NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Clinical Senate Review Of Gynaecological Oncology Multi-Disciplinary Team Processes at Northern Lincolnshire and Goole NHS Foundation Trust

On behalf of

The Chief Medical Officer Northern Lincolnshire and Goole NHS Foundation Trust

Final Report

Clinical Senates are independent non-statutory advisory bodies that were established to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Consideration of the implementation of the recommendations is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate
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Version Control

Document Version	Date	Comments	Drafted by
Draft v0.1	February 2023	Initial draft report	J Unwin
Draft v0.2	March 2023	Draft report amended to include comments from panel members	J Unwin
Draft v0.3	March 2023	Draft report reformatted	J Unwin
Draft v0.4	March 2023	Draft report amended to include activity figures	J Unwin
Draft v0.5	March 2023	Draft report amended following factual accuracy checks by the Medical Director of NLaG	J Unwin
Final Draft	March 2023	Final draft amended following comments received from NLaG	J Unwin

1. Chair's Foreword

1.1 Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides Gynaecological oncology services from the Diana Princess of Wales Hospital in Grimsby and the Scunthorpe General Hospital in Scunthorpe. There is a combined Gynaecological oncology multidisciplinary team (MDT) to review and make care and treatment decisions and plans for patients with suspected and/or confirmed gynaecological cancer.

1.2 We welcomed the opportunity to work with the gynaecology clinical staff and support teams to review, from a 'critical friend' perspective, the standards and the safety and efficiency of the processes and decision making within the gynaecological oncology multi-disciplinary team meeting.

1.3 The panel commend the gynaecological oncology team and the processes they adopt to ensure that the services they provide are safe and efficient and there is a lot of good elements already in place. The panel's advice and recommendations are given with the intention of providing constructive and supportive feedback to hopefully strengthen these processes further.

1.4 The panel would like to thank the NLaG colleagues who participated in the review for their time, work, open and honest discussion and for their clear commitment to providing great services for the populations they serve.

1.5 I would also like to take this opportunity to thank the panel of clinical experts who assisted with this review. I very much appreciate their enthusiasm and diligence in reviewing the ways of working and decision making in the NLaG gynaecological oncology MDT.

Chris Welsh - Senate Chair
NHS England – North (Yorkshire and the Humber)

2. Introduction

2.1. The Yorkshire and Humber Clinical Senate was approached in November 2022 by NHS England's Regional Medical Director for the North East and Yorkshire region to assess whether the Senate could assist NLaG's Chief Medical Officer with a critical friend review of the gynaecological oncology multi-disciplinary team (MDT) processes to ensure that they are fit for purpose, efficient and follow best practice.

2.2. Specifically, the Clinical Senate was asked to:

a. To assess that the processes adopted within the NLaG Gynaecological oncology MDT are appropriate for a district general hospital gynaecological oncology service, reflect best practice and an effective use of the available MDT resource.
b. To assess the extent to which the decisions being made in the NLaG Gynaecological oncology MDT are appropriate, well informed and in the best interests of patient care.
c. To provide any additional information or suggestions that NLaG may find helpful in improving the quality and efficacy of the Gynaecological oncology MDT processes or the wider service.
d. To ensure that the health inequalities of the local populations are not adversely impacted by any proposed changes to service delivery, and also ensure the local gynae MDT/NLAG undertakes those treatments permitted outside of the Cancer Centre (i.e. HUTH) and in accordance with recommended best practice (Improving Outcomes[1]).

3. Process of the Review

3.1 To carry out this review, the Senate formed an independent expert clinical panel comprising known subject matter experts. The details and short biographies of the panel can be found in Appendix 1.

3.2 The review involved site visits on 21 February 2023, to 2 of NLaG's hospitals, Scunthorpe General Hospital and Diana Princess of Wales Hospital in Grimsby. The itinerary for the visit is included at Appendix 3.

3.3 The panel members were split into two separate groups with one group attending and witnessing the MDT meeting on the Grimsby site and the other on the Scunthorpe site.

