

Manual for Cancer Services Breast Cancer Measures

Version 1.1



VERSION CONTROL SHEET

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Breast Cancer Measures

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National Cancer Peer Review and The Manual for Cancer Services

1 Introduction

The National Cancer Peer Review Programme provides important information about the quality of clinical teams and a national benchmark of cancer services across the country. It aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

The Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Robert Francis Jan 2013) said the creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement. Among the recommendations made is recommendation 49, Enhancement of monitoring and the importance of inspection, which states;

Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.

The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.

1.1 National Cancer Measures

The development of cancer measures is a dynamic process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;

- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new developments and initiatives in treatment and patient care;
- reflect the NHS Commissioning Board specialised service specifications.

1.2 Clinical Indicators/ Outcomes

Peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, clinical indicators have been introduced and form part of the review process along with a reduced number of structure and process measures.

2 Interpretation of the National Manual for Cancer Services

2.1 Guidance Compared to Cancer Measures

National guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive, far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated. Without this underlying type of mind-set guidance would not inspire, lead, motivate or guide and would probably be almost unreadable.

The Manual for Cancer Services has to take a different approach. It is written for the specific purpose of being used to assess a service; to aid self assessment and team development; to be fair compared to visits to other services elsewhere and to past and future visits to the same service. Therefore, the measures have to:

- be objective;
- be measurable;
- be specific, clear and unambiguous;
- be verifiable;
- state who exactly is responsible for what;
- be discriminating;
- be achievable;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure.

2.2 "The Responsibility for Assessment Purposes"

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task - this can be delegated according to local discretion, unless it is clear that a given task really is limited to a certain group.

2.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc. requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc.) implies that their agreement is not personal but that they are representing the consensus opinion

of that group.

2.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquires by peer reviewers when a peer review visit is undertaken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

2.5 "Quality" Aspects of Cancer Service Delivery

The peer review process recognises the qualitative as well as quantitative aspects of review and in addition to the objective recording of compliance against the measures there is a narrative part to the report that provides an overall summary of a team's performance.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at <http://www.cquins.nhs.uk>

Breast Network Group Measures

<p>Introduction</p> <p>The responsibility for review purposes for measures dealing with the functions of the network group lies with the chair of the network group.</p>		
<p>Key Theme</p> <p>Structure and Function</p>		
<p>Objective</p> <p><i>There are clinical networking structures in place to support equity of patient care.</i></p>		
Measure	Notes	Evidence
13-1C-101b	Network Group Membership	
<p>There should be a single network group, having the following membership: (1)</p> <ul style="list-style-type: none"> the MDT lead clinician from each of the associated MDTs; at least one nurse core member of an associated MDT; there should be a named chair who should be a core member of one of the associated MDTs; two user representatives; (2) one of the NHS employed members of the network group should be nominated as having specific responsibility for users' issues and information for patients and carers; a member of the network group nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the network group; named secretarial/administrative support; a breast surgeon; a clinical oncologist; a medical oncologist; a radiologist; a histopathologist. <p>There should be terms of reference agreed for the network group which include: (3)</p> <ul style="list-style-type: none"> the provision of clinical opinion on issues relating to breast cancer for the network; the development of patient pathways and clinical guidelines; the co-ordination and consistency across the network for cancer policy, practice guidelines, audit, research and service development; consulting with the relevant 'cross cutting' network groups where applicable. 	<p><i>(1) There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.</i></p> <p><i>Any one individual may fulfil more than one of the roles on the list, compatible with their discipline and status.</i></p> <p><i>(2) If there are no user representatives, there should be an agreed mechanism for obtaining user advice.</i></p> <p><i>(3) There may be additional points in the agreed terms of reference.</i></p>	<p>Constitution.</p> <p>Annual Report including meeting attendance spread sheet.</p> <p><i>The spread sheet should include names, roles and MDT represented.</i></p>
13-1C-102b	Network Group Meetings	
<p>The network group should meet regularly and record attendance.</p>	<p><i>The attendance of MDT representatives is reviewed</i></p>	<p>Constitution.</p> <p>Annual Report</p>

