of anonymised records should be attached as an appendix to the operational policy.</p> |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|--|---|---|--|
| Patient and Carer Feedback & Involvement | 08-2D-225 | Outline arrangements for patients to be offered permanent record of consultations. | Sample of the sheet used for recording what a patient has been given and ideally when - from the range of information that the team can provide. |
| | 08-2D-228 | 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. | Review teams will include users who will look at whole range of local, regional and national information material used by the team |
| Treatment (including palliative care) | 08-2D-230; 08-2D-231; 08-2D-232; 08-2D-233 08-2D-234 | The full set of network approved guidelines should be attached as well as the minutes of the MDT meeting when the team endorsed them. | 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. |
| | 08-2D-217 08-2D-218 08-2D-219 See list of areas for audit in Section C | The operational policy should describe: the arrangements of the team for dealing with surgical emergencies; the availability of stenting services; and the referral arrangements for tertiary care. | Teams should describe the process for onward referral and management of patients with anal cancer and liver metastases. |
| 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 | 08-2D-242 | Each team is expected to discuss 60 new cases each year. | 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 treatment modality. |
| | 08-2D-243 | Each surgeon is expected to carry out 20 operative procedures | Each team should record the figures for major benign operations as well as for cancer operations so that reviewers can assess that the designated members are carrying out a sufficient volume of complex colorectal surgery to sustain competence. |
| Team Attendance at Network NSSG Meetings | 08-2D-206 | 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 | 08-2D-209; | Include a breakdown of attendance by named member and by specialism for MDT meetings over the previous year. Target is 66% attendance by the core member of their named cover. | Please provide this as a schedule that shows the dates of meetings and the attendance at each one by named individual as well as a total figure for each person and a % attendance for each individual. |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|--|-----------------|--|---|
| Work programme | | | Include summary (if relevant) of progress against work programme for the previous year or of other achievements against identified team priorities |
| Meetings to discuss Operational Policies | 08-2D-212 | 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 | 08-2D-223 | Advanced Communication skills training | <p>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.</p> <p><i>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.</i></p> |
| Data Collection | 08-2D-237 | Need to identify that the NSSG agreed minimum dataset and dataset policy are being followed by the MDT. | |
| | 08-2D-242 | Evidence of new cases number in previous year. | |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|--------------------------|--|---|---|
| | 08-2D-243 | Evidence of the surgical workload of each consultant indicating the number of benign and malignant operations performed | This should include procedures performed with the intention of loco-regional clearance of colonic or rectal cancer (please refer to the Manual Measures for further details). |
| National/ Local Audit | 08-2D-238 08-2D-239 See list of issues 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 were presented by this MDT to the NSSG (If this has happened). | <p>Include update on the team's participation in any established national audit programme.</p> <p>The Network agreed audit should seek to prioritise clinical audit issues listed in section C.</p> <p>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.</p> <p>08-2D-238– 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.</p> <p>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.</p> |

| 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 | 08-2D-214 | 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 | 08-2D-226; 08-2D-227 | 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. | <p>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:-</p> <ul style="list-style-type: none"> • 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. <p>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.</p> |
| Research | 08-2D-240; 08-2D-241 | 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 | 08-2D-226 08-2D-227 | | Include details of planned work and also regarding learning from and acting on patient feedback already received. |
| Audit | 08-2D-238 08-2D-239 | | <p>Include details of the MDTs Audit programme (to include national, NSSG agreed or local audits that the group intends to participate in.</p> <p>Include details of planned actions in relation to any relevant National Audit programmes or outstanding actions from previous NSSG agreed or local audits.</p> |
| Data collection | 08-2D-237 | The requirements for assessing a local service requires the collection of data for a widening range of clinical aspects of the service including: surgery type and volume per operator; the number of out of hours emergency operations; number of stents performed by each named person listed in the operational policy. | Identify plans for collecting further information so that the MDT can respond to the national reports about clinical aspects of the service. |

| Category | Link to Measure | Guidance for Compliance*(please refer to full details of the measure) | Additional Guidance |
|---|-----------------|---|--|
| Research | 08-2D-241 | 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 –CQINs

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

APPENDIX 1. COMPLAINE CHECKLIST

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

IV = internal validation

EV = external validation

PR = peer review visit

OP = Operational policy

AR = Annual report

WP = Work programme

APP = Appendices

08-2D-2 - COLORECTAL MULTIDISCIPLINARY TEAM (MDT)

| 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 |
| 08-2D-201 | Single named lead clinician | | | | | | | | | | | | | | | | |
| 08-2D-202 | <i>Named core team members</i> | | | | | | | | | | | | | | | | |
| 08-2D-203 | Named consultant surgical core member(s) for anal cancer | | | | | | | | | | | | | | | | |
| 08-2D-204 | Named consultant clinical oncology core member(s) for anal cancer | | | | | | | | | | | | | | | | |
| 08-2D-205 | Named MDT for anal cancer | | | | | | | | | | | | | | | | |
| 08-2D-206 | Team attendance at NSSG meetings | | | | | | | | | | | | | | | | |
| 08-2D-207 | Frequency of treatment planning meeting | | | | | | | | | | | | | | | | |
| 08-2D-208 | MDT agreed cover arrangements for core members | | | | | | | | | | | | | | | | |

