



Peer review of cancer MDTs

Project Plan

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Document History

Version	Date	Comment
1	26/03/09	First Draft
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1.0 Background

The Multi-disciplinary Team (MDT) is understood to be the cornerstone of effective, safe and well-planned patient cancer care. The Cancer Control Programme (DHSS&PS NI, 2006) stated that “by 2007 all cancer patients will have their treatment plan agreed at appropriately constituted and resourced multidisciplinary team meetings”. These meetings have now been established for most cancer types and the last two years have seen significant investment in MDT support.

The Service Framework for Cancer Prevention, Treatment and Care (due for publication Spring 2009) includes a standard designed to build on the work undertaken to date. The standard relates to the effective functioning of MDTs (see Appendix 1). It includes three key performance indicators: % of patients presented at MDT meeting; attendance by core members of the team; and performance against the MDT measures within the Manual for Cancer Services Standards.

Peer review of MDTs has been in place in England and Scotland since 2001 and has recently been introduced in Wales. NICaN has secured funding through RMSG to begin a rolling programme of cancer peer review in Northern Ireland. Its introduction will be an important driver for service improvement and will ensure the delivery of quality assured, equitable cancer services that can be benchmarked against the UK norm.

This document outlines the proposed process and timescale for the implementation of the first round of reviews.

Aims

The aim of peer review of MDTs is to support the development of effective, safe and well planned care for cancer patients by reviewing MDT compliance with the measures contained within the Manual of Cancer Services, to identify issues related to the achievement of the measures and to identify and share good practice.

The aim of peer review is:

- to ensure services are as safe as possible.
- to improve the quality and effectiveness of care
- to improve the patient and carer experience of care
- to provide development and learning for everyone involved
- to encourage the sharing of good practice

2.0 The peer review process

The process for delivery of the programme will mirror that of the national Peer Review Programme (see Figure 1 below). The only amendment is the inclusion of an additional pre-visit during the Autumn which has been added to enhance the support available to teams in light of the fact that it is the first year of the programme.

Figure 1. An overview of the peer review visit process & timetable



MDTs will be assessed against the MDT measures within the Manual of Cancer Services Standards (DoH, 2004)¹ will look at a range of issues that relate to the delivery of effective care including (see Appendix 2 for full list):

- the development of operational protocols;
- the development of clinical management guidelines;
- participation in clinical trial;
- participation in audit;
- undertaking service improvement work;
- incorporating patient feedback into the planning of care; and
- patient information.

The peer review model in England has recently been extended in order to enhance the clinical focus of the review. Peer reviewers will now be reviewing a range of clinical issues / activity data that have been identified as areas for development within national audits. The clinical issues for each of the four tumour sites to be reviewed are outlined in Appendix 3. It is anticipated that, where this information is available to teams in-year, that they will use it to prioritise and agree their work programmes for the incoming year.

Programme Scope

The programme for 2009/10 will prioritise the following MDTs: colorectal; gynaecology; lung; and breast. These cancers represent just over half of all cancers newly diagnosed in Northern Ireland each year, excluding non-melanoma skin cancers.

3.0 Project Management Structure

The planning and implementation of the programme will be overseen by a regional Reference Group, which will function as a sub-group of the NICaN Board. The Reference Group will agree the measures for review and ensure that quality assurance, controls and performance management processes are appropriately planned and implemented. The reference group will provide direction to a Coordinating Team² who will coordinate the delivery of the programme. The agreed Terms of Reference for the Peer Review Reference Group are included in Appendix 4.

¹ The measures will be reviewed and amended to ensure that they are locally relevant.

² The coordinating team is the London Zonal Team has been appointed to coordinate and deliver the review visits for Northern Ireland. The team comprises a Quality Director, a Quality Manager and a Clinical Director.

4.0 Project Plan

The project plan is split into 5 phases:

- Project initiation - which includes defining and agreeing the scope of the review to include agreement of measures.
- Preparation & support – which includes publication of guidance and establishment of support mechanisms (e.g. CQuINs, familiarization workshops, pre visits, working groups)
- The review – which outlines time lines for submission, validation and review of data plus the visits themselves
- Provision of feedback – outlines timelines for production of feedback reports to Trusts and the commissioner.
- Programme evaluation

Appendix 5 provides an outline project plan. In addition to outlining key milestones such as dates of familiarization workshops, pre-visits and visits the project plan outlined dates for the completion of the following key products.

