Society for Endocrinology

Peer Review in Endocrinology

Self Assessment Questionnaire

Centre to be visited…….

Visit date……

Explanatory Notes

Introduction

The need for Peer Review of UK endocrine units was agreed by the Clinical Committee of the Society for Endocrinology in 2001. A series of voluntary external visits were piloted. The project is clearly relevant to the agendas of clinical governance in endocrinology, consultant appraisal and consultant revalidation. Other representative bodies (for example, the British Thoracic Society [1,2], British Renal Association [3], British Association of Stroke Physicians [4]) have successfully undertaken such schemes.

It is important that the Society for Endocrinology is active in this domain. No other nationwide scheme currently exists for endocrinology. Peer Review presents an opportunity to improve patient care, support and facilitate service provision and innovation. The process for peer review was revisited in 2017 and updated. The changes introduced in 2017 include:

- option of single centre peer review (in addition to the traditional "tertiary centre" and "feeder DGH" model)
- inclusion of Endocrinology Dashboard in the data collection
- inclusion of the "family and friends" patient feedback in the data collection

Purpose

The main purpose is to improve services for endocrine patients. Visits focus on basic standards of endocrine care and service provision. Visits form the basis for an exchange of ideas and experiences and allow areas of concern to be voiced.

Structure

Visits are made over one to two days by two to three consultant endocrinologists and one to two specialist endocrine nurses from different areas of the UK. A separate document (*'Planning a PR Visit'*) contains recommended timetables and templates for a visit.

Visit Report

The visit report will highlight examples of endocrine excellence, matters for consideration and recommendations for change. The report ought to provide a powerful lever to support local improvements (for example, to highlight a need for consultant or endocrine nurse expansion or secretarial support). The report will be supportive, rather than punitive, but will highlight any problems. Those reviewed will have an opportunity to correct any *factual* inaccuracies in a draft version of the report. The report will be confidential, and the final version will be sent to the SfE National Coordinator for Peer Review and to no other party without the express permission of the consultants reviewed. Those reviewed will have the opportunity to provide feedback on the review process. The reviewers will also be sent a feedback questionnaire.

Standards

The SfE has identified 10 standards against which the peer reviewed centres will be judged. The standards are listed below with explanatory notes:

Standard 1: Initial Referral, Assessment and communication

Standard Statement: Waiting times should be as short as possible and tailored to the clinical urgency. A senior endocrine opinion should be provided at the first clinic visit and post clinic communication should be prompt and detailed.

Rationale: Some endocrine patients need to be seen or have an opinion urgently (e.g. thyrotoxicosis[1]) whereas others are less urgent (e.g. hirsutism). All patients wish an authoritative specialist opinion at their first assessment (and/or at their first return visit). Good communication and prompt transfer of information among healthcare professionals are essential for effective individual treatment and patient well-being.

[*] *Some units may choose to operate 'shared care' protocols whereby the GP starts treatment and this is followed by a 'routine' hospital appointment (eg. Carbimazole for hyperthyroidism).*

Standard 2: Patient Focus

Standard Statement: Endocrine services should respond to patients' needs and preferences.

Rationale: Patient care outcomes are improved when patients and, as appropriate, their carers are involved in clinical care decisions. Information helps patients to make informed choices, which can reduce anxiety and encourage participation in recommended treatments.

Standard 3: Continual Professional Development and Training

Standard Statement: Endocrinologists and specialist nurses should manage conditions whose complexity is appropriate to their level of experience and competence.

Rationale: Specialist endocrinology requires experience and time dedicated to clinical practice to achieve best outcomes.

Standard 4: Endocrine Function Testing

Standard Statement: Appropriate endocrine function tests should be recommended for patients according to their endocrine problems.

Rationale: Endocrine investigation frequently requires the use of 'dynamic' endocrine function tests which may be hazardous in inexperienced hands. Test selection, safe working practices and correct sample handling are all crucial.

Standard 5: Interface with Clinical Biochemistry

Standard Statement: Endocrine assessment requires access to the reliable measurement of hormone concentrations in blood & urine.