		<i>as part of the MDT measures.</i>	including meeting attendance spread sheet.
13-1C-103b	Work Programme and Annual Report		
<p>The network group should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the director of the relevant area team.</p> <p>It should include details of any planned service developments and should specify the personnel responsible and the timescales for implementation.</p> <p>The network group should have produced an annual report for the SCN and relevant area team.</p>			<p>Work Programme.</p> <p>Annual Report including details of any service development.</p>
Key Theme			
Co-ordination of Care / Patient Pathways			
Objective			
<i>All patients receive agreed treatment that is consistent and equitable.</i>			
Measure		Notes	Evidence
13-1C-104b	Clinical Guidelines		
<p>The network group should produce clinical guidelines (i.e. how a given patient should be clinically managed, usually at the level of which modalities of imaging and pathology investigation and which modalities of treatment are indicated, rather than detailed regimens or techniques).</p>	<p><i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section, below. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i></p> <p><i>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted.</i></p>		<p>Clinical Guidelines.</p>
13-1C-105b	Chemotherapy Treatment Algorithms		
<p>The network group, in consultation with the relevant chemotherapy cross cutting groups should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.</p>	<p><i>Please see further details in appendix 3.</i></p>		<p>Annual Report.</p> <p>Work Programme.</p> <p>Examples of treatment algorithms should be seen at Internal Validation (IV) and Peer Review Visit (PR).</p>

Objective <i>All patients receive co-ordinated care.</i>		
Measure	Notes	Evidence
13-1C-106b	Patient Pathways	
<p>The network group should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs. (1,2)</p> <p>The pathways should include the following:</p> <ul style="list-style-type: none"> The network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), breast cancer patient pathways both for initial management and for follow up on completion of first line treatment. That any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT. 	<p>(1) <i>This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.</i></p> <p>(2) <i>Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.</i></p>	Constitution.
Key Theme Patient Experience		
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
Measure	Notes	Evidence
13-1C-107b	Patient Experience	
In the course of their regular meetings, the network group should annually review patient feedback of their associated MDTs and any actions implemented, and should agree an improvement programme with them.		Annual Report.
Key Theme Clinical Outcomes / Indicators		
Objective <i>All patients receive treatments intended to provide the best possible outcomes, consistent across the MDTs.</i>		
Measure	Notes	Evidence
13-1C-108b	Clinical Outcomes Indicators and Audits	
In the course of their regular meetings, the network group should annually review the progress (or discuss the completed results, as relevant), of their associated MDTs' outcome indicators and audits, which should have been carried out, or the data examined across all	<i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i>	Annual Report. Work Programme.

<p>its associated MDTs:</p> <ul style="list-style-type: none"> Any breast cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS). Clinical indicators identified in section 2 of the measures. Any additional audits for hospital practice, from the process measures in the NICE Breast Cancer Quality Standard (QS 12), which the network group has agreed across its relevant, associated MDTs. 	<p><i>The compliance for this measure relates to the discussion of the data.</i></p>					
<p>Objective <i>All patients have equitable access to treatments that could potentially improve outcome.</i></p>						
<table border="1" style="width:100%; text-align:center;"> <thead> <tr> <th style="width:20%;"></th> <th style="width:50%;">Measure</th> <th style="width:20%;">Notes</th> <th style="width:10%;">Evidence</th> </tr> </thead> </table>				Measure	Notes	Evidence
	Measure	Notes	Evidence			
<p>13-1C-109b</p>	<p>Discussion of Clinical Trials</p>					
<p>The network group should discuss the MDT's report on clinical trials, annually with each of its associated MDTs and agree an improvement programme with them.</p>		<p>Annual Report. Work Programme.</p>				

Breast MDT Measures

Introduction

The MDT is the group of people from different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay

