Intelligence

National Cancer Action Team

Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Head and Neck Measures

Version 2.1

DH INFORMATION READER BOX

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Contents

11-1A-2i - HEAD AND NECK SPECIFIC NETWORK BOARD MEASURES

Measure Number	Measure
11-1A-201i	Agreed Named Members and Terms of Reference of NSSG
11-1A-202i	Oversight of Head and Neck Cancer for the Whole Network
11-1A-203i	Policy for Named Hospitals for Head and Neck Cancer
11-1A-204i	The Distribution of Neck Lump Clinics
11-1A-205i	Distribution of Specialist Thyroid Clinics
11-1A-206i	Referral Guidelines for Primary Care Practitioners
11-1A-207i	Network Agreed Referral Proformas
11-1A-208i	Internal Referral Guidelines for Non-Designated Hospital Clinicians
11-1A-209i	Network/PCT Agreed Referral Policies Thyroid Lumps.
11-1A-210i	Network Agreed Named Hospital for Surgical Treatment Delivery
11-1A-211i	Network MDT Configuration
11-1A-212i	Catchment Population & MDTs Dealing with Thyroid Cancer
11-1A-213i	Distribution of Local Support Teams in the Network
11-1A-214i	The Role of the Local Support Team
11-1A-215i	The Guidelines for Referral of Patients with UAT
11-1A-216i	The Guidelines for Referral of Patients with Thyroid Cancer

11-1C-1i - FUNCTIONS OF NETWORK SITE SPECIFIC GROUPS (NSSGs)

Measure Number	Measure
11-1C-101i	NSSG Should Meet Regularly and Record Attendance
11-1C-102i	The Annual Review, Work Programme and Annual Report
11-1C-103i	Network Agreed Clinical Guidelines
11-1C-104i	Agreed Membership of the Thyroid Subgroup
11-1C-105i	Network Agreed Imaging Guidelines for UAT Cancer
11-1C-106i	Network Agreed Imaging Guidelines for Thyroid Cancer
11-1C-107i	Network Agreed Pathology Guidelines for UAT Cancer
11-1C-108i	Network Agreed Pathology Guidelines for Thyroid Cancer
11-1C-109i	Network Agreed Policy For Named Surgeons Authorised to Perform Lymph Node Resections
11-1C-110i	Agreed Network Wide Minimum Dataset
11-1C-111i	Network Audit

Measure Number	Measure
11-1C-112i	Agreed NSSG Three Year Service Delivery Plan
11-1C-113i	Discussion of Clinical Trials
11-1C-114i	Chemotherapy Treatment Algorithms
11-1C-115i	The TYACN Pathway for Initial Management
11-1C-116i	The TYA Pathway for Follow Up on Completion of First Line Treatment

11-1D-1i - FUNCTIONS OF THE LOCALITY GROUP

Measure Number	Measure
11-1D-101i	Named Members of the Local Support Team
11-1D-102i	Provision of Neck Lump Clinics
11-1D-103i	Provision of Thyroid Clinics
11-1D-104i	Designated Clinicians
11-1D-105i	HDU and ITU on Site
11-1D-106i	Written Policy for a Named Specialist Head and Neck Ward
11-1D-107i	Registered Nurse Staffing
11-1D-108i	Named Speech and Language Therapist
11-1D-109i	Named Dietician

11-2I-1 - UAT & UAT/THYROID MDT

Measure Number	Measure
11-2I-101	Lead Clinician and Core Team Membership
11-2I-102	Restorative Dentist Core Team Member
11-2I-103	Level 2 Practitioners for Psychological Support
11-2I-104	Support for Level 2 Practitioners
11-2I-105	Team Attendance at NSSG Meetings
11-2I-106	MDT Meeting
11-2I-107	MDT Agreed Cover Arrangements for Each Core Member
11-2I-108	Core Members (or Cover) Present for 2/3 of Meetings
11-2I-109	Annual Meeting to Discuss Operational Policy
11-2I-110	Policy for All New Patients to be Reviewed by MDT
11-2I-111	Policy for Communication of Diagnosis to GP
11-2I-112	Operational Policy for Named Key Worker
11-2I-113	Operational Policy for Principal Clinician
11-2I-114	Core Histopathology Member taking part in Histopathology EQA
11-2I-115	Core Nurse Member Completed Specialist Study
11-2I-116	Agreed List of Responsibilities for Core Nurse Members
11-2I-117	Attendance on the National Advanced Communication Skills Training Programme
11-2I-118	Operational Policy Specifying Discharge Criteria
11-2I-119	Aftercare and Rehabilitation Protocol
11-2I-120	Clinical Follow Up Protocol
11-2I-121	Core Consultant Member spend 50% of Time on Care of UAT Cancer
11-2I-122	Agreed Service Specification for Rescue of Reconstructive Surgical Flap Failure
11-2I-123	Agreed Policy for Patient to Discuss Treatment Options
11-2I-124	Extended Membership of MDT
11-2I-125	Patient Permanent Consultation Record
11-2I-126	Patient Experience Exercise
11-2I-127	Provision of Written Patient Information for UAT Cancer
11-2I-128	Pre-treatment Assessment Sessions
11-2I-129	Agree and Record Individual Patient Treatment Plans
11-2I-130	MDT Agreement to Network Guidelines for Referral from Diagnosis and Assessment Service
11-2I-131	Single Named Designated Hospital for Surgical Procedure
11-2I-132	MDT Agreement to Network Imaging Guidelines for UAT Cancer
11-2I-133	MDT Agreement to Network Pathology Guidelines for UAT Cancer

Measure Number	Measure
11-2I-134	MDT Agreement to Network Clinical Guidelines for Treatment of UAT Cancer
11-2I-135	Agreed Collection of Minimum Dataset
11-2I-136	Network Audit
11-2I-137	Discussion of Clinical Trials for UAT
11-2I-138	MDT to Discuss at Least 100 New Cases per Year
11-2I-139	Named Core Team Members for Thyroid Cancer
11-2I-140	Extended Membership of MDT for Thryroid Cancer
11-2I-141	MDT Agreement to Network Imaging Guidelines for Thyroid Cancer
11-2I-142	MDT Agreement to Network Pathology Guidelines for Thyroid Cancer
11-2I-143	MDT Agreement to Network Clinical Guidelines for Thyroid Cancer
11-2I-144	Network Audit for Thyroid Cancer
11-2I-145	Discussion of Clinical Trials for Thyroid Cancer
11-2I-146	MDT Agreement to Network Surgeon Authorised to Perform Lymph Node Resections
11-2I-147	Provision of Written Patient Information for Thyroid Cancer
11-2I-148	Joint Treatment Planning for TYAs

11-2I-2 - THYROID ONLY MDT

Measure Number	Measure
11-2I-201	Single Named Lead Clinician with Agreed Responsibilities
11-2I-202	Level 2 Practitioners for Psychological Support
11-2I-203	Support for Level 2 Practitioners
11-2I-204	Team Attendance at NSSG Meetings
11-2I-205	MDT Meeting
11-2I-206	MDT Agreed Cover Arrangements for each Core Member
11-2I-207	Core Members (or cover) Present for 2/3 of Meetings
11-2I-208	Annual Meeting to Discuss Operational Policy
11-2I-209	Policy for All New Patients to be Reviewed by MDT
11-2I-210	Policy for Communication of Diagnosis to GP
11-2I-211	Operational Policy for Named Key Worker
11-2I-212	Operational Policy for Principal Clinician
11-2I-213	Core Histopathology Member Taking Part in Histopathology EQA
11-2I-214	Core Nurse Member Completed Specialist Study
11-2I-215	Agreed List of Responsibilities for Core Nurse Members
11-2I-216	Attendance on the National Advanced Communication Skills Training Programme

Measure Number	Measure
11-2I-217	Clinical Follow up Protocol
11-2I-218	Agreed Policy for Patient to Discuss Treatment Options
11-2I-219	Extended Membership of MDT
11-2I-220	Patient Permanent Consultation Record
11-2I-221	Patient Experience Exercise
11-2I-222	Provision of Written Patient Information
11-2I-223	Agree and Record Individual Patient Treatment Plans
11-2I-224	MDT Agreement to Network Guidelines for Referral from Diagnosis and Assessment Service
11-2I-225	MDT Agreement to Network Imaging Guidelines for Thyroid Cancer
11-2I-226	MDT Agreement to Network Pathology Guidelines for Thyroid Cancer
11-2I-227	MDT Agreement to Network Clinical Guidelines for Treatment of Thyroid Cancer
11-2I-228	Agreed Collection of Minimum Dataset
11-2I-229	Network Audit for Thyroid Cancer
11-2I-230	Discussion of Clinical Trials
11-2I-231	MDT Agreement to Network Surgeons Authorised to Perform Lymph Node Resections
11-2I-232	Joint Treatment Planning for TYAs

Introduction

1.1 Aim of the Manual for Cancer Services

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 will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and patient/carer representation, provides important information about the quality of clinical teams and a national benchmark of cancer services across the country.