Rationale: An effective clinical endocrine service is dependent on a good relationship with an endocrine biochemistry laboratory.

Standard 6: Endocrine Imaging

Standard Statement: A high-quality imaging service is mandatory for endocrine assessment.

Rationale: Endocrine assessment (particularly of patients with endocrine tumours) requires access to multimodal imaging (ultrasonography, CT, MRI, radionuclide, selective catheterisation, etc). Assessment of bone structure and thyroid function may require quantitative techniques (DEXA and radionuclide uptake, respectively).

Standard 7: Interface with Endocrine Pathology

Standard Statement: Endocrine biopsies and surgical specimens should be assessed by a pathologist with a special interest in endocrine disorders.

Rationale: Many endocrine disorders are rare and the histopathological definition of malignancy may be difficult. Experienced and rapid interpretation of thyroid cytology from FNA is important and access to immunological tests to assist endocrine diagnosis.

Standard 8: Links with other Specialties and specialist services provided

Standard Statement: Endocrine management is frequently multidisciplinary and requires close working relationships with several specialties.

Rationale: Interaction is necessary with the following specialties:

1. Pituitary surgery
2. Endocrine surgery (thyroid, parathyroid, pancreas via a HPB centre, adrenal)
3. Nuclear Medicine
4. Oncology / radiotherapy
5. Ophthalmology (neuro-ophthalmology & Graves' Orbitopathy)
6. Fertility services
7. Paediatric endocrinology
8. Radiology
9. Clinical Genetics

Standard 9: High-Cost Endocrine Therapies

Standard Statement: Patients should have equal access to all funded high cost endocrine therapies – provided they are recommended by an endocrinologist according to national/international, evidence-based guidelines.

Rationale: 'Postcode prescribing' has been a problem throughout the UK. Within endocrinology this has particularly affected the prescribing of somatostatin analogues, gonadotrophins and GH for adult replacement therapy. Now it affects use of vaptans, cinacalcet, pegvisomant and pasireotide as well as high cost cancer therapies such as PRRT and use of some oncology treatments such as everolimus and other drugs under NICE review.

Standard 10: Endocrine Audit & Databases

Standard Statement: All endocrine patients, with appropriate consent, should be placed on a clinical management system, which contains core information about their diagnosis & care, and allows ongoing useful clinical information to be recorded for use in direct patient care and service audit/QI

Rationale: Data collection and audit/QI facilitate effective healthcare since outcomes can be monitored and lead, where necessary, to improvements in the quality of treatment and care. Such data also facilitate research into rare endocrine disorders. This may also help patient recruitment into relevant clinical trials.

References

1. Page RL, Harrison BDW. Setting up Interdepartmental Peer Review. Journal of the Royal College of Physicians of London 1995; **29**, 319-324 (www.brit-thoracic.org.uk)
2. Page RL, Harrison BDW. Interdepartmental Peer Review. British Medical Journal 1997; **314**, 765-766
3. Cameron J.S. Treatment of adult patients with renal failure. Recommended standards and audit measures. 2nd Edition. Royal College of Physicians 1997 (www.renalreg.com)
4. http://www.rcplondon.ac.uk/resources/clinical-resources/stroke-programme/peer-review

Action

Please complete the Self Assessment Questionnaire as fully as possible. It may be possible for the IT Department, Endocrine Business Manager and their administrative team to enter the activity data and other factual details, in collaboration with the Lead Clinician for Endocrinology.

The completed Questionnaire should be sent to Natasha Archer (natasha.archer@endocrinology.org) for forwarding to the reviewers at least 4 weeks before the visit so that pre-visit planning can be undertaken. Neighbouring hospitals may wish to submit documentation for review, in the context of other local centres being reviewed, without a formal review themselves.