	Measure	Notes	Evidence
13-2B-101	Core Membership		
	<p>There should be a single named lead clinician with agreed list of responsibilities for the breast MDT who should then be a core team member.(1)</p> <p>The MDT should provide the names of core team members and their cover for named roles in the team. (2)</p> <p>The core team specific to the breast cancer MDT should include:</p> <ul style="list-style-type: none"> • two designated breast surgeons; • a clinical oncologist; • a medical oncologist (where the responsibility of chemotherapy is not undertaken by the clinical oncology core member); • an imaging specialist; (3) • a histopathologist who should be taking part in the specialist EQA for breast cancer; (4) • two breast nurse specialist; • MDT co-ordinator/secretary; (5) • at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6) • an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies 	<p><i>1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i></p> <p><i>(2) Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</i></p> <p><i>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</i></p> <p><i>(3) The role of the imaging specialist can be met by a group of named specialists provided each meets the required workload.</i></p> <p><i>(4) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and</i></p>	<p>Operational Policy including confirmation of any specific requirements of the roles.</p> <p>Annual Report including meeting attendance spread sheet.</p> <p><i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i></p>

<p>is integrated into the function of the MDT.</p>	<p><i>EQA requirements.</i></p> <p><i>(5) The co-ordinator/secretary role needs different amounts of time depending on team workload.</i></p> <p><i>(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals. If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.</i></p> <p><i>The definition of the levels may be found in appendix 4.</i></p>	
<p>13-2B-102 MDT Quorum</p>		
<p>The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday.</p> <p>The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1)</p> <p>The quorum for the breast cancer MDT is made up of the following core members, or their cover: (2)</p> <ul style="list-style-type: none"> • one designated breast surgeon; • one clinical oncologist; • one medical oncologist (where the responsibility of chemotherapy is not undertaken by the clinical oncology member); • one imaging specialist; • one histopathologist; • one breast nurse specialist; • one MDT co-ordinator. 	<p><i>(1) The % should be calculated over the last complete calendar year prior to the assessment.</i></p> <p><i>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i></p> <p><i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i></p>	<p>Annual Report including meeting attendance spread sheet.</p> <p><i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i></p>
<p>13-2B-103 MDT Review</p>		
<p>There should be an operational policy whereby patients should be reviewed by the multidisciplinary team for discussion of the treatment-care plan at, at least the following stages in their pathway: (1)</p> <ul style="list-style-type: none"> • initial diagnosis; • any local, or loco-regional recurrence; • first instance of distant metastasis. <p>The policy should specify that the results of patients holistic needs should be taken into account in the decision making.</p> <p>There should be a written procedure governing how to deal with referrals which need a treatment planning</p>	<p><i>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways.</i></p> <p><i>It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.</i></p> <p><i>(2) e.g. Letters, emails or phone calls between certain specified members,</i></p>	<p>Operational Policy.</p>

decision before the next scheduled meeting. (2)	<i>retrospective discussion at the next scheduled meeting</i>	
Objective		
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes		
Measure	Notes	Evidence
13-2B-104	Core Members Attendance	
All core members of the MDT should attend at least two thirds of the number of meetings.	<i>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</i>	Annual Report including meeting attendance spread sheet. <i>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</i>
13-2B-105	Minimum Individual Workload	
Each surgical core member should undertake a minimum of 30 breast cancer procedures a year.		Annual report / Service profile.
13-2B-106	MDT Minimum Workload	
The MDT should discuss at least 100 new breast cancer patients per year at the MDT meetings.		Annual report / Service Profile.
Key Theme		
Co-ordination of Care / Patient Pathways		
Objective		
<i>All patients receive agreed treatment that is consistent and equitable.</i>		
Measure	Notes	Evidence
13-2B-107	Clinical Guidelines	
The MDT should agree the clinical guidelines specified in measure 13-1C104b .	<i>Where available, these should reflect national guidelines and policy.</i>	Operational Policy. Clinical Guidelines should be available for IV and PR visit.
Objective		
All patients receive co-ordinated care.		
Measure	Notes	Evidence
13-2B-108	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 13-1C-106 .	<i>This should include follow up and referral pathways.</i>	Operational Policy.