National quality standards/measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services (e.g. chemotherapy, radiotherapy). It is intended that the National Cancer Intelligence Network (NCIN) clinical reference groups will review the measures within the manual for cancer services annually to ensure they are clinically relevant and it is intended that the measures will underpin the NICE Quality Standards relating to cancer.

An independent evaluation of the National Cancer Peer Review Programme demonstrated strong support for the programme to continue, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when data becomes available.

In response to this the number of measures has been reduced by over one third in 2008 and more recently by a further 10%. In addition "Clinical Lines of Enquiry" (CLE) have been introduced, based on outputs/outcomes to support the Manual for Cancer Services. The revised process for peer review will be implemented in April 2011 but the measures contained within this manual will remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Although the NHS is not mandated to adhere to the measures in the Manual for Cancer Services, it is currently used by the National Cancer Peer Review Programme as part of their local assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality.

1.2 Background and Context

Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy sets out how the future direction for cancer will be aligned with Equity and Excellence: Liberating the NHS in addition to meeting its stated aim to saving an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive information about cancer services for individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

1.3 Measures within the National Cancer Peer Review Manual

The peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, 'Clinical Lines of Enquiry' have been introduced and it is intended these outcome indicators will form part of the measures along with a reduced number of structure and process measures.

The development of cancer measures is an ongoing 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 initiatives such as Iapco, information prescriptions.

The relationship between the NICE Improving Outcomes Guidance and Quality Standards and the Manual for Cancer Services is explained in more detail in appendix A.

1.4 Reviewing the Measures

The National Cancer Peer Review (NCPR) Programme 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 NCPR programme has been keen to take the opportunity to reduce the burden on the NHS in line with the efficiency gains asked of all NHS organisations. The revised methodology will reduce the burden on the service without substantially impacting on the quality assurance process. It is envisaged that these changes will reduce the burden on the service by almost 50% from the previous process.

Appendix A

Interpretation of the National Manual for Cancer Services

1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes 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 and 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.

It may use influential and important ideas and models, which are however complex or not precisely definable, such as "network-wide patient care pathways" or "culturally-sensitive information". It always contains useful and necessary value judgements which use words like "sufficient", "appropriate", "robust" and "comprehensive", but it often has to leave unanswered the key question - what exactly is it which makes the issue under examination "sufficient", "appropriate", "robust" and "comprehensive" or not? It uses concepts which, although crucial, may not be measurable. It ranges widely from things which everybody gets right as a matter of course already through to principles which, if taken literally, nobody would comply with ever.

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset, 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 and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit; state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous standards - in order to be developmental -not just arbitrarily moving the goal posts.

All this results in the rather esoteric style of the manual. Please judge the measures on their merits in the light of the above and not in comparison to the guidance.

1.2 "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 ascertain group.

1.3 "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.

1.4 Confirmation of Compliance

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

1.5 "Quality" Aspects of Cancer Service Delivery

Many of the measures expect that policies, procedures, job descriptions and other documents will be in place. In reviewing compliance with the measures (for instance measure met or not) during validation, verification and visits, reviewers will look only for the presence of such documents, unless aspects of the content are specified in the wording of the measure. Where some aspect of the content is specified then this will be taken into account in determining compliance. As part of the improvement of cancer services, reviewers may comment on the content of documents and agreements but this will not affect the determination of compliance.

Work is ongoing to enable us to subject more of the "quality" aspects of cancer service delivery to objective measures for future rounds of peer review.

Many reviewers have a legitimate and valuable contribution to make by way of comments on areas which are a matter of opinion rather than fact or authoritative and evidence based standards. This recognises the qualitative as well as quantitative approach to reviews. This contribution can be made by way of a textual report in addition to the objective recording of compliance against the measures. This report is separate from the review against the measures and is inevitably more subjective and open to debate. However, there are many ways in which it can add to the overall picture gained from the peer review.

1.6 Structure of the Measures

Each measure has a three part number, for example 11-1A- 201j.

- The first part indicates the year the measure was first issued, for example 11 is 2011.
- The second part relates to a particular topic see below, for example 1A.
- The third part is made up of a unique measure number in the topic and where relevant a suffix letter indicating a specific tumour and cross cutting services, for example 201j (see below).

Index of Suffix Letters

a - Generic to all tumour sites	**r** - Specialist Palliative Care specific
b - Breast specific	**s** - Chemotherapy specific
c - Lung specific	**t** - Radiotherapy specific
d - Colorectal specific	**u** - User Group specific
e - Gynaecology specific	**v** - Rehabilitation specific
f - UGI specific	**w** - Complementary Therapy specific
g - Urology specific	**x** - Psychological Support specific
h - Haematology specific	**y** - Acute Oncology
i - Head and Neck specific	
j - Skin specific	

Each network will be made up of several localities/trusts and several NSSGs / cross cutting groups, each with multiple MDTs and services. These MDTs and services will each need to demonstrate compliance with the relevant quality measures. A network overview will be developed by bringing together the findings relating to individual MDTs and services as well as those concerning network organisation and structures.

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.

HEAD AND NECK SPECIFIC MEASURES

Introduction to the Head and Neck Measures

The NICE Improving Outcomes Guidance (IOG) for head and neck cancers outlines a structure for service delivery which is agreed across a cancer network, organised and commissioned at network level. It covers services for carcinomas of the upper aero-digestive tract (UAT cancer), including those affecting the skull base and salivary gland tumours and also thyroid cancer, and outlines joint policies for head and neck sarcomas between head and neck cancer MDTs and sarcoma MDTs.

It requires a degree of consolidation of treatment services resulting in an MDT for UAT cancer which should deal with a minimum of 100 new cases a year. A further degree of consolidation of services is required for the treatment of salivary gland tumours and UAT tumours involving the skull base.

MDTs for thyroid cancer may function separately from UAT, or as part of a combined MDT, with a UAT team but in whatever form, they should cover a minimum catchment population of one million for referral of thyroid cancer.

It is expected that some networks will need to refer patients with rarer types of head and neck cancer, to MDTs in a neighbouring network.

There are clear requirements for the network-wide organisation of rapid diagnosis and assessment, prior to MDT discussion and similarly for the organisation of services for rehabilitation and support. This involves designating certain hospitals as referral points, designating certain clinicians to deal with diagnosis and initial assessment and establishing local rehabilitation and support teams.

In order for MDTs to experience the full range of the disease the "designated clinicians" for diagnosis and assessment should be drawn from members of the MDT, at least in the case where they are serving the local (secondary) catchment of the MDT. For the same reason the UAT MDT should supply the UAT consultants to staff the fast-track neck lump service which serves the local (secondary) catchment of the MDT, and the consultants staffing clinics which assess patients with thyroid lumps should be core members of thyroid MDTs, at least in the clinic which serves the local catchment of the MDT.

In order for the consolidation of services and the creation of MDTs to add their full value to the process of treatment delivery as well as to treatment planning decisions, there are requirements for the curative operations to be performed by MDT members and for them all to take place in a single named hospital with a designated head and neck ward.

These considerations have determined the format of this head and neck section of the Manual for Cancer Services and have necessitated specific measures for head and neck cancer for the Network Board, the Network Site Specific Group (NSSG) and the Locality Group. These have been incorporated into head and neck specific parts of topics 1A, 1C and 1D.

The Shape of the Service

Diagnosis and Assessment

The diagnosis and assessment of patients who fulfil the guidelines for "urgent suspicion of head and neck cancer and thyroid cancer", should be carried out only by personnel who are agreed and designated by the network ("designated clinicians") acting only in similarly agreed, named hospitals. Specific, fast-track clinics for neck lumps should be provided. The clinics' working procedures should be agreed jointly by the haematology and head and neck NSSGs. The location in the network of named fast-track neck lump clinics should be agreed by the Network Board in consultation with the NSSGs. Clinics for the diagnosis and assessment of thyroid lumps should be specified and provided, either as part of the remit of a neck lump clinic or a specialised thyroid clinic.

MDTs - Team Criteria

The configuration of MDTs in the network, including which cancer types each one deals with, should be agreed network wide. Each team should fulfil certain criteria.

(a) The UAT MDT

- it should be listed as part of the named services of a named locality in the network;
- it should declare the cancer types it deals with (including whether it deals with thyroid cancer*, salivary gland tumours and cancer involving the skull base);
  * This would classify it as a combined UAT and endocrine MDT - *see below*;
- it should deal with a minimum of 100 squamous carcinomas of the UAT per year, each presenting for the first time to the MDT;
  there should not be more than one UAT MDT in any one hospital;
- it should be the only MDT dealing with UAT cancer for its catchment area;
- it should provide the head and neck consultant staff for the designated clinicians and the fast-track neck lumps service for the local (secondary) catchment of the MDT.