Importantly, please assemble the supporting documentation which may include some or all of the following:

- Endocrine Unit handbook
- Protocol sheets + PIU day case documents
- Patient Information sheets (paper and electronic)
- Shared Care documents (eg thyroid disease, somatostatin analogues, GH)
- Commissioned surveys (eg clinic appointment waiting times, letter turnaround, MRI/DEXA waiting times) and other peer review or annual reports (eg thyroid and pituitary MDT reports, ENETs, osteoporosis peer review)
- Recent Endocrine Audit reports
- Specialist Endocrinology Dashboard data
- Unit Research summary
- Local GMC specialist Training Survey
- Web site URLs if appropriate

These supporting papers can be given to the Reviewers on the day of the visit.

Pre-visit Questionnaire

Section 1: GENERAL INFORMATION ABOUT YOUR REGION/DISTRICT	
What is the population of your Region or District?	
Does your Region or District have any particular characteristics (social deprivation, preponderance of elderly, rural access problems etc)?	
How many hospitals *provide endocrine services* within your Region? List and name all the hospitals regionally relevant to endocrine care, involved in a network. If there is one dominant tertiary centre for complex referrals name it?	
How many beds does your hospital have?	
Please provide a summary describing your Unit, its functionality, services provided, areas of specialist interest, training, audit / QI and research activities.	
How many endocrine consultants are there in *your centre*? Please give names and indicate the number of hours per week each individual allocates *specifically to endocrinology* (not including GIM or Diabetes). Please indicate the amount of time in direct clinical care of endocrine	DCC and SPA per week -

patients (as well as total related to endocrinology in job plan) a) b) c) d) e) f) g)	
How many diabetes consultants are there in your centre? Please give names h) i) j) k) l) m)	
Please outline the number of middle level and junior doctors who are part of your team and their role in the services that your Unit provides.	
How many CLRN sessions does your unit hold?	
Do you have an electronic records system in your hospital? If so please describe briefly functionality and impact on service since introduction.	

Section 2: OUT PATIENTS (Standards 1 and 2)	
Out Patient Workload (Standards 1) (Please use separate sheets if necessary)	
Number of **Endocrine New Patients** seen annually in your centre (excluding nurse-led clinics). Please ask your IT Department to provide figures on your activity, ideally over the last 3 years. If possible please give a breakdown for different sub-speciality clinics • General Endocrine • Thyroid • Pituitary • Reproductive Endocrinology • Adolescent/Transitional • Late Effects of childhood cancer • Adrenal • Neuroendocrine tumours • Other	

Number of **Endocrine Review Patients** seen annually in your centre (excluding nurse-led clinics, telephone, virtual clinics). Please ask your IT Department to provide figures on your activity ideally over the last 3 years. If possible, please also provide figures / give a reflection by different sub-speciality clinics and whether nurse led clinics: • General Endocrine • Thyroid • Pituitary • Reproductive Endocrinology • Adolescent/Transitional • Late Effects of childhood cancer • Adrenal • Neuroendocrine tumours • Other	
Do you have a dedicated endocrine Investigation Unit? If not, where would you perform dynamic endocrine testing? Number of **Endocrine Day Cases** seen annually in your Investigation Unit. Please ask your IT Department to provide figures on your activity ideally over the last 3 years.	
Do you have a dedicated endocrine specialist nurse(s)? **Endocrine Specialist Nurse activity.** Please ask your IT Department to provide figures on your activity ideally over the last 3 years. • New patients • Follow-up patients • Telephone consultations • Educational group sessions • Other	
What is the average time between arrival of a referral letter on Trust premises and prioritisation by the consultant? (Please base your responses on data from your IT Department, if that is not possible please provide data based on a survey of a representative sample).	
What is the average time between arrival of a referral letter on Trust premises and an appointment being issued? (Please base your responses on data from your IT Department, if that is not possible please provide data based on a survey of a representative sample). • Urgent • Non-Urgent	

What is the average waiting time for **New Patients**? (please ask your IT Department to provide figures, if that is not possible please provide data based on a survey of a representative sample) • Urgent • Non-Urgent	
What are the number of Choose and Book slots available per week for entire endocrine department and % of total new outpatients?	
What are the number (and %) of 18-week breaches in last 12 months?	
Number (and % of total) of 2-week cancer waiting time breaches in last 12 months where applicable.	
Are there shortages of appropriately timed **Review** appointments for any of the endocrine clinics? Please specify (giving as much detail as possible, eg availability of follow-up appointments, when patients need to be reviewed soon/semi-urgently). Please base your responses on data from your IT Department, if that is not possible please provide data based on a survey of a representative sample.	
Are the clinics dedicated to Endocrinology or mixed (General Medicine, Diabetes & Endocrinology)? List the specialist endocrinology clinics (and / or consultants with a specialist interest in a condition)?	