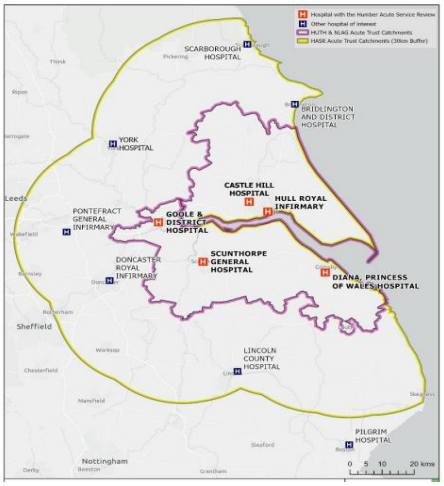
3.4 The report was drafted during February and was provided to the Senate panel members for additional comments in March 2023 and to the NLaG team for factual accuracy on 13 March 2023.

1 Improving Outcomes: A Strategy for Cancer (publishing.service.gov.uk)

4. Overview of the in-scope services

4.1 Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) serves 450,000 people living across Northern Lincolnshire and the East Riding of Yorkshire.

4.2 The trust provides secondary care services from three hospitals in the area, Scunthorpe General Hospital (SGH), Grimsby's Diana Princess of Wales Hospital, (DPoW), and Goole and District Hospital.



4.3 For more specialist and tertiary level care patients from the NLAG areas are referred to the Royal Infirmary in Hull part of Hull University Teaching Hospitals NHS Trust (HUTH).

4.4 For the purposes of this review, the services within scope are the gynaecological oncology services delivered from SGH and DPOW, and more specifically the MDT processes for the gynaecological oncology patients.

4.5 Specialised gynaecological oncology services delivered by HUTH are not in the scope of this review.

5. Background

5.1 Gynaecological oncology services are provided by the NLaG trust from the Diana Princess of Wales Hospital in Grimsby and the Scunthorpe General Hospital in Scunthorpe. Gynaecological oncology is provided on both sites. There is a combined Gynaecological oncology MDT to review and make care and treatment decisions and plans for patients with suspected and/or confirmed gynaecological cancer. Patients considered to require treatment in a tertiary care setting are referred on for further consideration and treatment planning through the central MDT hosted by Hull University Teaching Hospitals.

5.2 NLaG wished to review the current practices and processes associated with the Gynaecological oncology MDT to ensure that they are:

a. Efficient
b. Add value to the patient pathway
c. Appropriate
d. Follow recommended best practice (Improving Outcomes Guidance) and
e. Result in the best possible outcomes for patients.

5.3 The Yorkshire and Humber Clinical Senate was therefore asked to consider the appropriateness of the current MDT processes and to provide recommendations on whether there are opportunities to improve the Gynaecological Oncology MDT service and its compliance with best practice and what risks, issues, opportunities or concerns the Senate may advise the Trust to consider for the service.

6. Clinical Senate Review – Findings

6.1 The Clinical Senate panel members attended the combined MDT meeting at DPOW and SGH and the following are summary findings about what was witnessed and discussed with the attendees at the meetings:

Service Specific Information

6.2 The Gynaecological Oncology service comprises 2 Consultant Gynaecologists with a special interest in oncology. Seven Consultant Gynaecologist colleagues and one SAS doctor provide support to the gynaecological oncology service. The service is enhanced by 2 fulltime Cancer Nurse Specialists (CNS) and dedicated cancer tracking staff. The CNS provide cross cover arrangements for absences, this is not the case for the cancer tracking staff.

6.3 The service benefits from a Consultant Radiologist and a Consultant Histopathologist with specialist expertise in gynaecological oncology. The histopathologist is supported by 3 other colleagues who provide cover for absences however, this is not the case for the radiologist.

6.4 The demand for gynaecological oncology is approximately 1600 per annum which means that 20 to 30 patients per week are discussed in the combined MDT, of which 75% go on to receive a confirmed cancer diagnosis. The MDT is held 52 weeks of the year.

6.5 The panel heard that achievement of the cancer specific waiting time targets of 14, 28 and 62 days was 'hit and miss'. The waiting time for surgery was stated to be 4 weeks maximum and delays to patient pathways were reported to be mainly associated with transfers of care to the specialist centre.

6.6 Whilst currently not in place, there is an ambition to develop and deliver a same day/one stop shop hysteroscopy service to streamline the patient pathway.

6.7 Radiotherapy is provided by HUTH and chemotherapy treatment is available at DPOW by a nurse led chemotherapy service under the supervision of the visiting consultant oncologists.

Structure and format of the combined MDT Meeting

6.8 **DPOW:** The meeting was attended by a Consultant Gynaecologist, Cancer Nurse Specialist (CNS), Cancer Tracker, Consultant Radiologist and Consultant Histopathologist, both with specialist expertise in gynaecological oncology. This meeting was also attended by Mr Neil Hebblethwaite and Nurse Melissa Duffew, who were supported by the Clinical Senate Manager, from the Clinical Senate.