- An agreed list of review measures
- Evidence guides for each tumour site
- A briefing pack for reviewers.
- A peer review handbook outlining agreed process and timescales for the review to include:
 - Identification of measures that will be subject to self assessment (i.e. will require submission evidence prior to the visit)
 - A process for the submission of self-assessment data
 - A process for the analysis and follow-up of self-assessment data prior to visit
 - Timeline for submission of self assessment data, pre-visits, visits, delivery of report.
 - Reporting structures, timelines and format.
 - Identification and handling of concerns
 - Use of CQuINs
- NI version of CQuINS.
- Trained lay reviewers.

5.0 Assumptions

- That ongoing funding will be available to allow the delivery of a sustained programme of peer review of cancer MDTs
- That there is commitment from commissioners and providers for the programme.
- That all relevant MDTs will be actively using the CaPPs system.
- That CaPPs queries can be written to facilitate collation of much of the required clinical activity data.

6.0 Constraints

Time: The main constraint facing the programme is the short timescale. The Project Plan must take account of this. Monitoring of progress against agreed milestones must take place to ensure preparation and roll out are delivered in a timely fashion. Adopting learning from other parts of the UK will help speed up the implementation of the programme.

Funding: It is anticipated that the funding will enable the peer review of four MDTs. The Project Board will assess projected project costs against allocated funds and determine whether there are any constraints or risks in this area.

Trust capacity: The programme will create additional workload pressures for Trusts. The Network will put in place a range of support mechanisms in order to minimise this but there is a risk that workload pressures could impact on the extent to which Trusts can demonstrate compliance.

Audit & information: It may not be possible to gather all of the required clinical activity data for this round of reviews. Where it is not possible to access the data this year, steps should be taken to put in place systems to enable its collection in future years.

7.0 Benefits

The programme is expected to deliver the following benefits:

- enhanced multi-professional working;
- confirmation that cancer services are of approved quality and are consistent across the region;
- speedy identification of areas of risk or serious concerns about the safety or quality of services where they occur so that they can be rectified;
- enhanced local system management processes to support governance and appropriate allocation of resources within cancer;
- will inform and be informed by ongoing quality monitoring and service improvement;
- highlight any regional issues which require a Network intervention / response;
- highlight areas of good practice;

- support the informed commissioning of cancer services;
- maximises application of CaPPs.

8.0 Preliminary Risk Assessment

The principle risks of the project are as follows and should be read in conjunction with the previous section on Constraints

1. Short timescales: Close monitoring of progress is required. Significant risks of not meeting the agreed deadline should be communicated immediately by the Coordinating Team to the Reference Group or by the Reference Group to NICaN Board.
2. Peer review of MDTs may raise issues of risk or concern which need to be actioned. It is important that there is no blame culture and that peer review is seen as a developmental and supportive process. Some of the issues raised may be difficult to address within current funding constraints. It is important that such issues are identified where they exist so that we can take steps to proactively manage the risk. The peer review process provides a means to identify such risks and ensures that Trusts produce action plans that will work to manage or address any issues of risk or inequity identified. The peer review process will also inform the prioritisation of future cancer services investment towards the delivery of safer, more equitable cancer services.
3. Trusts may want to raise issues related to NICaN as part of the review and feel inhibited from doing so due to their involvement in the delivery of the programme. The Peer Review Reference Group will need to establish processes and safeguards to ensure that Trusts are given an opportunity to provide any such feedback and that it is fully reported on.

Appendix 1 – Effective Multidisciplinary Team Standard from Service Framework for Cancer Prevention, Treatment and Care