13-2B-109	Treatment Planning	
<p>The MDT should agree and record individual patient's treatment plans. The record should include:</p> <ul style="list-style-type: none"> the identity of patients discussed; the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration); confirmation that the holistic needs have been taken into account. 		<p>Operational Policy.</p> <p>Example of treatment plan to be available for IV and PR visit.</p>
13-2B-110	Attendance at the Network Group	
<p>The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.</p>		<p>Annual Report including meeting attendance spread sheet.</p>
Key Theme		
Patient Experience		
Objective		
<i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
	Measure	Notes
	Evidence	
13-2B-111	Key Worker	
<p>There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented.</p>		<p>Operational Policy.</p> <p>Examples of patient notes should be available for IV and PR Visit.</p>
13-2B-112	Patient Information	
<p>The MDT should provide written material for patients and carers which includes:</p> <ul style="list-style-type: none"> information specific to that MDT about local provision of the services offering the treatment for that cancer site; information about patient involvement groups and patient self-help groups; information about the services offering psychological, social and spiritual/cultural support, if available; information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); information about services available to support the effects of living with cancer and dealing with its 	<p><i>Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.</i></p> <p><i>It is recommended that the information is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.</i></p> <p><i>For the purpose of</i></p>	<p>Operational Policy.</p> <p>Examples should be available for IV and PR Visit.</p>

emotional effects.	<i>self-assessment the team should confirm the written information which is routinely offered to patients.</i>	
13-2B-113	Permanent Record of Consultation	
<p>The MDT should be offering patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed:</p> <ul style="list-style-type: none"> • diagnosis; • treatment options and plan; • relevant follow up (discharge) arrangements. 		Operational Policy.
13-2B-114	Patient Feedback	
<p>The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered.</p> <p>The exercise should at least ascertain whether patients were offered:</p> <ul style="list-style-type: none"> • a key worker; • assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); • the MDTs information for patients and carers (written or otherwise); • the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. <p>The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.</p>	<p><i>The exercise may consist of a survey, questionnaire, focus group or other method.</i></p> <p><i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i></p> <p><i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i></p>	Annual Report / Service Profile.
Key Theme		
Clinical Outcomes / Indicators		
Objective		
All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.		
Measure	Notes	Evidence
13-2B-115	Clinical Indicators Review / Audit	
<p>The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings:</p> <ul style="list-style-type: none"> • any breast cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS); 	<p><i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i></p> <p><i>The compliance for this measure relates to the discussion of the data.</i></p>	Annual Report / Service Profile. Work Programme.

<ul style="list-style-type: none"> clinical indicators identified in section 2 of the measures; any additional audits for hospital practice, from the process measures in the NICE Breast Cancer Quality Standard (QS 12), which the network group has agreed across its relevant, associated MDTs. 			
<p>Objective <i>All patients have equitable access to treatments that could potentially improve outcomes.</i></p>			
Measure		Notes	Evidence
13-2B-116	Discussion of Clinical Trials		
<p>The MDT should produce a report at least annually on clinical trials, for discussion with the network group. The report should include:</p> <ul style="list-style-type: none"> details of the MDT's trials portfolio including the extent of local provision of the national portfolio; the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets; the MDT's programme for improvement for the above, as proposed to the network. <p>The MDT should agree a final programme for improvement at the network group discussion meeting.</p>		<p><i>For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</i></p>	<p>Annual Report.</p>

Section 2 Clinical Indicators/Lines of Enquiry

Introduction

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self assessment report and any plans for improvement should be included in their work programme.

Clinical Indicators

The NCIN Breast Service Profile

The indicators included in the breast service profile have been discussed with cancer commissioners and clinicians working in MDTs as being important elements for objective dialogue in terms of clinical practice and service delivery. The profile highlights areas where an MDT is doing well and may also highlight areas for improvement, although it is also important to consider recent progress against the indicators in the dialogue.