6.9 **SGH:** The meeting was attended by a Consultant Gynaecologist, Cancer Nurse Specialist (CNS), Cancer Tracker, and the same Consultant Radiologist and

Consultant Histopathologist as the DPOW meeting. This meeting was also attended by Prof Chris Welsh and Miss Rachel O'Donnell, who were supported by the Senate Administrator, from the Clinical Senate.

6.10 The Consultant Gynaecologists, CNSs and Cancer Trackers were present in the room on each site and the rooms were video linked, with audio, to each other. The Consultant Radiologist was present at the SGH meeting and the Consultant Histopathologist, who is based in Lincoln, dialled into the combined meeting.

6.11 Each meeting attendee was able to see and interact with attendees from the other site, as well as with the virtual attendee and each member of the combined MDT was able to see the radiological scans that were presented. The video link needed to be re-set on a couple of occasions at the beginning of the meeting as the sound quality on the day of the review was poor. The panel subsequently learned that the problem with the audio was rectified after the meeting had concluded.

6.12 The cancer tracking staff had access to the cancer tracking system, Somerset, and real time data entry into that system was carried out for patients under the care of each of the local teams. However, the MDT attendees could see information about patients whose care originated from their base site only and the virtual attendee could not see any Somerset information.

6.13 The combined meeting had a shared agenda that listed the patients to be discussed based on the radiological findings, followed by those based on histopathology results.

Processes and Use of Best Practice

6.14 The panel understands that the local clinical practice follows British Gynaecological Cancer Society (BGCS) clinical guidelines and recommendations. However, the panel learnt that local network clinical guidelines, standard operating procedures and patient pathways information were not yet developed or documented for use in the local MDT.

6.15 On a weekly basis there are 2 gynaecological oncology MDT discussions: the combined MDT at NLaG which takes place on a Tuesday and the specialist MDT at HUTH on a Friday. When a patient is determined to require care from the specialist centre the cases are referred and discussed at the specialist MDT in the same week.

6.16 HUTH obtains pathology testing and reports from out of the area, therefore there is a local process in place at NLaG whereby the Consultant Histopathologist will double report histological findings to reduce any possible pathology delays for patients that require specialist care.

6.17 The panel observed that of all the cases listed to be discussed at the NLaG MDT there were 1 or 2 patients for whom the MDT discussion did not add value due to either incomplete or aged diagnostic tests. It was explained that the MDT process is used as a safeguard to ensure that patients, for whom there is a high degree of suspicion, but no confirmation, of a cancer, are not 'lost' and are tracked.

6.18 The panel members felt that the use of MRI may be greater than would normally be expected for the patient group. It was explained that the demand for MRI was led by the patient protocols from the specialist centre.

6.19 The panel observed that the clinical decision making to refer a patient to the specialist centre was entirely appropriate.

7. Recommendations

7.1 The NLaG MDT staff should be commended for the passion and commitment to delivering quality patient care and for going above and beyond to deliver a 52-week service.

7.2 There are several very positive messages about the MDT processes observed by the Senate. The meeting ran smoothly, there was appropriate decision making regarding onward referral to the specialist centre, and in particular the Senate noted good practice in relation to the real time data entry and the double reporting of histopathology tests.

7.3 The following recommendations are offered to enhance the NLaG gynaecological oncology MDT processes:

7.3.1 To demonstrate auditable good practice, BGCS[2] compliant clinical guidelines should be developed with the Humber and North Yorkshire Cancer Alliance and the specialist centre for the gynaecological oncology network. In the meantime, it is recommended that a local MDT standard operating protocol is developed that describes how the MDT will operate including quoracy and a definition of minimum standards. The document should be shared and promoted with colleagues and reviewed on an annual basis

7.3.2 To facilitate a comprehensive and consistent dataset at the point of referral into the local MDT, develop a uniform cancer MDT referral template for colleagues to use that will allow complete and up to date information to be available and to be discussed at the local MDT

7.3.3 Reconfigure the job plans of the CNS to allow fuller involvement in MDT processes such as triage and advance preparation to maximise the efficiency of the MDT and to maximise and fully utilise the skill set of the CNS

7.3.4 For quality control purposes, ensure that all MDT participants can see the real time data entry into the Somerset system

7.3.5 Consider opportunities for cross cover for the Consultant Radiologist and the cancer tracking staff, especially in the context of the service being delivered over 52 weeks

7.3.6 Ensure that all members of the MDT are aware of and actively engaged with the key performance indicators associated with maximum waiting time targets

7.3.7 Guidance[3] suggests that all cases of gynaecological cancer should be discussed at the central MDT and whilst the central MDT processes at HUTH are out of

2 Home - British Gynaecological Cancer Society (bgcs.org.uk)

3 e10-cancer-gynae-0414.pdf (england.nhs.uk)

scope of this review, it is nonetheless recommended that regular audits are carried out to ensure this standard is met.