<p>All patients who are suspected³ or have a diagnosis of cancer should have their care managed by an appropriately constituted⁴ and effective <i>multidisciplinary team</i> (MDT) which meets weekly or fortnightly (in accordance with the manual of Cancer Services Standards).</p>
<p>Rationale: MDT working is the recognised model for providing care to cancer patients. MDTs bring all the relevant health care professionals together to ensure the patient gets the best care possible. While there have been big improvements in the number of patients being discussed at Multidisciplinary Team Meetings (MDMs), not <i>all</i> patients are being discussed at MDMs. Other areas for improvement include:</p> <ul style="list-style-type: none"> ▪ the membership of the MDT; ▪ the frequency of meetings; ▪ the need for written operational or clinical guidelines; and ▪ the need to collect data that allows the MDT to audit its activity. <p>Evidence: The Manual of Cancer Services Standards www.cquins.dh.gov.uk</p>
<p>Responsibility for delivery / implementation</p> <p>NICaN Board Commissioners Trust Chief Executives Tumour-specific, multidisciplinary, cancer teams</p>
<p>Quality Dimension</p> <p>Timely & Patient Centred Effective team working will ensure prompt investigation, diagnosis and management of all patients, in line with the individual's wishes.</p> <p>Safe, Efficient & Effective Evidence-based care is easier to guarantee in structured team practice. High volume patient services (within an institution and at the individual clinician level) have better outcomes for patients and deliver better value for money.</p> <p>Equitable All patients will have access to a specialist service. Teams will deliver care to regionally-agreed-standards so all patients will have the same access to drugs and therapies.</p>

³ Patients suspected of having cancer are those that have been referred by their GP as a “red flag” or suspect cancer under the NICaN GP Referral Guidance for Suspect Cancer. It also includes patients whose referral forms have been upgraded to “red flag” by a consultant.

⁴ For the constitution or core membership of each MDM please refer to Appendix 4.

Appendix 1 – Effective Multidisciplinary Team Standard from Service Framework for Cancer Prevention, Treatment and Care

Performance Indicator	Data source	Expected Performance Level	Date to be achieved by
Percentage of people with suspected / diagnosed with cancer who are discussed at an MDM	Minimum dataset for the MDM	80% 95%	March 2011 March 2012
Percentage attendance by individual core members or their agreed cover at the multidisciplinary meetings.	Record of attendance	66%	April 2011
MDT performance against MDT measures outlined in the Manual Cancer Services Standards	External peer review	Baseline to be established Trusts to evidence action against peer review recommendations	2011 Annually

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Appendix 2 – Outline of peer review measures from Manual of Cancer Services

Number	Measure
2A-101	Single named lead clinician 1*
2A-102	Agreed responsibilities with host trust lead clinician 1*
2A-103	MDT listed as part of the named services within the network locality 1*
2A-104	Named core team members 1*
2A-105	Team attendance at least 2/3 NSSG meetings 1*
2A-106	Named single lead Histopathologist 1*
2A-107	Named single lead imaging Consultant 1*
2A-108	All Consultants core member of at least one MDT 1*
2A-109	If separate pre diagnostic MDT membership named 1*
2A-110	Meet and record core attendance & protocols for referral before next scheduled meeting 1*
2A-111	Core member (or cover) present for 1/2 of meetings 1*
2A-112	Core members (or cover) present for 2/3 of meetings 1
2A-113	MDT agreed cover arrangements for core member 1*
2A-114	Annual meeting to discuss operational policy 1*
2A-115	Policy for all new patients to be reviewed by MDT 1*
2A-116	Policy for communication of diagnosis to GP 1
2A-117	Completed audit of timeliness of diagnosis notification 1
2A-118	This measure has been deleted
2A-119	Operational policy for named key worker 1*
2A-120	Implementation of key worker policy 1
2A-121	Core Imaging specialist reporting 1*
2A-122	Core Nurse member undertaking or enrolled for specialist study 1*
2A-123	Core Nurse member completed specialist study 1
2A-124	Core Nurse member undertaking or enrolled for communication skills study 1*
2A-125	Core Nurse member completed communication skills study 1
2A-126	Agreed responsibility for core nurse members 1*
2A-127	Agreed list of additional responsibilities for one core nurse member 1*
2A-128	Extended membership of MDT 1*
2A-129	Agreement for communication to patients and policy for access to MDT by patients/carers 1*
2A-130	Patient permanent consultation record 1*
2A-131	Patient experience survey 1*
2A-132	Presentation and discussion of patient experience survey 1
2A-133	Implementation of action point arising from survey 1
2A-134	Provision of written patient information 1*
2A-135	Patients notes checklist 1
2A-136	Agree and record individual patient treatment plans 1*
2A-137	NSSG agreed clinical guidelines 1
2A-138	NSSG agreed referral guidelines 1*