(b) UAT MDT which deals with salivary gland tumours
In addition to the criteria under (a):

- it should be the only MDT dealing with salivary gland tumours in the network.

(c) UAT MDT which deals with UAT cancer invading the skull base
In addition to the criteria under (a):

- it should have a named neurosurgical member of the core or extended team;
- it should be the only MDT in the network dealing with UAT cancer invading the skull base.

(d) UAT MDT which deals with thyroid cancer (combined UAT and endocrine MDT)

In addition to the criteria under (a):

- it should serve a catchment population of one million or more for referral of thyroid cancer;
- it should be the only MDT dealing with thyroid cancer in the network unless, by reason of population (two million or more), the network is able to and wishes to provide more than one thyroid MDT, in which case it should be the only MDT dealing with thyroid cancer for its catchment population;
- it should provide the designated clinicians for thyroid cancer for the local (secondary) catchment population of the MDT.

(e) MDT which deals with thyroid cancer but not UAT cancer (endocrine only MDT)
The following criteria apply, without the addition of those under (a):

- it should be listed as part of the named services of a named locality in the network;
- it should serve a population of one million or more for referral of thyroid cancer;
- it should be the only MDT dealing with thyroid cancer in the network unless, by reason of population (two million or more), the network is able to and wishes to provide more than one thyroid MDT, in which case it should be the only MDT dealing with thyroid cancer for its catchment population;
- it should provide the "designated clinicians" for thyroid cancer for the local (secondary) catchment population of the MDT.

Head and Neck Wards

Specialised, designated in-patient facilities for the care of patients with head and neck cancer should be provided in certain designated hospitals, associated with named head and neck MDTs.

Local Support Teams

The location, membership and catchment areas of local teams for rehabilitation and support of patients with head and neck cancer, should be agreed by the Network Board in consultation with the NSSG.

Building the Head and Neck Cancer Network

The measures assign the responsibility for establishing the head and neck cancer network to the Network Board, acting in agreement with the NSSG and the PCTs.

The logical progression as laid out in topic 1A for the Network Board is as follows:

i) agree the identity and location of the hospitals which will be designated for the diagnosis and assessment of head and neck cancer patients;

ii) agree the location of the fast-track neck lump clinics and, if applicable, specialist thyroid clinics;

iii) agree the referral arrangements between PCTs and the designated hospitals with their specified clinics (primary care referral guidelines);

iv) agree the list of named UAT MDTs with their locations and (if applicable) which UAT MDTs will deal with (a) thyroid cancer; (b) salivary gland tumours; (c) UAT cancer involving the skull base. These may include MDTs in a neighbouring network;

v) if applicable, agree the list, with their locations, of the MDTs which will deal with thyroid cancer but not UAT cancers (endocrine only MDTs). These may include MDTs in a neighbouring network;

vi) agree and specify the operating hospitals and specialist head and neck wards associated with each MDT;

vii) agree the referral guidelines between the diagnostic/assessment services (designated clinicians and fast-track clinics) and the MDTs;

viii) agree the location of the local rehabilitation/support teams with the PCTs;
Note: The location of the diagnostic/assessment services, local rehabilitation and support teams and MDTs, together with the cancer types the MDTs deal with, make up the network configuration for head and neck cancer.

ix) from the referral arrangements between the PCTs and the diagnostic/assessment services, and between the diagnostic/assessment services and the MDTs, confirm the referring catchment populations for thyroid cancer for those MDTs which deal with thyroid cancer.
Note: The catchment population should be one million or more.

Reviewing Head and Neck Cancer

i) The configuration of the head and neck cancer network: comprising the establishment of the NSSG and whether there is a separate thyroid subgroup; deciding the designated hospitals and the location of fast track neck lump clinics, thyroid clinics, head and neck cancer wards, local support teams, and deciding the location and case mix of the MDTs.This is the responsibility for review purposes of the Chair of the Network Board and is reviewed under topic 1A - cancer networks - head and neck specific measures, compliance counting towards the review of the Network Board.

ii) Provision of the diagnostic and assessment service: comprising the provision of designated clinicians, fast-track clinics and thyroid clinics. This is the responsibility for review purposes of the Chair of the Locality Group whose locality hosts the designated hospital in question and is reviewed under topic 1D

- functions of locality groups, compliance counting towards the review of the locality group.

iii) Provision of the head and neck cancer wards and local support teams. This is the responsibility for review purposes of the Chair of the Locality Group whose locality hosts the designated hospital and local support team in question, and is reviewed under topic 1D - functions of locality groups, compliance counting towards the review of the locality group.

iv) Functions of the NSSG - applied either to a combined UAT/thyroid NSSG or to a UAT NSSG and a separate thyroid subgroup. This is the responsibility for review purposes of the Chair of the NSSG and is reviewed under topic 1C - functions of network site specific groups, compliance counting towards the review of each NSSG.

v) The head and neck MDT - applying the relevant sets of the following three sets of measures to each MDT in the network:

(1) measures for a UAT MDT;

(2) measures in addition to (1) for a combined UAT/thyroid MDT;

(3) measures for a thyroid-only MDT.

vi) This is the responsibility for review purposes of the Lead Clinician of the MDT in question and compliance counts towards the review of that MDT.

TOPIC 11-1A-2i - HEAD AND NECK SPECIFIC NETWORK BOARD MEASURES

TRUSTS, HOSPITALS AND SERVICES

Calman-Hine assumed that the whole of a cancer network was divided into either cancer centres or cancer units. This works geographically in some networks where all tertiary services were grouped conveniently in one city, serving surrounding DGHs which provided only secondary services. For many networks, things are more complicated, so for this round of peer review, a simpler way of dividing a cancer network into manageable parts, has been devised. Previously designated centres and units can still fit into this (see below). The whole of each cancer network is considered to be divided into parts which the network itself defines pragmatically on the grounds of concentrations of population and the arrangement of hospital services and the best way that the network board judges them to be grouped for its own purpose of managing the cancer network.

For the purpose of the peer review, these parts have to have a label. They will be known in the manual as 'localities'. The hospitals, MDTs and services which make up any given locality, are entirely at the discretion of the network.

All of the cancer network should be included in one or other locality. Each locality should have a group which oversees it for the network - the locality group, having the representation and terms of reference set out in the measures. The reason for the existence of localities is to ensure that the network's policies, procedures and action plans are implemented across real services 'on the ground' and a real dialogue takes place regarding developments and commissioning.

It can be seen from the above that:

- a previously designated 'cancer centre' or 'cancer unit', will be reviewed under this arrangement of 'localities';
- in many cases a locality will be synonymous with a trust and the palliative care services and PCTs associated with its local catchment area.

NOMENCLATURE

Within the network measures a number of groups have been defined. These groups each need a name for the purposes of the measures, and for data collection from the peer review. The names are purely labels for the measures. Provided a group is formed and put forward for assessment against the appropriate set of measures, the name used locally is a local matter. The result of its review will be recorded and collated for the network database under its measures' name, to avoid confusion.

The overall management group has changed its name in the measures from round one "Network Management Group" to "Network Board", to reflect the terminology in the document "Shifting the Balance of Power - The Next Steps". It is meant to be the same body, although its required membership and scope have expanded. As explained above, cancer centre groups and cancer unit groups, as referred to in the round one measures, have been replaced by the more generic and flexible concept of the 'locality group', but the continued local use of the former names is entirely at local discretion and such groups (possibly needing modification of membership, etc) should be put forward for review against the locality group measures.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

ESTABLISHMENT OF NETWORK SITE SPECIFIC GROUPS (NSSGs)

The responsibility for review purposes for measures 11-1A-201i to 11-1A-218i lies with the Chair of the Network Board.

Agreed Named Members and Terms of Reference of NSSG

11-1A-201i

There should be a single NSSG, having a membership fulfilling the following:

- the MDT lead clinician from each MDT in the network;
- at least one nurse core member of a MDT in the network;
- there should be a named chair drawn from the above membership;
- two user representatives;
- one of the NHS employed members of the NSSG should be nominated as having specific responsibility for users' issues and information for patients and carers;
- a member of the NSSG nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the NSSG;
- named secretarial/administrative support.

There should be terms of reference agreed for the NSSG which include:

the NSSG should be recognised as:

- the board's primary source of clinical opinion on issues relating to cancer for the network;
- the group with corporate responsibility, delegated by the board, for co-ordination and consistency across the network for cancer policy, practice guidelines, audit, research and service improvement;
- consulting with the relevant "cross cutting" network groups on issues involving chemotherapy, cancer imaging, histopathology and laboratory investigation and specialist palliative care; and with the head of service on issues involving radiotherapy.