8. Conclusion

8.1. The request of the Senate, as set out in the Terms of Reference:

a. *To assess that the processes adopted within the NLaG Gynaecological oncology MDT are appropriate for a district general hospital gynaecological oncology service, reflect best practice and an effective use of the available MDT resource*.

8.2 The Senate panel found that the processes adopted within the NLaG gynaecological oncology MDT are appropriate for a district general hospital service and they do reflect best practice, albeit that at the current time there are no local, auditable documented guidance or procedure documents to reflect this.

b. To assess the extent to which the decisions being made in the NLaG Gynaecological oncology MDT are appropriate, well informed and in the best interests of patient care.

8.3 As stated in section 6.16 there were 1 or 2 patients included on the MDT for discussion for which there was incomplete or out of date information. However, the rationale for including the patients for discussion was to ensure that the patients were 'safeguarded' by the MDT.

8.4 The panel had no concerns about the clinical decision making and it was evident that the MDT participants were committed to delivering high quality patient care.

8.5 We have recommended the development of a standard referral template which will indicate the need for timely and complete diagnostics for patients to be included in the MDT discussion. We are encouraging the CNS to become more involved in the preparation of the MDT, to ensure the completeness and timeliness of information.

c. To provide any additional information or suggestions that NLaG may find helpful in improving the quality and efficacy of the Gynaecological oncology MDT processes or the wider service

8.6 The recommendations are outlined in section 7 and the panel felt that it was important to highlight that these recommendations should be looked upon as helpful, minor changes to what they felt was a good and useful MDT process and meeting. It will be important to develop and maintain good communication with colleagues in the wider service and collaborating and agreeing joint clinical guidelines would be a key recommendation.

d. To ensure that the health inequalities of the local populations are not adversely impacted by any proposed changes to service delivery, and also ensure the local gynae MDT/NLAG undertakes those treatments permitted outside of the Cancer Centre (i.e. HUTH) and in accordance with recommended best practice (IOG).

8.7 The Senate panel does not feel that there is a need to change the gynaecological oncology service delivery model. It was apparent that the local NLaG MDT added value to patient care and was a necessary function to triage patients for timely onward referral to the specialist centre. Furthermore, the MDT provides local support to general gynaecology colleagues in dealing with patients with suspected gynaecological cancer.

8.8 From what the Senate panel observed on the day of the review the local MDT was referring patients appropriately to the specialist centre, in accordance with best practice (IOG guidelines). However, as recommended in section 7, it would be beneficial for the local MDT to work with the wider network and cancer alliance to agree, document and share clinical guidelines and to develop and document MDT operating procedures for transparency and for training and governance purposes.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Prof. Chris Welsh – Yorkshire & the Humber Clinical Senate Chair

Chris Welsh worked initially as a vascular surgeon at the Northern General Hospital Sheffield before becoming Regional Postgraduate Dean for the Trent Region in 1995. Chris was then appointed Medical Director for Sheffield Teaching Hospitals NHS Foundation Trust in 2001. In 2008 he worked as the Clinical Chair of the Next Stage Review NHS Yorkshire and the Humber, "Healthy Ambitions" before being appointed as Medical Director for NHS Yorkshire and the Humber and then NHS Midlands and East before becoming Director of Education and Quality Health Education England. Most recently Chris has served as Independent Review Director to the South Yorkshire and Bassetlaw ICS Hospital Services Review.

Miss Rachel O'Donnell – Consultant GynaeOncologist

Miss Rachel O'Donnell is a consultant GynaeOncologist at Newcastle's Royal Victory Infirmary with a special interest in diagnosis and treatment of gynaecological cancers. Rachel graduated from Edinburgh Medical School in 2005 and completed Obstetrics and Gynaecology training in Edinburgh before undertaking a Fellowship at the Northern Gynaecological Oncology Centre (NGOC). Rachel went on to complete her PhD in translational ovarian cancer research in 2016 and was awarded a NIHR Clinical Lectureship 2016-2020.