The inclusion of benchmarking to identify whether a particular indicator is significantly at variance to the national mean is a helpful way to identify those aspects of service delivery which might be the focus of initial discussion. It is anticipated that many trusts will be significantly different to the mean on one or two indicators. In general for any trust, the more indicators that are significantly at variance, the greater the need for understanding why this should be the case. This explanation may be grounded in the population age and socio-economic status. It is also important to note that whether a higher value or a lower value than the mean is regarded as “good” is dependent on the individual indicator.

Some indicators are relatively straightforward to interpret (e.g. cancer waiting times) whereas other indicators may need more discussion and local intelligence to understand the context and case mix of patients managed within the particular service. Documents for both the general guidance on the service profiles, and the data definitions, are provided alongside the Service Profile to inform their interpretation and discussion.

MDTs should discuss their profiles with reference to the areas where benchmarking shows there are areas for improvement. All the profiles and further background information can be found on the Cancer Commissioning Toolkit www.cancertoolkit.co.uk.

Section	#	Indicator
Size	1	Number of new cases (invasive and non-invasive) managed per year, 2011
	2	Number of newly diagnosed (invasive and non-invasive) patients per year, 2010
Demographics (based on newly diagnosed patients, 2010)	3	Patients (from #2) aged 70+
	4	Patients (from #2) with recorded ethnicity
	5	Patients (from #4) with recorded ethnicity which is not White-British
	6	Patients (from #2) who are Income Deprived (1)
	7	Male patients (from #2)
	8	Patients (invasive from #2) with a nationally registered Nottingham Prognostic Index
	9	Patients (from #8) with nationally registered NPI in excellent or good prognostic groups
	10	Patients with Charlson co-morbidity >0 (to be included in later profile)
Specialist Team	11	Peer review: does the specialist team have full membership? (2)
	12	Peer review: proportion of peer review indicators met
	13	Peer review: are there immediate risks? (3)
	14	Peer review: are there serious concerns? (3)
	15	CPES (4): Patients surveyed and % reporting being given name of a CNS (5,6)
	16	Surgeons not managing 30+ cases per year
Throughput	17	Number of urgent GP referrals for suspected cancer
	18	Cases (from #1) managed at this trust with invasive cancer
	19	Cases (from #1) managed at this trust with non-invasive cancer
	20	Estimated proportion of tumours with emergency presentations [experimental]
	21	Newly diagnosed patients (from #2) referred via the screening service
Waiting times	22	Q2 2012/13: Urgent GP referral for suspected cancer seen within 2 weeks
	23	Q2 2012/13: Treatment within 62 days of urgent GP referral for suspected cancer
	24	Urgent GP referrals for suspected cancer diagnosed with cancer [experimental]
	25	Cases treated that are urgent GP referrals with suspected cancer [experimental]
	26	Q2 2012/13: First treatment began within 31 days of decision to treat
	27	Q2 2012/13: Urgent breast symptom referrals (cancer not suspected) seen in 2 wks
	Practice	28
29		Surgeries which are day case or one overnight stay (all cases from #1)
30		Mastectomy procedures (from #32) with immediate reconstruction (invasive only)
31		Major surgeries in invasive breast cancer (from #18) (7)
32		Surgical cases (from #31) receiving mastectomy (invasive only)
33		Median length of stay (days) for elective surgical admissions (from #1, all cases)
34		Mean length of stay (days) for elective surgical admissions (from #1, all cases)
Outcomes and Recovery	35	Surgical cases (from #31) readmitted as an emergency within 28 days
	36	First outpatient appointments and proportion of all outpatient appointments
	37	Patients treated surviving at one year (to be included in later profile)
Patient Experience - CPES (4)	38	Patients surveyed & % reporting always being treated with respect & dignity (6)
	39	Number of survey questions and % of those questions scoring red(8)
	40	Number of survey questions and % of those questions scoring green(8)

Appendix 1 Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarized as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between network groups for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Network Groups