Notes:

- *There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.*
- *If the local user group do not wish, or are unable, to nominate a user representative but there is an agreed mechanism for obtaining user advice then the measure will be deemed to have been complied with.*
- *There may be additional points in the agreed terms of reference. Recommendations may be found in appendix 2.*

Compliance: The named members and NSSG chair agreed by the Chair of the Network Board.
The terms of reference agreed by the Chair of the Network Board and the Chair of the NSSG.

Oversight of Head and Neck Cancer for the Whole Network

11-1A-202i

The Network Board should agree one of the two following formats for the oversight of head and neck cancer for the whole network.

Either

Format 1

A single group for the network which deals with upper aero-digestive tract (UAT) cancer and thyroid cancer, having the structure, functions and terms of reference specified in measure 11-1A-201i, i.e. A combined UAT, endocrine network site-specific group (NSSG).

Or

Format 2

A single group for the network which deals with UAT cancer, having the structure, functions and terms of reference specified in measures 11-1A-201i plus a separate, single subgroup of the NSSG for the network which deals with thyroid cancer. (See measure 11-1C-104i) e. A UAT NSSG with a separate, endocrine (thyroid) subgroup.

Notes:

- *Whichever format, 1 or 2, is agreed, there should be only one group which deals with UAT cancer and only one group which deals with thyroid cancer, for the network.*
- *If there are any MDTs in the network which are combined UAT/thyroid MDTs, it is recommended that format 1 is agreed for the network oversight.*

Compliance: The format agreed by the Chair of the Network Board.
The reviewers should enquire as to the working practice of the network.

Note: Regarding Subsequent Measures
Wherever agreement by 'PCT leads' is required, this may be by a PCT CE or delegated representative.

Policy for Named Hospitals for Head and Neck Cancer

11-1A-203i The Network Board, in consultation with the NSSG(s) for head and neck cancer, should agree with the PCTs in the network:

(i) A policy that the diagnosis and assessment of patients with head and neck cancer symptoms should only take place in certain 'designated' hospitals, which fulfil the following criteria:

- they have specialised facilities for investigation of head and neck patients;
  Note: neither a strict definition nor an 'on-the-ground' inspection of such facilities is necessary for the peer review.
- they have contracted direct patient care sessions with at least two 'designated clinicians' for head and neck diagnosis and assessment. See measure 11-1D-104i;
- they are the only hospitals for which there are contact points specified in the primary care referral guidelines for head and neck cancer.

(ii) The named hospitals, designated as in (i), for the network, distributed such that the PCTs agree that their populations have sufficient access.

Notes:

- *Not every hospital in the network need be a designated hospital.*
- *Not every designated hospital need host a UAT or thyroid MDT, but all such MDTs should be hosted by a designated hospital.*
- *Not every designated hospital need host a neck lump clinic or thyroid clinic as specified in measures 11-1A-204i/11-1A-205i and 11-1D-102i/11-1D-103i but all such clinics should be held in a designated hospital.*

Compliance: The policy and the named hospitals agreed by the Chair of the Network Board, the Chair of the NSSG and the network PCT leads.
The primary care referral guidelines.

The Distribution of Neck Lump Clinics

11-1A-204i The Network Board, in consultation with the NSSG(s) for head and neck cancer and the NSSG for haematological malignancy, should agree with the PCTs in the network the distribution of neck lump clinics as specified in measure 11-1D-102i. They should fulfil the following criteria:

- they should be the clinics named for referral of patients with neck lumps in the primary care referral guidelines;
- they should be hosted by a designated hospital;
- they should be distributed such that the PCTs agree that their populations have

sufficient access;

- it should be agreed for each clinic whether it will have clinicians designated for thyroid cancer and assess patients with thyroid lumps.

Note:

If there are one or more clinics agreed with PCTs, fulfilling the above criteria, this confers compliance with this measure, whether or not the individual clinics comply with measure 11-1D-102i.

Compliance: The named clinics and their host designated hospitals agreed by the Chair of the Network Board, the Chair of the Head and Neck NSSG and NSSG for haematological malignancy and the network PCT leads.

The primary care referral guidelines.

SPECIALIST THYROID CLINICS

Introduction

Patients with thyroid lumps may be assessed, as agreed by the network, in specialist thyroid clinics or as part of general neck lump clinics.

Distribution of Specialist Thyroid Clinics

11-1A-205i The Network Board in consultation with the NSSG responsible for thyroid cancer should agree with the PCTs in the network:

Either

To have no specialist thyroid clinic (in which case the primary care referral guidelines should specify that all thyroid lumps are referred to neck lump clinics).

Or

The distribution of specialist thyroid clinics as specified in measure 11-1D-103i. They should fulfil the following criteria:

- they should be the clinics named in the primary care referral guidelines, for referral of patients with thyroid lumps only (as opposed to non-thyroid neck lumps as well);
- they should be hosted by a designated hospital;
- they should be distributed such that, in combination with any neck lump clinics which also assess thyroid lumps, the PCTs agree that their populations have sufficient access to thyroid cancer diagnosis and assessment.

Note:

It is acceptable for review purposes for a network to agree a mixture of both specialist thyroid clinics and neck lump clinics which also assess thyroid lumps. The specialist thyroid clinics' distribution should comply with this measure and the neck lump/thyroid lump clinics distribution should comply with measure 11-1A-204i.

Compliance: The agreement between the Chair of the Network Board, the Chair of the NSSG and the network PCT leads, to have no specialist thyroid clinics, or, agreed by the same parties, the named clinics and their host designated hospitals.

The primary care referral guidelines.

REFERRAL GUIDELINES

In view of the need for the network to have decided the configuration of the diagnostic and assessment services, the responsibility for review purposes for producing referral guidelines lies with the Chair of the Network Board in consultation with the Chair of the NSSG.

Referral Guidelines for Primary Care Practitioners

11-1A-206i The Network Board, in consultation with the head and neck NSSG, should agree with the PCT leads in the network referral guidelines for their primary care practitioners regarding patients with head and neck symptoms. The guidelines should follow the schemas

illustrated in figures 1 to 3.

See appendix 1A below.

The designated clinicians, thyroid clinics and neck lump clinics should be named and specified, together with their host, designated hospitals and contact points.

The schemas themselves with named local services and contact points, or compatible ones, would be considered as compliant referral guidelines.

The referral guidelines for primary care should be distributed to at least the following in the network:

- primary care medical practices;
- primary dental practices;
- designated consultant clinicians;
- non-designated head and neck consultant clinicians (ENT surgeons, endocrine surgeons, OMFS surgeons, oral medicine specialists, endocrinologists, restorative dentistry consultant).

Compliance: The guidelines agreed by the Chair of the Network Board, the Chair of the NSSG for head and neck cancer and network PCT leads.

The reviewers should enquire of the distribution process.

Note:

It is not necessary to make an exhaustive check on this. Minor shortcomings in the completeness of distribution should not prevent compliance.

APPENDIX 1A

Head and Neck Cancer Primary Care Referral Guidelines

Introduction

The key questions for the primary care practitioner, which then govern the type and destination of the referral of a patient with potential head and neck cancer are:

Q. Does the patient have a neck lump or not?

For patients with neck lumps:

Q. Is the lump clinically thyroid or not?

Q. Are there 'urgent' features to the lump itself?

Q. Are there other 'urgent' features, not directly of the lump itself? If so, are they pointing to UAT or to haematological malignancy?

Q. Does the patient have stridor?

For patients with no neck lump:

Q. Are there 'urgent' features or not?

Q. Does the patient have stridor?

The key question for a non-designated clinician in hospital, which governs the referral-on of a patient with potential head and neck cancer is:

Q. Is cancer clinically certain or is a biopsy deemed necessary for the initial diagnosis of malignancy?

The answers to these questions determine the 2 or 3 steps through the referral schemas given below.