Are multidisciplinary, specialist clinics held for certain groups of patients? For example: ➢ Gynaecological Endocrinology (including assisted reproduction & menopausal problems) ➢ Endocrine Oncology ➢ 'Late Effects' of Childhood Cancer ➢ Transition Clinics ➢ Pituitary ➢ Graves' orbitopathy ➢ Metabolic Bone Disease ➢ Neuroendocrine Tumours ➢ Endocrine Genetics ➢ Turner Syndrome ➢ Others (please give details)	

Which clinics do you routinely receive referrals from other hospitals within your region (and beyond). Which conditions would you consider referring on to different hospital for a specialist service?	

Out Patient Staffing & Clinic Support (Standards 1 and 2)	
Do you consider there are sufficient consultants for the endocrine out-patient workload? What is the maximum ratio of consultants: registrars in clinics?	
Are any clinics regularly held in the absence of a consultant?	
Is there sufficient junior medical staff to help with clinics? Are they provided with written guidelines for investigation & management? Are there significant differences between consultants in investigation and management of endocrine conditions? If so please comment on justification.	
Are your secretarial facilities adequate?	
What system of generating letters does your trust have? What is the average 'dictation to typing' interval? (Please attach results of recent surveys, including information on use of voice recognition, outsourcing, self-typing and comment on functionality of system)	
What is the average 'dictation to dispatch' interval? (Please attach results of recent surveys)	
Is electronic communication used? • Endocrine out patient referrals • Clinic letters to referring clinicians • E-mail consultations with GPs	

Out Patient Facilities (Standard 2)	
Do you have a dedicated Endocrine clinic area or are clinics held within a general out patient facility?	
Is there a stadiometer in clinic?	
Is there a set of bariatric scales in clinic?	
Do you have a phlebotomy service?	
Are there facilities for cold-spinning blood samples or for rapid specimen transport to the endocrine laboratory?	
Are there sufficient consulting rooms and examination rooms?	
Are there adequate computers to allow X-ray viewing in the consulting rooms?	

General Points on Out Patients (Standards 1 and 2)	
Are the clinics generally well-run and efficient? If not, what are the main problems?	
Do patients have any requested endocrine blood tests before seeing the doctor (new and follow up)?	
Is there a supply of local leaflets about various endocrine conditions? Is there a supply of leaflets about the Pituitary Foundation and other Endocrine self-help groups?	
Are patients given written instructions on how to manage their condition? Are they routinely copied into letters?	
What is the policy on patients who DNA?	

Section 3: IN PATIENTS (Standard 2)	
In Patient Workload (Standard 2)	
What is the total number of endocrine **admissions** annually in your centre? (please provide figures from your IT Department for the past 3 years).	
What is the total number of **general medical admissions** annually for all Consultants with an interest in Endocrinology in your centre? What is the consultant on-call frequency for GIM?	
What is the total number of endocrine **consultations** annually (for in-patients in other wards in your centre)?	
Is there a specialist on-call rota for endocrinology? If so, what frequency? Is there a regular service for GP / other advice?	

In Patient Staffing (Standard 2)	
Are there sufficient consultants to support the in-patient workload?	
Are there sufficient junior doctors to support the in-patient workload?	
Are there sufficient middle-grade staff available to provide continuous specialist cover for endocrinology?	
Is the ward staffed adequately with nurses, PAMs & support staff?	

In Patient Facilities (Standard 2)	
Is the ward a General Medical ward or a dedicated Endocrine ward? Are there any issues in admitting patients for endocrine investigations?	
Is the ward appropriate for Endocrine patients? Does it have a side-room(s) for those with cancer or for adolescent patients?	
Is there a 'high dependency' area in the ward (or hospital) for patients with severe metabolic problems?	
Are the imaging facilities easily accessible?	