Rachel is MDT lead and leads the Gynaecology Oncology services, which are based within the dedicated Women's Health Unit. She works alongside the consultant and advanced nursing practitioner teams, offering specialist outpatient diagnostics and therapeutics, incorporating advanced technologies for scanning, hysteroscopy, colposcopy and minor outpatient operative procedures.

Surgically Rachel undertakes advanced open, laparoscopic and robotic surgery and coordinates multidisciplinary surgery with colorectal, upper GI, sarcoma, urology and plastics surgery teams.

She runs the regional Specialist Vulval Clinic providing specialist multidisciplinary care for women with complex benign, premalignant and cancerous vulval conditions and is also a core member of the regional sarcoma MDT.

Rachel is a core member of the GynaeOncology Research Group at Newcastle University's Translational and Clinical research Institute and supervises Doctorate and Masters students. She has both wet-lab and clinical research studies in progress.

Mr Neil Hebblethwaite – Consultant Gynaecologist

I have been a consultant Gynaecologist for 30 years at South Tees Hospitals NHS Foundation Trust. I am the Chair of the Women and Children's Collaborative at South Tees and I have been unit lead for Gynaecological Cancers and member of

Gynaecological Oncology MDT at the trust since the introduction of The IOG guidelines in 1995.

Mrs Melissa Duffew – Lead Gynaecology Oncology Nurse Specialist

Having qualified from Teesside University in 2009 as a registered nurse, I soon developed a passion for women's health and have spent most of my career working within gynaecology.
Previous roles have included working within gynaecology outpatients across different specialities. I have also worked as a nursing sister within a GP practice, specialising in women's health and chronic disease management.

I have been in my current role for over 4 years and have the responsibility to co-ordinate and facilitate patients through their cancer pathway. As a cancer nurse specialist, my role is to provide specialist advice, information, and support to women with a gynaecological cancer. I regularly prepare, attend, and participate in the regional Gynae-Oncology MDT.

As the Lead Nurse of this service, I have been involved with several service improvement projects. During this time, I have developed an internal referral system online to allow for a more streamlined and secure referral process. I have also worked alongside Cancer Services to roll out Stratified Follow up within our Trust, again, integrating this into our IT systems to allow for auditing and monitoring. More recently, I have been involved with developing and implementing an improved PMB pathway. This has included the use of nurse led clinics for those that are deemed as low risk, having been triaged based upon their ultrasound scan results. I have also initiated and now conduct a weekly nurse led clinic, for routine Gynae Oncology follow up patients.

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

There were no declarations of interest.

Appendix 3

ITINERARY FOR THE REVIEW

Yorkshire and the Humber Clinical Senate Visit to
Scunthorpe & Grimsby Hospitals
Tuesday 21st February 2023

AGENDA

9:00 – 9:30	Clinical Senate Expert Panel Arrival – Scunthorpe Hospital, Main Out Patient Entrance – Church Lane. (Parking advised in multi storey car park opposite main entrance) Contact Service Manager Family Services, will meet the team in the main entrance – see attached site map
9.30am	Senate Panel pre meet.
10.30am	Taxi will transport half of the panel to Grimsby Hospital. Collect taxi at main entrance.
11.15am	Arrival at Grimsby Hospital. Service Manager, Family Services will meet the panel at the reception of the Women's and Children's Unit.
11.15am	The Service Managers will escort the panel members to the joint MDT on both sites.
11.30am	GynaeOncology MDT - runs for 1.5 hours with time allocated for Q&A at the end of the MDT.
13:45pm	Collect taxi from Grimsby hospital main entrance for return to Scunthorpe hospital Scunthorpe based panel members will be escorted back to the Family services meeting room
14.30pm	The panel return to the Scunthorpe site meeting room for post review de-brief

15.30 – 16.00 – Panel Feedback session - Team link to follow

Appendix 4

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CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Northern Lincolnshire and Goole NHS Foundation Trust – Gynaecological oncology Multi-Disciplinary Team processes

Sponsoring Organisation: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), supported by the Humber and North Yorkshire Integrated Care Board (ICB).