FIGURE 1: SCHEMA (Numbers refer to numbered footnotes below)

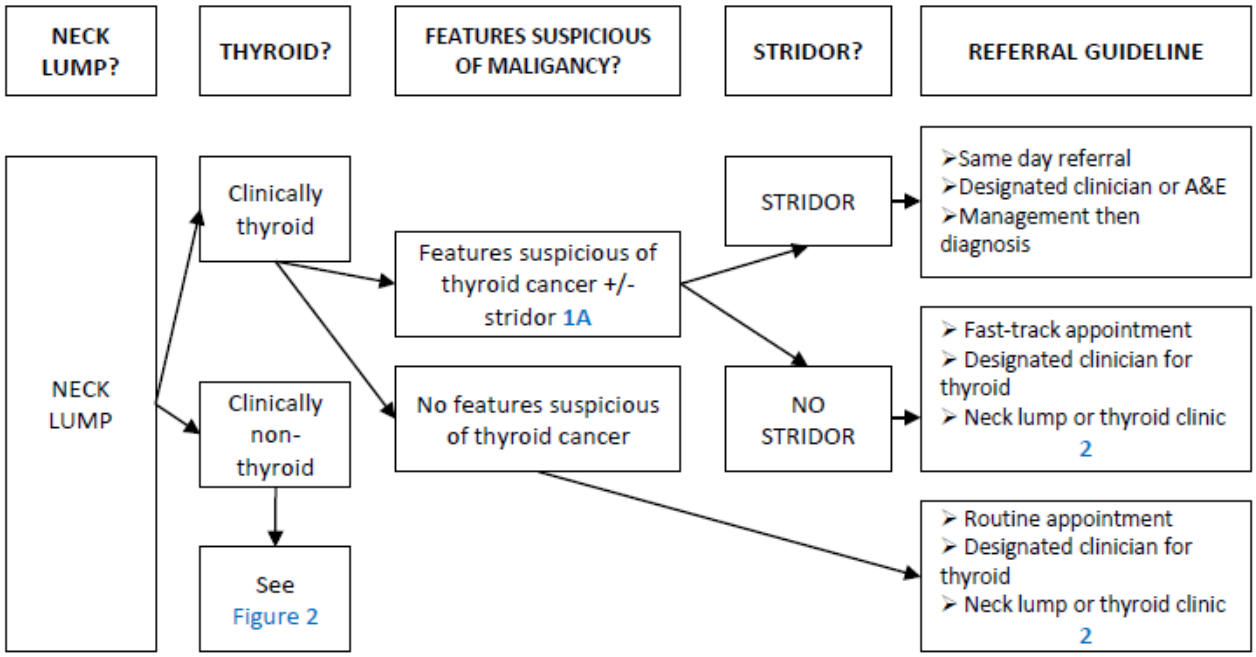


FIGURE 2: SCHEMA (Numbers Refer to Numbered Footnotes)

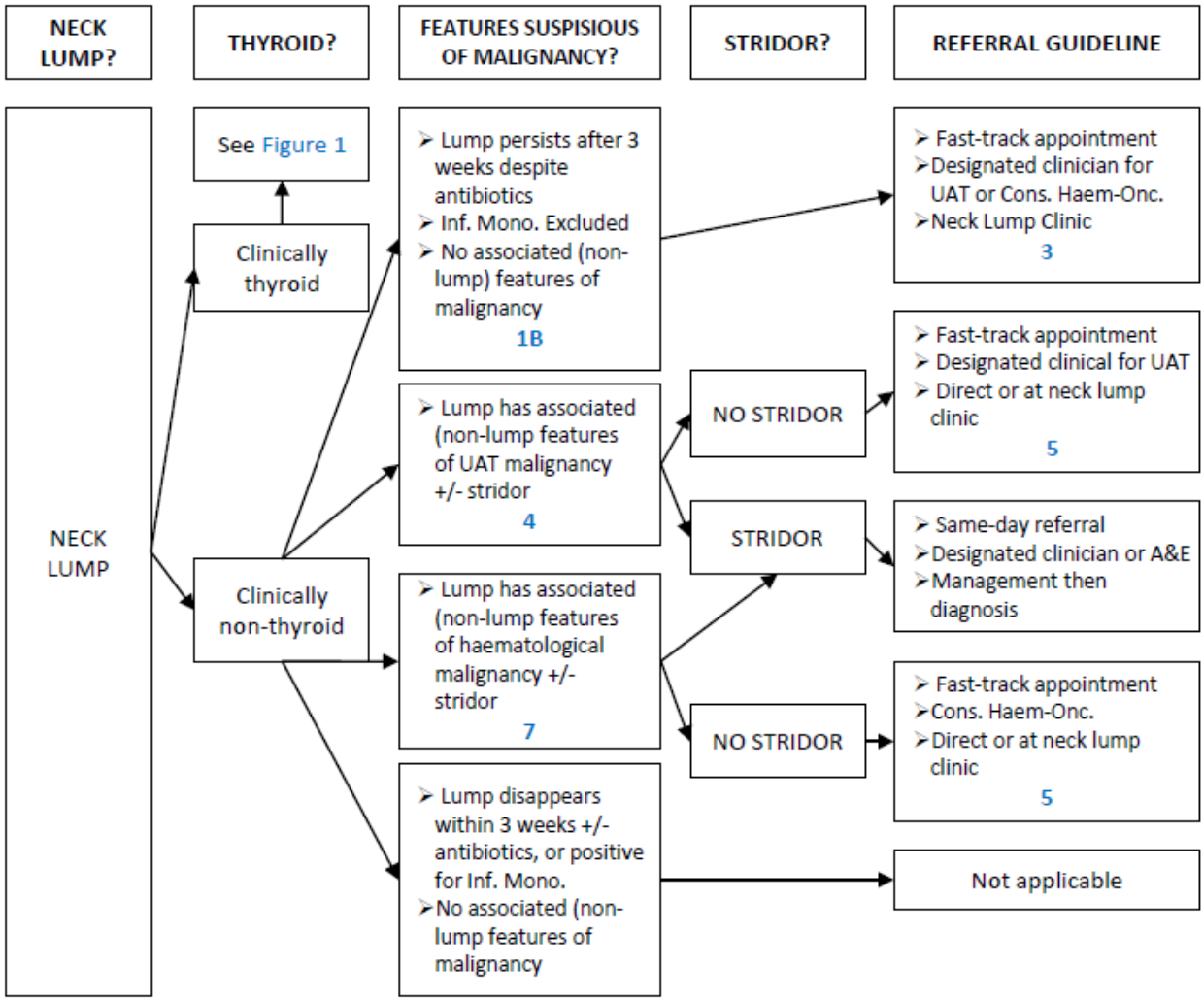
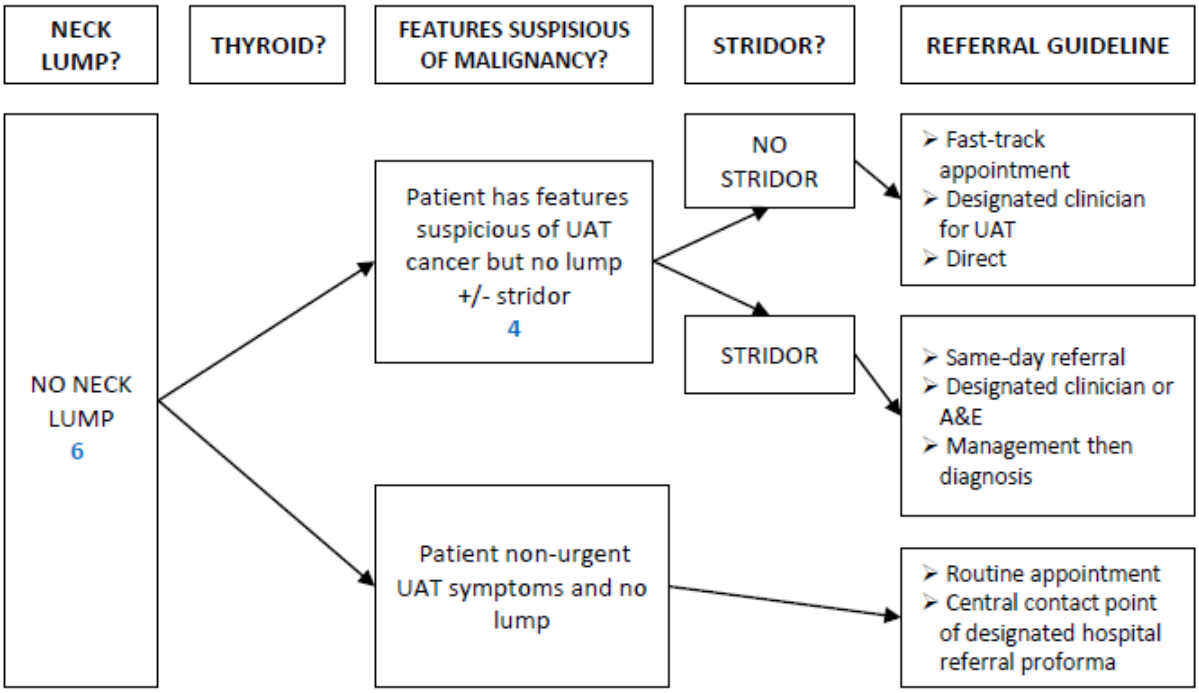


FIGURE 3: SCHEMA (Numbers refer to numbered footnotes)



Notes to numbered points on Figures 1-3

1A Features suspicious of cancer associated with a thyroid lump (reference: guidelines for the management of thyroid cancer in adults, 2002, British Thyroid Association and Royal College of Physicians):

- Solitary nodules increasing in size;
- Patient has history of neck irradiation or family history of thyroid cancer;
- Patient over 65;
- Unexplained hoarseness or voice change associated with a goitre;
- Associated cervical lymphadenopathy.