| 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 |
| 08-2D-209 | Core members (or cover) present for at least 2/3 of meetings | | | | | | | | | | | | | | | | |
| 08-2D-212 | Annual meeting to discuss operational policy | | | | | | | | | | | | | | | | |
| 08-2D-213 | <i>Policy for all new patients to be reviewed by MDT</i> | | | | | | | | | | | | | | | | |
| 08-2D-214 | <i>Policy for communication of diagnosis to GP</i> | | | | | | | | | | | | | | | | |
| 08-2D-215 | <i>Operational policy for named key worker</i> | | | | | | | | | | | | | | | | |
| 08-2D-216 | Core histopathology member taking part in histology EQA | | | | | | | | | | | | | | | | |
| 08-2D-217 | MDT/NSSG agreed guidelines on management of surgical emergencies | | | | | | | | | | | | | | | | |
| 08-2D-218 | MDT/NSSG agreed secondary to tertiary referral 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 |
| 08-2D-219 | MDT/NSSG agreed list of personnel judged competent for colorectal stenting | | | | | | | | | | | | | | | | |
| 08-2D-220 | Core nurse member completed specialist study | | | | | | | | | | | | | | | | |
| 08-2D-221 | Agreed list of responsibilities for core nurse specialist(s) | | | | | | | | | | | | | | | | |
| 08-2D-222 | Agreed list of additional responsibilities for one core nurse specialist(s) | | | | | | | | | | | | | | | | |
| 08-2D-223 | <i>Attendance at national advanced communication skills training programme</i> | | | | | | | | | | | | | | | | |
| 08-2D-224 | Extended membership of MDT | | | | | | | | | | | | | | | | |

| 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 |
| 08-2D-225 | Patients permanent consultation record | | | | | | | | | | | | | | | | |
| 08-2D-226 | Patient experience exercise | | | | | | | | | | | | | | | | |
| 08-2D-227 | Presentation and discussion of patient experience survey | | | | | | | | | | | | | | | | |
| 08-2D-228 | Provision of written patient information | | | | | | | | | | | | | | | | |
| 08-2D-229 | Treatment planning decision | | | | | | | | | | | | | | | | |
| 08-2D-230 | MDT/NSSG agreed network clinical guidelines for colorectal cancer | | | | | | | | | | | | | | | | |
| 08-2D-231 | MDT/NSSG agreed network guidelines for the clinical management of anal 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 |
| 08-2D-232 | MDT/NSSG agreed network guidelines on the resection of liver metastases | | | | | | | | | | | | | | | | |
| 08-2D-233 | MDT/NSSG agreed network referral guidelines between teams for anal cancer | | | | | | | | | | | | | | | | |
| 08-2D-234 | MDT/NSSG agreed network referral guidelines between teams for the resection of liver metastases | | | | | | | | | | | | | | | | |
| 08-2D-235 | MDT/NSSG agreed network investigation protocol for colorectal cancer | | | | | | | | | | | | | | | | |
| 08-2D-236 | MDT/network agreed collection of minimum dataset | | | | | | | | | | | | | | | | |
| 08-2D-237 | MDT/NSSG agreed policy for the electronic collection of portion 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 |
| 08-2D-238 | MDT/NSSG participation in network audit | | | | | | | | | | | | | | | | |
| 08-2D-239 | MDT present results from participation in audit to NSSG | | | | | | | | | | | | | | | | |
| 08-2D-240 | MDT/NSSG agreed list of approved trials | | | | | | | | | | | | | | | | |
| 08-2D-241 | MDT/NSSG remedial action from MDT's recruitment results | | | | | | | | | | | | | | | | |
| 08-2D-242 | MDT to discuss 60 new cases per year | | | | | | | | | | | | | | | | |
| 08-2D-243 | 20 or more operative procedures per core individual core member per year | | | | | | | | | | | | | | | | |
| 08-2D-244 | No more than 2 clinical oncologists practising radiotherapy for anal cancer in radiotherapy | | | | | | | | | | | | | | | | |

| 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 |
| | department and they should be core members | | | | | | | | | | | | | | | | |

Appendix 2. Definition of membership of Colorectal Cancer MDTs

Local MDM

Core

- At least two colorectal surgeons;
- Clinical oncologist who takes responsibility for radiotherapy for rectal carcinoma;
- An oncologist who takes responsibility for chemotherapy (this may be the clinical oncologist who is also responsible for rectal carcinoma, or it may be another oncologist, clinical or medical);
- Imaging Specialist;
- Histopathologist;
- Colonoscopist of any of the following disciplines: surgeon, physician or specialist nurse;
- Colorectal nurse specialist;
- Member of a specialist palliative care MDT (doctor or nurse);
- MDT co-coordinator/secretary
- A member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers.

Additional members

- Gastroenterologist
- Liver Surgeon (who is a member of a liver resection MDT)
- Thoracic Surgeon with expertise in lung resection
- Interventional Radiologist
- GP
- Dietician
- Liaison Psychiatrist/Clinical Psychologist
- Social Worker

Anal Cancer: Regional / specialist MDM

These apply to any colorectal MDT treating patients with anal cancer, with curative intent:

- At least one and no more than two consultant surgical core members, under whose care all operations for anal cancer take place for the patients of the MDT;
- At least one and no more than two consultant lead clinical oncology core team members under whose care all curative chemotherapy and/or radiotherapy (including chemo-radiotherapy) for anal cancer takes place, for the patients of the MDT.