Is there an adequate facility for in-patient radioiodine therapy? If not, where do patients travel to for these therapies?	

Patient feedback (Standard 2)	
Have you collected endocrine specific patient feedback? Please provide data and any changes made on the back of the feedback?	

Section 4: Secretarial Support and Other Facilities (Standards 1 and 2)	
Does each consultant have at least 1 WTE of secretarial support?	
Is there sufficient secretarial support for the clinical needs of the department?	
Is there sufficient secretarial support to service the additional demands of education and research?	
Are the IT infrastructure & support satisfactory?	
Is there adequate office space and computer access for Consultants, Endocrine Specialist Nurses and Trainees?	

Metabolic Ward/Endocrine Testing/Day Cases (Standard 4)	
Is there a unit for Endocrine Investigation? If not, where are patients sent for dynamic testing and is it satisfactory?	
Is it staffed by Specialist Endocrine Nurses? Is the Unit adequately staffed?	
Is there an up to date Endocrine Handbook?	
Are there resuscitation facilities?	
Are there facilities for cold-spinning samples?	
Is there a waiting list for endocrine investigations? If so, what is the current waiting time for routine tests?	

Chemical Pathology/Endocrinology (Standard 5)	
Is there a chemical pathologist who specialises in endocrine biochemistry?	
Are the turnaround times adequate for routine hormone assays (eg. cortisol, thyroxine and prolactin), as clinical need dictates?	
Are the arrangements adequate for Supra-Regional endocrine assays?	
Does the local laboratory participate in NEQAS?	
Are there any particular investigation problems or limitations to highlight? For example • How is adreno-medullary function assessed? • Is there access to mass spectrometry testing? • Is there access to SHBG or free testosterone assays? • Are there acceptable time frames for specialist tests if not done in house?	

Imaging Facilities (Standard 6)	
Is there an MRI scanner (or more than 1)?	
What is the waiting time for 'routine' pituitary MRI? (please ask you IT Department to provide figures, if that is not possible please provide data based on a survey of a representative sample)	
Are there facilities for bone densitometry?	
What is the waiting time for DEXA? (please ask you IT Department to provide figures, if that is not possible please provide data based on a survey of a representative sample)	
Are facilities for radionuclide scans satisfactory?	
What is the waiting time for a radionuclide scan? (please ask you IT Department to provide figures, if that is not possible please provide data based on a survey of a representative sample)	
Are facilities for ultrasound satisfactory?	

What is the waiting time for USS? (please ask you IT Department to provide figures, if that is not possible please provide data based on a survey of a representative sample)	
Is arranging urgent imaging a problem? How is this achieved?	
Is there a radiologist with a special interest in endocrine radiology?	

Pathology Services (Standard 7)	
Are the histology services satisfactory?	
Is there a pathologist with particular interest in Endocrine pathology?	
Who does the thyroid FNAs?	
Is there is specialist cytopathologist?	
Are the microbiology services satisfactory?	
Is the immunopathology service satisfactory?	

Cancer Treatment (Standard 8)	
Is liaison with radiotherapy and oncology satisfactory?	
Do you provided any specialist endocrine cancer services or joint clinics? What specialist MDTs are available?	
Section 5: SPECIALIST NURSES (Standards 2-4). **This section to be filled in by lead endocrine specialist nurse.**	
How many endocrine specialist nurses (ESN) work in your department?	
How many hours per week of ESN time is dedicated to endocrinology? Are they full time or part-time? How many posts are exclusively endocrine?	
How are staff banded?	
Are ESN encouraged to take part in departmental reviews and patient reviews (MDTs and case reviews)?	
Do nurses have their own caseload? Please indicate approximate size	
Are there any nurse led clinics in your department? If there are not, could the service benefit from nurse led clinics? Are nurses comfortable in suggesting service redesign and has this happened in the last 5 years initiated by the nursing staff?	
Is there adequate secretarial and admin support?	
Do ESNs have their own office separate from the clinical assessment area?	
Do ESN's have access to funding for training and development?	
Do ESNs have access to study leave?	
Are ESNs encouraged to take part in research and audit?	
Are ESNs encouraged to attend conferences?	
Are ESNs encouraged to present cases or research/audit-locally, nationally and internationally, by poster or oral presentation? How many nurse led audits / presentations have been done in the last 5 years? How are these activities funded?	
What resources would you need to further develop your service?	
Do you have line management appropriate to your specialist role?	