1B Features suspicious of cancer associated with the non-thyroid neck lump itself (reference: Department of Health Referral Guidelines for the Diagnosis of Cancer, reviewed 2005):

- Persists for three weeks despite antibiotics;
- Infectious Mononucleosis excluded.

2 Depending on network-agreed local arrangements, designated clinicians for UAT assessment may also be designated for thyroid assessment and the services may be provided in one common, neck lump clinic; or endocrinologists/endocrine surgeons may be designated for assessment of thyroid cancer only and work in a specific thyroid clinic.

3 See measure 11-1D-102i regarding the requirements for common working between designated clinicians for UAT cancer assessment and consultant haemato-oncologists.

4 Features suspicious of UAT cancer which are not features of the lump itself (reference: Department of Health Referral Guidelines for the Diagnosis of Cancer, revised 2005):

- Hoarseness for more than six weeks;
- Oral mucosal ulcer persisting for more than three weeks;
- Oral swelling persisting for more than three weeks;
- Red or red and white patches of the oral mucosa;
- Dysphagia for more than three weeks;
- Unilateral nasal obstruction, especially with purulent discharge;

- Unexplained tooth mobility, not associated with periodontal disease;
- Cranial neuropathies;
- Orbital masses.

5 Referral to a neck lump clinic or direct to a designated clinician is at the discretion of the referrer depending on the nature of the presenting features.

6

- In the absence of a thyroid lump, there are unlikely to be any other head and neck features which would discriminate towards thyroid cancer compared to UAT cancer. Stridor is dealt with independently.
- Features of haematological malignancy, without neck lumps are not relevant to head and neck specific guidelines.
- The very rare cases of UAT and thyroid cancer presenting only with features due to distant metastases are not covered by these guidelines. They are better dealt with as part of guidelines on the diagnosis and management of a separate entity "carcinoma of unknown origin".

7 Features suspicious of haematological malignancy (reference: Department of Health Referral Guidelines for Suspected Cancer).

Network Agreed Referral Proformas

11-1A-207i There should be a referral proforma, the format of which is agreed across the network, which fulfils the following criteria:

- it is used for patients with UAT symptoms which are outside the 'urgent suspicion of cancer' definition (reference: Department of Health Referral Guidelines for the Diagnosis of Cancer), and who have no neck lumps;
- it allows for the referrer to categorise a patient by presenting features, so that the hospital can direct the referral to the relevant specialty (e.g. ENT, OMFS);
- the network-wide format is made locally specific by identifying a single referral point for each designated hospital to which proformas can be sent for direction to individual specialists.

Note:

The network may also agree the proforma method for urgent referrals of patients suspected of having cancer, according to the primary care referral guidelines. This is not subject to review.

Compliance: The referral proformas, localised for each designated hospital, agreed by the Chair of the Network Board and the Chair of the NSSG.

The reviewers should enquire of the working practice of the network.

Internal Referral Guidelines for Non-Designated Hospital Clinicians

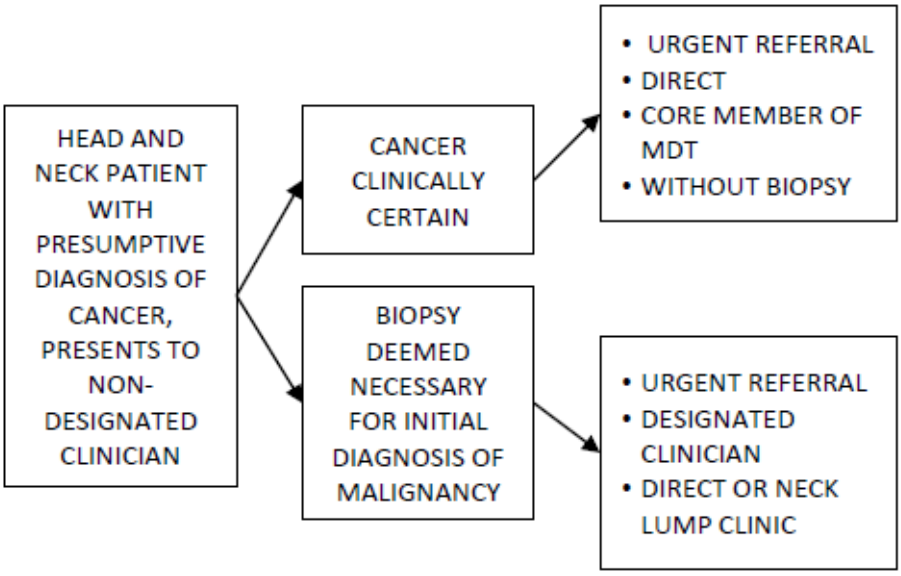
11-1A-208i The Network Board, in consultation with the head and neck NSSG, should agree internal referral guidelines for non-designated hospital clinicians, for the onward referral of patients presenting with features suspicious of head and neck cancer.

The guidelines should follow the schema illustrated in figure 4.

The guidelines should mention locally specific, named, designated clinicians.

The schema itself, or a compatible one, would be considered as compliant guidelines.

FIGURE 4 SCHEMA



Internal referral guidelines for hospital clinicians - head and neck cancer presenting to non-designated clinicians.

The internal referral guidelines should be distributed to at least the following in the network:

- designated consultant clinicians;
- non-designated head and neck consultant clinicians (ENT surgeons, endocrine surgeons, OMFS surgeons, oral medicine specialists);
- endocrinologists.

Compliance: The guidelines agreed by the Chair of the Network Board and the Chair of the NSSG.

The reviewers should enquire of the distribution process.

Note:

It is not necessary to make an exhaustive check on this. Minor shortcomings in the completeness of distribution should not prevent compliance.

Network/PCT Agreed Referral Policies Thyroid Lumps.

11-1A-209i The Network Board, with PCT leads and the NSSG, should agree the named PCTs or individual primary care medical practices, which will refer patients with lumps clinically of thyroid origin, to which named, designated hospitals, one practice referring to only one hospital.

Notes:

- *The principle of a given primary care practice or PCT, stating that patients will be referred to a given, designated hospital, is not intended to restrict patient or GP choice. A rational network of diagnostic and treatment services can only be developed if:*

  i) *there is an agreement on which hospital the patients will normally initially be referred to, and which MDT they will then normally be referred to for treatment, and*

  ii) *the resulting referral catchment populations are counted once, for planning purposes.*

- *This measure is required for review purposes only for thyroid cancer, since there is a requirement in the head and neck IOG for a minimum referring catchment population*

for thyroid MDTs (one million) but not for UAT MDTs.

- *It is accepted that individual patients with thyroid lumps will, on occasion, be referred to different hospitals and MDTs depending on specific circumstances.*

Compliance: The list of named, designated hospitals receiving referrals of patients with thyroid lumps, and the list of each hospital's named referring PCTs or individual practices, agreed by the Chair of the Network Board, Chair of the NSSG and network PCT leads.

Network Agreed Named Hospital for Surgical Treatment Delivery

11-1A-210i The Network Board should agree in consultation with the NSSG and the chairs of the locality groups in the network, certain hospitals where the curative surgical treatment for head and neck cancer will take place. The hospitals should each fulfil the following criteria:

- they should be a designated hospital for the diagnostic and assessment service.
- they should be the hospital where one or more named MDTs carry out all their curative surgical procedures for head and neck cancer;
- they should have a designated head and neck ward.

Notes:

- *Not all designated hospitals need to be hospitals where MDTs perform curative surgery but all such hospitals should be designated hospitals.*
- *This measure does not **mandatorily** apply to simple, complete excision biopsies performed by the diagnostic and assessment service for the diagnosis of T_1 lesions and which are thought to be sufficient for cure.*
- *Similarly, this measure does not **mandatorily** apply to thyroidectomies for thyroid cancer. However, simple excision of T_1 lesions and thyroidectomies **may be** carried out in the hospitals designated for surgical treatment delivery.*

Compliance: The list of named hospitals and the specified head and neck wards with the named MDTs associated with each hospital agreed by the Chair of the Network Board, the Chair of the NSSG and the chairs of the locality groups.

Notes:

Each MDT should be associated in this way with only one named hospital.

The actual provision of the ward facilities is the responsibility for review purposes of the relevant locality group, in topic 1D.

All locality group chairs should agree the list, whether or not their locality hosts one of the listed hospitals.

The board, for its compliance, should produce the network distribution of operating hospitals. The individual MDTs, for compliance with the relevant team measure, should operate only in the agreed hospital.

Network MDT Configuration

11-1A-211i The Network Board should agree in consultation with the NSSG and the lead clinicians of each trust in the network, the list of named MDTs and their locations in the network, stating for each MDT, which team type it is in terms of the following types of case mix it deals with:

i) UAT MDT without the additional tumour types outlined below in (ii);
ii) UAT MDT also dealing with one or more of: salivary gland tumours, UAT cancer involving the skull base, thyroid cancer (naming the additional cancer types for each MDT);
iii) thyroid cancer (endocrine) only MDT.