Appendix 2 – Outline of peer review measures from Manual of Cancer Services

Number	Measure
2A-139	NSSG agreed diagnosis assessment imaging guidelines 1*
2A-140	NSSG agreed diagnosis assessment pathology guidelines 1*
2A-141	MDT / Network agreed collection of minimum data set 1*
2A-142	MDT / NSSG agreed policy for the electronic collection of specific portions of MDS 1*
2A-143	This measure has been deleted
2A-144	This measure has been deleted
2A-145	MDT / NSSG agreed participation in network audit 1*
2A-146	MDT present results from participation in audit to NSSG 1
2A-147	MDT / NSSG agreed list of approved trials 1
2A-148	MDT agreed core member responsible for integration of service improvement 1*
2A-149	Patient cancer journey process mapping and action plan 1*
2A-150	One resulting service improvement action point with supporting data 1
2A-151	Network service improvement lead capacity/demand study 1

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Appendix 3 – Clinical issues to be included in review

Breast
<ul style="list-style-type: none"> • Each MDT to manage at least 100 new cases per annum • Each MDT to have 2 named personnel in the core team from each professional group • Ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings • 50% plus of time of core team members devoted to the breast cancer service • Variation in workload of CNSs in different MDTs* • Does MDT offer triple assessment* • Auditing of sentinel node biopsies and of axillary node clearance* • % patients receiving radiotherapy post conservation surgery* • Network has agreed guidelines for early breast cancer follow up • % patients offered chemotherapy prior to surgery • Clear arrangements for patients being offered access to immediate reconstruction surgery by MDT or by referral onto another team –see recent NICE report. • No. of reconstruction ops per Trust per annum • Mastectomy v Breast Conservation Surgery (BCS) rates * • Length of stay / day surgery rates • Ongoing support /advice for patients after their initial treatment is completed • Consistent follow up within and between Teams. • Range and quality of clinical data collected locally and submitted to central system
Lung
<ul style="list-style-type: none"> • Ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings (problems thoracic surgeons, palliative care, and histopathology) • Variation in workload of CNSs in different MDTs* • Access to PET scans • Ensuring all suspected lung cancer cases referred to MDT for discussion • % of suitable cases receiving active cancer treatment as first recorded treatment • % patients receiving surgical resection as first treatment • % diagnosed by histology or cytology (target 80-85%). • % SCLC cases receiving chemotherapy* • Range and quality of clinical data collected locally and submitted to central system • % patients receiving CT prior to bronchoscopy*

* Denotes a measure that is included in the Service Framework for Cancer Prevention, Treatment and Care

Appendix 3 – Clinical issues to be included in review

Colorectal
<ul style="list-style-type: none"> • Ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings (Problems with gastroenterology and histopathology input) • Variation in workload of CNSs in different MDTs* • Trends in % of MDT confirmed cases having surgery • Post op. mortality • Complications rate • Post op. length of stay • Use enhanced recovery programme • Audit of emergency surgery performed especially by other surgeons than the core MDT members* • Number of cases discussed for first time after surgery has occurred. • Extent of access to stenting • Rate of laproscopic surgery • Audit of no. of lymph nodes examined per surgical specimen (min. of 12 recommended) ; Audit of the collection of ASA grade info. * • Min. 60 new cases per annum per MDT p.a • Resection op. Workload per surgeon p.a. • % of surgical cases having pre or post operative radiotherapy. • How are patients offered access to laproscopic surgery • Guidelines for extent of early rectal cancer services provided by local team and access to TEMs service • Guidelines for managing metastatic disease (links to specialist pancreatic MDT) • Guidelines for managing anal cancers. • Range and quality of clinical data collected locally and submitted to central system • TME - % operations where mesorectum removed intact* • Impact of Bowel screening⁵
Gynae
<ul style="list-style-type: none"> • Ensuring treatment decisions are made with all core clinical inputs being present at MDT meetings • 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 designated centre • Extent of ovarian surgery occurring outside designated centre • % of emergency ovarian cancer operations. • Percentage of patients undergoing pelvic node dissection who have had 15 or more nodes removed* • Percentage of patients receiving adjuvant chemotherapy for ovarian cancer who start treatment within 4 weeks of surgery*

⁵ This will not be assessed during 2009/10 review as impact will not yet be evident.