Section 6: TEACHING AND TRAINING (Standard 3)	
Consultants	
Are the consultants able to keep abreast of developments in Endocrinology by attending local, regional and BES meetings?	
Are the consultants able to fulfil their CPD requirements? How much dedicated CPD in endocrinology has each consultant achieved in last 3 years?	
Junior Medical Staff	
Does the unit hold regular formal 'topic teaching' meetings for junior staff? What other opportunities are there for junior doctors to experience endocrinology and present at meetings?	
Does the Unit have written policy documents on various conditions? **(Standards 2,4)**	
Are there any red or green flags on GMC training survey? How have these been addressed or shared (if good practice)? When was the most recent SAC training inspection report?	
Are adequate IT & library facilities available on-site?	
What opportunities are there for juniors to undertake research or write case reports?	
Is the commitment of Specialist Registrars to GIM impacting on specialty training? If so how?	
Does the Specialist Registrar rotation include a period dedicated to specialty alone with no commitment to GIM?	
Are the registrars able to take study leave? Do they attend regional study days or are there videoconferencing facilities if unable to attend in person?	
Nursing Staff	
Does the unit hold regular training sessions for nurses?	
Undergraduate Teaching	
Please describe the Unit's undergraduate teaching activities.	

Section 7: RESEARCH (Standard 8)	
Is the unit active in research? If so, please provide the unit research summary	
If not, is this because of lack of staff, time or resources?	

Section 8: AUDIT (Standard 10)	
Does the unit regularly audit its activities? If so, please give examples of recent audit reports	
Does the unit maintain an endocrine diagnostic database?	

Section 9: MEETINGS (Standards 3 and 8)	
Are post-clinic case discussion meetings held? If so, how frequently? If so, what are the main objectives of such meetings?	
Are there morbidity and mortality and departmental governance meetings?	
Does the unit have regular radiology meetings?	
Does the unit have regular meetings with pathologists?	
Are there regular meetings with chemical pathologists?	
Is there any formal liaison with surgeons to discuss cases?	
Is there an Endocrine Network regional meeting (regular collaboration with other endocrine colleagues) and if so please describe how it operates. Is there a record of attendance and minutes?	

Section 10: RELATIONSHIPS WITH OTHER DEPARTMENTS (Standards 1 and 2)	
Are there any special links with particular consultants in other departments such as? ➢ General endocrine surgery ➢ Neuro/pituitary surgery ➢ Radiotherapy and oncology ➢ Assisted Reproduction ➢ Nuclear Medicine ➢ Ophthalmology Are any of these linkages unsatisfactory?	
Are any of these activities performed in other hospitals? If so, does this present any particular problems?	
Are the links with Primary Care satisfactory? Is there a dedicated email and phone service? Do 'shared care' arrangements work well?	

Section 11: MEDICAL RECORDS (Standard 1)	
Does your hospital have electronic records?	
Are these satisfactory?	
Are there difficulties in locating notes for outpatient clinics or viewing past history?	
Is there a flow sheet for serial results?	

Section 12: BUDGET HOLDING (Standard 9)	
Does the unit have its own budget?	
Are there any problems with this?	
Are there problems with funding of expensive endocrine therapies such as Pegvisomant or Cinacalcet? If so, how many hours per week does the Lead Clinician have to spend on these negotiations?	

Section 13: LOCAL PERCEPTIONS FOR CHANGE	
Please describe any innovations that your centre has implemented in the domain of endocrine care.	
What are the changes most wanted by the endocrine unit?	
How would they like the endocrine unit to be developed?	
Does this relate to any of the local NHS priorities for change?	