This list of MDTs with their case mix types and their locations is the network MDT configuration for head and neck cancer.

Each MDT should comply with the team criteria relevant to its case-mix type as listed in the introduction to the head and neck measures.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The network MDT configuration agreed by the Chair of the Network Board, the Chair of the NSSG and the trust lead clinicians. Evidence of team criteria is self-evident from: • the number of teams of a given type and their locations; • the named facilities and services of the host trusts; • the team members and the designated clinicians who provide the diagnostic and assessment service to the local catchment of the MDT. *Note:* *The catchment populations of thyroid cancer MDTs are dealt with in a separate measure below.*
Catchment Population & MDTs Dealing with Thyroid Cancer	
11-1A-212i	The Network Board should agree, in consultation with the NSSG and the lead clinician of each MDT dealing with thyroid cancer, the catchment population for referral to each of these teams. This should be a minimum of one million. The population should be estimated in each case from the referring catchment populations of their referring designated hospitals and their own local catchment population. *Note:* *All MDTs in a network dealing with thyroid cancer should be offered for review against this measure if there is more than one such team in, say, the larger networks.*
Compliance:	The named MDTs dealing with thyroid cancer, in the network, with the relevant catchment populations agreed by the Chair of the Network Board, Chair of the NSSG and relevant MDT lead clinicians. *Notes:* *When the team receive referrals from other networks, as agreed in network guidelines, the catchment population of the referring network should be counted towards the total catchment population of the receiving team in the receiving network.* *The catchment populations should count once and for only one network's compliance.* *For the board to comply with this measure, all thyroid MDTs in the network should have a catchment population of one million or more.*
LOCAL SUPPORT TEAMS	
Distribution of Local Support Teams in the Network	
11-1A-213i	The Network Board should, in consultation with the NSSG, agree with the locality groups the distribution of local support teams in the network, for patients with head and neck cancer. The distribution should fulfil the following: • one or more teams should be established by each designated hospital for head and neck cancer in the network; • each team should cover a named geographical area; • the whole network should be covered by means of such areas. *Notes:* • *The role of the local support team in the care of patients with head and neck cancer is dealt with in measure below.* • *Each locality group which establishes a team will be subject to review against the measures in relating to such teams, applied separately to each team they establish.* • *There are no measures relating to the total number of teams per network or the size of the area covered by a team, but the IOG for head and neck cancer, in estimating the cost of building the head and neck network, uses an illustrative figure of four to six teams for a network of 1.5 million population (rounded to whole team numbers).*
Compliance:	The named teams, with their respective associated designated hospitals and areas covered, agreed by the Chair of the Network Board, Chair of the NSSG and chairs of the

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	locality groups. *Note:* *The agreement should involve all locality group chairs including those whose locality does not host a local support team.*
The Role of the Local Support Team	
11-1A-214i	The Network Board in consultation with NSSG should agree with the locality groups, the role of the local support teams in the care of patients with head and neck cancer. The local support team should: • be the team, other than the MDT, which manages the aftercare and rehabilitation of head and neck cancer patients for a named geographical area of coverage; • work with head and neck cancer MDTs which deliver the definitive anti-cancer treatment and immediate support, and refer patients to the local support team; • work according to protocols agreed with the referring MDTs regarding which types of care are delivered by the local support team and for which parts of the patient care pathway (see the relevant MDT measure). *Note:* *The network may agree additional items for the local support team role. This is not subject to review.*
Compliance:	The role of the local support team, agreed by the Chair of the Network Board, the Chair of the NSSG and the chairs of the locality groups. *Note:* *The agreement should involve all locality group chairs including those whose locality does not host a local support team.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

REFERRAL GUIDELINES FROM THE DIAGNOSTIC AND ASSESSMENT SERVICE TO THE MDTS

Introduction

The Network Board, in consultation with the NSSG for head and neck cancer, should agree network-wide guidelines for designated clinicians and designated hospitals to refer patients with head and neck cancer to named head and neck MDTs. If there is a combined UAT/endocrine NSSG, all the guidelines should be agreed with it. If there is a UAT NSSG and a separate endocrine (thyroid cancer) subgroup, each of the groups should agree their respective set of guidelines with the board. For their compliance with these measures (topic 1A), the board should produce the guidelines and the individual MDT, for their compliance with the relevant MDT measures (topic 2I), should agree to abide by them. The compliance counts towards the review of the Network Board and the individual MDT.

UAT CANCER

The Guidelines for Referral of Patients with UAT

11-1A-215i

The Network Board should agree, in consultation with the NSSG, the guidelines for referral of patients with UAT cancer from the designated hospital(s) in the network to the MDTs for UAT cancer. The guidelines should specify:

- which named, designated hospital should refer to which named MDT(s);
- the single MDT to which patients with salivary gland cancer should be referred;
- the single MDT to which patients with UAT cancer, involving the skull base, should be referred.

Note:

The MDT(s) in question may be in a neighbouring network.

Compliance: The guidelines agreed by the Chair of the Network Board and the Chair of the NSSG. Where a MDT is in a neighbouring network, the guidelines should be agreed by the Chair of the Board of the receiving network.

THYROID CANCER

The Guidelines for Referral of Patients with Thyroid Cancer

11-1A-216i

The Network Board should agree, in consultation with the NSSG, the guidelines for referral of patients with thyroid cancer from the designated hospital(s) in the network to the MDT(s) for thyroid cancer. The guidelines should specify:

- which named designated hospital should refer to which named MDT.

A given designated hospital should refer only to one MDT.

Note:

The MDT in question may be in a neighbouring network.

Compliance: The guidelines agreed by the Chair of the Network Board and the Chair of the NSSG. Where a MDT is in a neighbouring network, the guidelines should be agreed by the Chair of the Board of the receiving network.

TOPIC 11-1C-1i - FUNCTIONS OF NETWORK SITE SPECIFIC GROUPS (NSSGs)

Introduction

The measures in this section should be applied separately to each NSSG in the network.

If a network has MDTs for any given cancer site, but has no NSSG, the results for this section, regarding that cancer site, should be classed as 'non-compliant'.

If a network has no MDTs for one of the six cancer sites covered by IOG-based measures, the results for this section, regarding that cancer site should be classed as 'not-applicable'.

Because of the varying requirements of the different IOGs the NSSGs have differing responsibilities, therefore the way the measures in this section apply differs between the various cancer sites. The responsibility for review purposes for measures dealing with the function of NSSGs lies with the chair of the group.

I. COMBINED UAT/ENDOCRINE (THYROID) NSSG

The following measures from The Manual for Cancer Services apply:

11-1C-101i, 11-1C-102i, 11-1C-109i - 11-1C-112i	Applied once to cover both UAT and thyroid related activities
11-1C-103i, 11-1C-113i	Applied twice, once for UAT and once for thyroid activities, the compliance from each counting separately
11-1C-105i, 11-1C-107i	Applied once - to cover UAT activities
11-1C-106i, 11-1C-108i	Applied once - to cover thyroid related activities

II. SEPARATE UAT NSSG AND THYROID SUBGROUP: Each group is reviewed separately and independently (Note a dublicated set of Measures will be applied to the thyroid subgroup).

The following measures from The Manual for Cancer Services apply:

11-1C-101i, 11-1C-102i, 11-1C-109i - 11-1C-112i	Applied once to each group
11-1C-103i, 11-1C-113i	Applied once to each group
11-1C-105i, 11-1C-107i	Applied once - to UAT group
11-1C-106i, 11-1C-108i	Applied once - to thyroid group