Appendix 3 – Clinical issues to be included in review

- Percentage of patients who are undergoing radical *chemoradiation* for cervical cancer completing treatment within 7 weeks of starting the course of treatment*
- Percentage of patients with gynaecological cancer who have been assessed for voiding difficulties*
- Impact of cervical screening
- Percentage patients with voiding difficulties who have received specialist physiotherapy*
- Range and quality of clinical data collected locally and submitted to central system

* Denotes a measure that is included in the Service Framework for Cancer Prevention, Treatment and Care

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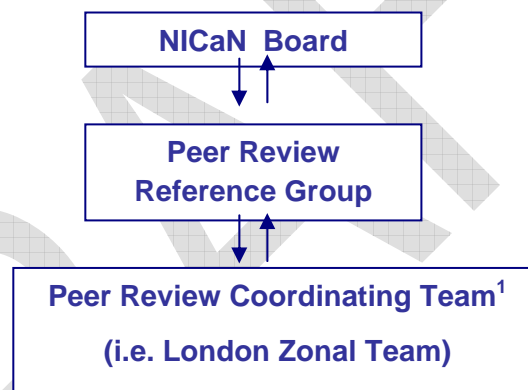
Appendix 4 – Terms of Reference

Peer Review of Cancer MDTs

Overview of project structure

The planning and implementation of the programme of peer review of cancer MDTs will be overseen by the Peer Review Reference Group. This document outlines the agreed terms of reference for the Peer Review reference Group.

The Peer Review Reference Group will function as a sub-group of the NICaN Board. The Reference Group will agree the measures for review and ensure that quality assurance, controls and performance management processes are appropriately planned and implemented. The Reference Group will provide direction to the Coordinating Team⁶.



1. Purpose of the Reference Group

The Reference Group for the Peer Review of Cancer has been established to plan and support the implementation of a Programme of Peer Review of Cancer MDTs for Northern Ireland.

⁶ The peer review programme in England is organised by four zonal teams, one of which covers London and the South East. The London team will provide coordination for Northern Ireland.

Appendix 4 – Terms of Reference

2. Aims and objectives

- To establish and maintain ownership and effective communication with local stakeholders within the Network
- To agree MDT peer review measures;
- To promote consistency of implementation of the agreed cancer measures and identify any issues of interpretation, seeking advice when required from the Zonal Coordinating Team.
- To agree and implement quality assurance, controls and performance management arrangements to support the programme;
- To maintain an overview of implementation of agreed actions following visits and to provide support to trusts where required; and
- To receive reports on the progress of the peer review programme within the network and agree with the zonal coordinating teams any actions required.
- To provide local knowledge and guidance to assist the process of selection of teams/services to be visited.
- To receive and note peer review visit reports. Providing an overview of consistency, identifying any strategic issues and bringing them to the attention of the NICaN Board.
- To support collaborative working and sharing of good practice across all agencies within the zone.

Appendix 4 – Terms of Reference

3. Membership

The group will be Chaired by Dr. Dermot Hughes, Medical Director, NICaN.

Constituent	Name	Job Title
NICaN Clinical Lead	Dr Dermot Hughes	Medical Director
	Cara Anderson	Network Director
Regional Board	Hugh Mullen	Director of Performance Management & Service Improvement
	Beth Malloy	Programme Director, Cancer
Public Health Agency	Dr Adrian Mairs	Director of Public Health
NI Cancer Registry	Dr. Anna Gavin	Director
RQIA	Theresa Nixon	Director of Quality Assurance
Trusts	Jim McGuigan Sarah Williamson Sally Campalani	Belfast
	Anne Kyle Margaret O'Hagan Patricia McClelland	Northern
	Stephen Kirk Wilma Boyd-Carson	South Eastern
	Rory Convery Alison Porter	Southern
	Michael Reilly Elizabeth England Fiona Beattie	Western
Public / patient representative	Nicola Porter	NICaN PPI Forum Lead
Peer review coordinating team	Mr Mike Bellamy	Quality Director, London Zonal team
	Mrs Lorraine Winship	Quality Manager, London Zonal team
	Mr John Bolton	Clinical Lead, London Zonal team

Appendix 4 – Terms of Reference

4. The Role of the Chair

The Chair of the Project Board is accountable for the delivery of the project. Specific responsibilities of this role include:

- Chairing Project Board meetings;
- Ensuring Terms of Reference are drafted and approved;
- Signing off the Project Initiation Document and Project Plans;
- Ensuring that the Reference oversees the implementation of the peer review of MDTs
- Ensuring that the Project continues to be viable;
- Chairing occasional meetings of the Coordinating Team;
- Recommending action to the NICaN Board if the project tolerance is exceeded.