- The network group should be the only such network group for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the network group should be associated with more than one MDT.
- For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.
 - *Notes: The network group **need** only be associated with one specialist/supranetwork type MDT but **may** be associated with more than one.*

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with:

- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.
 - *Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.*

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
 - *Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances. This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.*

- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.
 - *Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.*
- The MDT should be associated with a single named network group for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
 - *Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one network group, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate network group for each of its specialty sites.*

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the 'local' type MDTs.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.
- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.
- The specialist MDT should act as the 'local' type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.
 - *Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site.*
- The specialist MDT should be associated with a single named network group, (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

Appendix 2 Roles and Responsibilities

Roles and Responsibilities

Introduction

Role of the Network Group

The network group should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all MDT leads from the relevant associated organisations.

The network group should:

- agree a set of clinical guidelines and patient pathways to support the delivery of high quality equitable services across the network;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;
- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure actions following peer review are implemented;
- review and discuss identified risks/untoward incidents to ensure learning is spread;
- agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Responsibilities of the MDT lead clinician

The MDT lead clinician should:

- ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
- ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
- ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that the MDT meetings and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- provide the link to the network group either by attendance at meetings or by nominating another MDT member to attend;
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported.

Appendix 3 Chemotherapy Treatment Algorithms

Introduction

Introduction; (Definitions). Regimens, Protocols and Algorithms

For the purposes of peer review, a chemotherapy **regimen** is defined by the therapeutic chemotherapy drugs used, often expressed as an acronym e.g. 'FEC'. A change of one or more of these drugs themselves would normally be necessary for it to be classed as a change of regimen. In some cases major changes in the dose or route of administration of one or more of the drugs effectively changes the regimen but these cases are generally known and recognised nationally. A given network is free to choose any further changes which they classify as changing the regimen, as long as it is in accord with the above definition and national exceptions; i.e. they are free to make their definition of a regimen narrower, but not wider. This is relevant to measures in the chemotherapy section ([Topic 3S](#)).

For the purposes of peer review, a chemotherapy **treatment protocol** is defined as constituting all the parameters specified in the bullet points in chemotherapy measure [11-3S-122](#). A change in any of these parameters would change the treatment protocol but any change other than the therapeutic drugs themselves (apart from the national and local exceptions specified above) would change only the protocol, not the regimen as well.

For the purposes of peer review a chemotherapy **treatment algorithm** may be described as a guideline which specifies the acceptable range of regimens for each relevant step on the patient pathway. Treatment algorithms are cancer site-specific. They are not specific to individual patients, i.e. they are not individual treatment plans. Thus, a treatment algorithm for breast cancer would include a statement of the range of regimens agreed as acceptable for adjuvant chemotherapy and for first, second and third line palliative chemotherapy etc. Illustrative examples of treatment algorithms in different formats may be found in appendix 1 of the chemotherapy measures. There may be other formats which would be acceptable to the reviewers.

In practice, a change of regimen or order of regimens may no longer comply with a previously agreed treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply. The measure for the network groups is concerned only with chemotherapy **algorithms**.

Notes: The intention is not to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.

The network group should produce the algorithms for its compliance with this measure and the relevant chemotherapy multi-professional teams should produce a compatible list of algorithms for the network group's cancer site for their own service (measure [11-3S-122](#)). The relevant chemotherapy multi-professional teams should each agree lists with all the network groups relevant to their practice, for compliance with their measure.

The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the network group agreed list.

This exercise should include oral chemotherapy.

This measure is assessed as part of the responsibility of each network group, but from the chemotherapy cross cutting group's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time. Updates require changes only when judged clinically necessary by the network group.

Appendix 4 Psychological Support Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels. The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note: Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.

The additional training is as follows:

I. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

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II. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the one of the national voluntary regulatory bodies for counselling;
- an NHS psychotherapist accredited by one of the national voluntary regulatory bodies for psychotherapy.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note:

All of the above should have completed an induction at level 3. that meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.