Terms of reference agreed by: Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Dr Kate Wood, Medical Director, NLaG

Date: 11/01/2022

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1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh

Clinical Senate Review Team Members:

Mr Neil Hebblethwaite, Consultant Gynaecologist

Miss Rachel O'Donnell, Consultant Gynae/oncologist

Nurse Melissa Duffew, Cancer Nurse Specialist

2. AIMS AND OBJECTIVES OF THE REVIEW

Gynaecological oncology services are provided by the NLaG trust from the Diana Princess of Wales Hospital in Grimsby and the Scunthorpe General Hospital in Scunthorpe. Gynaecological oncology is provided on both sites. There is a combined Gynaecological oncology multidisciplinary team (MDT) to review and make care and treatment decisions and plans for patients with suspected and/or confirmed gynaecological cancer. Patients considered to require treatment in a tertiary care setting are referred on for further consideration and treatment planning through the central MDT hosted by Hull University Teaching Hospitals. The central (specialist) MDT is not part of the scope of this review. NLaG wish to review the current practices and processes associated with the Gynaecological oncology MDT to ensure that they are appropriate, follow recommended best practice (Improving Outcomes Guidance) and result in the best possible outcomes for patients.

The Yorkshire and Humber Clinical Senate is therefore asked to consider the appropriateness of the current MDT processes and to provide recommendations on whether there are opportunities to improve the Gynaecological oncology MDT service and its compliance with best practice and what risks, issues, opportunities or concerns the Senate may advise the Trust to consider for the service.

Objectives of the clinical review (from the information provided by the commissioning sponsor):

In order to assess the current practices of the Gynaecological oncology MDT the Senate will undertake an independent clinical review with the following objectives:

1. To assess that the processes adopted within the NLaG Gynaecological oncology MDT are appropriate for a district general hospital gynaecological oncology service, reflect best practice and an effective use of the available MDT resource.

2. To assess the extent to which the decisions being made in the NLaG Gynaecological oncology MDT are appropriate, well informed and in the best interests of patient care.

3. To provide any additional information or suggestions that NLaG may find helpful in improving the quality and efficacy of the Gynaecological oncology MDT processes or the wider service.

4. To ensure that the health inequalities of the local populations are not adversely impacted by any proposed changes to service delivery, and also ensure the local gynae MDT/NLAG undertakes those treatments permitted outside of the Cancer Centre (i.e. HUTH) and in accordance with recommended best practice (IOG).

Scope of the review:

All processes associated with the inputs to the MDT process, the discussions and deliberations within the Gynaecological oncology MDT and the subsequent direction of the next part of the patient pathway following the MDT output and within the scope of the review. The central (specialist) MDT hosted by Hull University Teaching Hospitals does not fall within the scope of this review.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: n/a
Agree the Terms of Reference: 01/12/2022
Receive the evidence and distribute to review team: TBC
Interviews with MDT participants: Mid – end February 2023
Draft report submitted to commissioners: 17 March 2023
Senate Council ratification; May 2023
Final report agreed: May 2023
Publication of the report on the website: TBC

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring organisation and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

Documentation presented to the local NLaG Gynaecological oncology MDT

Minutes and documented outputs from the local NLaG Gynaecological oncology MDT

The Senate panel members will attend and witness the proceedings of the MDT meeting

The review team will review the evidence within these documents and within the meetings and supplement their understanding with a clinical discussion with participants of the MDT.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the sponsoring organisation, NHS England and NHS Improvement (if this is an assurance report) and made available on the Senate website. Publication will be agreed with the commissioning sponsor.

The publication date will be agreed with the sponsoring organisation during the development of these terms of reference. It is expected that the report will be published soon after its agreement and at the latest 8 weeks followings its sign off by the Council (ie by the next Council meeting following its ratification)

8. EVALUATION

The Senate will ask the sponsoring organisation to contribute to a Case Study to help summarise the work undertaken and assess the impact of the Senate advice. This will be emailed to the named organisational lead following the publication of the report with a request for an evaluation of our impact, a testimonial and suggestions as to how we may improve our processes.

9. RESOURCES

The Yorkshire and the Humber clinical Senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

10. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

The review report may be used by NHS England and NHS Improvement in their formal service change assurance process.

11. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England and NHS Improvement for inclusion in its formal service change assurance process if applicable
v. complete the Case Study and request for evaluation issued by the Senate after the publication of the Senate report.

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review the draft report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 5

EVIDENCE PROVIDED FOR THE REVIEW

The Trust provided the following documentation to the Senate for consideration after the onsite review:

Agenda for Gynaecological Oncology MDT meeting
Waiting time and performance information