5. Meeting arrangements and frequency

The group will aim to meet every six weeks, usually on a Tuesday afternoon (dates to be circulated in advance). Papers will be circulated no less than five working days prior to the meeting.

The Chair will be Dr. Dermot Hughes.

A quorum will be not less than 50% of all members as listed above. and must include the Chair or Vice Chair.

The meetings will be managed and the corporate records held by the NICaN Team.

6. Reporting and accountability

The Group will be a sub-committee of the NICaN Board. The Group will report on progress on the peer review of cancer MDTs at each Board meeting.

7. Review arrangements

The group has been established with a specific focused remit and is likely to be time limited to the period of the peer review of MDTs implementation timescale. The Terms of Reference will be reviewed at the end of the first peer review programme.

Appendix 5 – Outline Project Plan

	Apr '09	May '09	June '09	July '09	Aug '09	Sept '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10
1.0 Project initiation												
1.1 Agree scope of review with NICA Board, Regional Board, DHSS&PS & RQIA	█											
1.2 Letter to go to Trust CEOs re programme	█											
1.3 Agree timeline for review programme with coordinating team	█											
1.4 Agree local amendments to manual measures	█											
1.5 Agree clinical issues / activity data to be reviewed	█	█										
1.6 Letter to trust CEOs re programme		█										
2.0 Information & audit												
2.1 Identify regional audit / information requirements arising from peer review	█	█										
2.2 Produce CaPPs queries to facilitate collation of data		█	█	█								
2.3 Identify how additional audit requirements can be met & action appropriately		█	█									

Appendix 5 – Outline Project Plan

	Apr '09	May '09	June '09	July '09	Aug '09	Sept '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10
3.0 Preparation & support												
3.1 Set up peer review page on www.cancerni.net	■											
3.2 Produce peer review handbook		■										
3.3 Approve amended evidence guides		■										
3.4 Handbook & evidence guides circulated via trusts and regional groups + place on website			■									
3.5 Modify CQUiNs	■											
3.6 Initiate access to CQUiNs		■										
3.7 Circulate information re shadowing opportunities	■											
3.8 Complete material for familiarization workshops		■										
3.9 NiCaN team members to shadow peer review visits		■										
3.10 Briefing report on Trusts / Network for review team		■										
3.11 Production of briefing pack for reviewers			■									
3.12 Trust familiarisation workshops			■									
3.13 PR preparation groups established – all tumour sites			■	■	■							

Appendix 5 – Outline Project Plan

	Sept '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	July '10	Mar '10
3.0 Preparation & support continued												
3.14 Identify reviewers												
3.15 Patient reviewers to be identified												
3.16 Pre-visits to each Trust by London Zonal team												
3.17 Arrangements made for peer review visits												
3.18 Packs for reviewers to be completed												
3.19 Patient reviewers to receive one-day training												
4.0 The review process												
4.1 Trusts to upload evidence data to CQUINS ⁷												
4.2 External validation of self assessment												
4.3 Electronic feedback to trusts from Zonal team ⁸												
4.4 Pre-visits to trusts ⁹												
4.5 Resubmission of evidence ¹⁰												
4.6 Peer review visits ¹¹												

⁷ Upload of self assessment to CQUINS by 12th February

⁸ Electronic feedback on self assessment during last 2 weeks of February

⁹ Pre-visits to trusts in first week of March

¹⁰ Resubmission of evidence by end of March

¹¹ Review visits 3rd & 4th week of April

Appendix 5 – Outline Project Plan

	Sept '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	July '10	Mar '10
5.0 Provision of feedback												
5.1 Draft Trust feedback reports produced ¹²												
5.2 Trusts to return factual corrections to zonal Quality Director ¹³												
5.3 Final reports issued to trust & commissioners ¹⁴												
5.4 Reports published on CQUINs												
6.0 Programme evaluation												
6.1 Undertake programme evaluation												
6.2 Evaluation circulated to key stakeholders												

¹² By end of May 2010

¹³ By 11th June 2010

¹⁴ By 30th June 2010