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
NSSG Should Meet Regularly and Record Attendance	
11-1C-101i	The NSSG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed in the measures of the MDT.*
Compliance:	A list of meetings and attendance records in the last 12 months.
GENERAL ACTIVITIES	
The Annual Review, Work Programme and Annual Report	
11-1C-102i	The Chair of the NSSG should have an annual review with the Network Lead Clinician and/or appropriate member of the Network Board. The NSSG should have agreed an annual work programme with the board. The NSSG should have produced an annual report for the board.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
Compliance: Documentation sufficient to show that a review meeting took place with the Network Lead Clinician and/or an appropriate member of the Network Board. The annual work programme agreed by the Chair of the NSSG and Chair of the Network Board. The annual report agreed by the Chair of the NSSG and the Chair of the Network Board. *Note:* *This should be face to face. An email is not an acceptable mechanism for the review.*
CLINICAL GUIDELINES
Introduction The responsibility for review purposes for the network guidelines measures lies with the team lead clinician, the NSSG and Chair of the Network Board. For their compliance with this measure the NSSG should produce the guidelines, and the individual MDTs, for their compliance with the relevant team measures, should agree to abide by them. Network guidelines should be reviewed at least every three years or when new guidance is available. The measures count towards the review of the NSSG and the individual team.
Network Agreed Clinical Guidelines
11-1C-103i The NSSG should agree network-wide clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques). *Notes:* *More details of regimens and techniques may be agreed if desired.* *Compliance:* The clinical guidelines agreed by the Chair of the NSSG and the Chair of the Network Board.
The following measure is applicable to the UAT NSSG where there is a thyroid cancer sub group.
Agreed Membership of the Thyroid Subgroup
11-1C-104i The NSSG should agree the membership of the thyroid subgroup, a named chair of the subgroup and terms of reference between the subgroup and the NSSG. *Compliance:* The thyroid subgroup membership terms of reference and the named chair, agreed by the Chair of the NSSG. *Note:* *The documentation for compliance for the measures in topic 1C applied to the thyroid subgroup may be authorised (where authorisation is applicable) by the Chair of the NSSG or the Chair of the thyroid subgroup.*
IMAGING GUIDELINES
Introduction These measures should be applied to the relevant group if there is a separate NSSG for UAT and thyroid cancer subgroup. For their compliance with these measures the NSSG should, in consultation with the MDTs and the Network Imaging Group, produce the network-wide imaging guidelines. Each individual, relevant MDT, for their compliance with the relevant measure on imaging guidelines in the MDT section, should agree to them. The guidelines should be distributed to the designated clinicians.
Network Agreed Imaging Guidelines for UAT Cancer
11-1C-105i The NSSG should agree the network-wide imaging guidelines for the diagnosis and assessment of UAT cancer, including salivary gland cancers and UAT cancer involving the skull base. The guidelines should address: • imaging modalities; • their specific indications; • which parts of the imaging protocol should be the responsibility of the diagnostic and assessment service and which should be that of the MDT;

- the guidelines should be distributed to the designated clinicians for diagnosis and assessment of UAT cancer.

Note:

Where designated clinicians who are also members of the MDT are involved, this last point is less relevant.

Compliance: The imaging guidelines for UAT cancer agreed by the Chair of the NSSG and the Chair of the Network Board.

Network Agreed Imaging Guidelines for Thyroid Cancer

11-1C-106i The NSSG should agree the network-wide imaging guidelines for the diagnosis and assessment of thyroid cancer. The guidelines should address:

- imaging modalities;
- their specific indications;
- which parts of the imaging protocol should be the responsibility of the diagnostic and assessment service and which should be that of the MDT;
- the guidelines should be distributed to the designated clinicians for the diagnosis and assessment of thyroid cancer.

Note:

Where designated clinicians who are also members of the MDT are involved, this last point is less relevant.

Compliance: The imaging guidelines for thyroid cancer, agreed by the Chair of the NSSG and the Chair of the Network Board.

PATHOLOGY GUIDELINES

Introduction

These measures should be applied to the relevant group if there is a separate NSSG for UAT and thyroid cancer subgroup. For their compliance with these measures, the NSSG in consultation with the MDTs and the network pathology group, produce the network-wide pathology guidelines. Each individual, relevant MDT, for their compliance with the relevant measure on pathology guidelines in the MDT section, should agree to them. The guidelines should be distributed to the designated clinicians.

Network Agreed Pathology Guidelines for UAT Cancer

11-1C-107i The NSSG should agree the network-wide pathology guidelines for the diagnosis and assessment of UAT cancer, including salivary gland cancers and UAT cancer involving the skull base. The guidelines should address:

- laboratory and histopathological/histochemical investigations;
- their specific indications;
- which parts of the investigational protocol should be the responsibility of the diagnostic and assessment service and which should be that of the MDT;
- the guidelines should be distributed to the designated clinicians for UAT cancer;
- a requirement that there should be prior discussion of the case with an oncologist or haemato-oncologist (which one, at the clinician's discretion) before core or excisional biopsies of non-thyroid neck lumps are carried out.

Note:

Where designated clinicians who are also members of the MDT are involved, this last point is less relevant.

Compliance: The pathology guidelines for UAT cancer agreed by the Chair of the NSSG and the Chair of the Network Board.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
Network Agreed Pathology Guidelines for Thyroid Cancer
11-1C-108i The NSSG should agree the network-wide pathology guidelines for the diagnosis and assessment of thyroid cancer. The guidelines should address: • laboratory and histopathological/histochemical investigations; • their specific indications; • which parts of the investigational protocol should be the responsibility of the diagnostic and assessment service and which should be that of the MDT; • a policy whereby any diagnostic biopsy sample that shows or is thought to show thyroid cancer is sent for review to a histopathologist core member of the thyroid MDT; • the guidelines should be distributed to the designated clinicians for thyroid cancer. *Note:* *Where designated clinicians who are also members of the MDT are involved, this last point is less relevant.* *Compliance:* The pathology guidelines for thyroid cancer agreed by the Chair of the NSSG and the Chair of the Network Board.
Network Agreed Policy For Named Surgeons Authorised to Perform Lymph Node Resections
11-1C-109i The NSSG should in consultation with all the MDTs in the network (UAT, combined UAT/thyroid or thyroid) produce a policy regarding which named surgeons in the network are authorised to perform lymph node resections on thyroid cancer patients. *Notes:* i) *Any surgeon so authorised, should be a core member of a UAT MDT or combined UAT/thyroid MDT or thyroid MDT. (They may be a member of more than one MDT).* ii) *This measure does not apply to the simple excision of lymph nodes for diagnosis.* iii) *Where a network receives referrals of thyroid cancer patients from another network, the consultation should include the MDTs from the referring network, and if relevant, naming surgeons in that network.* *Compliance:* The policy naming the surgeons, including if relevant any surgeons from referring networks, agreed by the Chair of the NSSG and the lead clinician of each MDT including, if relevant, the lead clinicians of the MDT(s) in the referring network. *Note:* *The NSSG for its compliance, should produce the policy and each individual MDT should agree to abide by it for it's compliance with measure 11-2I-146.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Agreed Network Wide Minimum Dataset

11-1C-110i The NSSG should agree a network-wide minimum dataset (MDS). The MDS should include the data items required for:

- the cancer waiting times monitoring, including Going Further on Cancer Waits, in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Services;
- the Cancer Registration Dataset as specified in the National Contract for Acute Services.

The MDS must include all items required for the national contract, any additional items should use definitions and codes taken from the National Cancer Dataset and the NHS Data Dictionary.

Note:

The NSSG may agree additional data items.

The NSSG should agree a network-wide policy specifying:

- which team should collect which portion of the MDS;
- when each data item should be captured on the patient pathway;
- how the data will be stored and managed within local data systems.

Compliance: The MDS and policy for collection agreed by the Chair of the NSSG and the Chair of the Network Board.

Note:

The NSSG for their compliance with this measure should, in consultation with the MDTs, agree the MDS, and the individual MDTs, for compliance with their relevant measure, should agree to collect it and abide by it.

NETWORK AUDIT

Introductory Notes

For review purposes a network audit project is an audit project related to the cancer site or sites of the NSSG and the activities of its MDTs. The same project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified.

The individual MDTs, for compliance with their relevant MDT measure, should agree to participate in the audit.

Network Audit

11-1C-111i The NSSG should agree at least one network audit project with the Network Board.

Notes:

Additional projects may be agreed.

The NSSG should annually review the progress of the network audit project or discuss the results of the completed network audit project.

Compliance: The audit agreed by the Chair of the NSSG and the Chair of the Network Board.

Written confirmation of an annual review sufficient to show compliance with the measure.

Agreed NSSG Three Year Service Delivery Plan

11-1C-112i The NSSG should agree proposed service developments for its cancer site for the three contracting years, as advice to the board, for the network proposed service delivery plan.

Compliance: The plan agreed by the Chair of the NSSG.

Discussion of Clinical Trials

11-1C-113i The NSSG should discuss at least annually, the report on clinical trials from each of its MDTs (see relevant MDT measures).

The following should be present at the discussion:

- the Chair of the NSSG or a nominated representative;
- the NSSG research lead
- the lead clinician of the MDT or nominated representative from that MDT;
- the clinical lead of the research network or a nominated representative from the research network.

A programme for improvement for clinical trial entry for the MDT should be agreed at the discussion.

Compliance: Confirmation of discussions, sufficient to show compliance with the measure, including those present.

The programmes for improvement, agreed by the lead clinicians of the MDTs and the clinical lead for the cancer research network.

Notes:

The discussion with various individual MDTs may take place at different meetings of the NSSG. All of the MDTs of the NSSG need to have attended such a meeting for the measure to be compliant.

CHEMOTHERAPY TREATMENT ALGORITHMS

Introduction

- 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 the definition of a regimen narrower, but not wider.
- 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 ranges of regimen options for named steps 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 in the chemotherapy measures. There may be other formats which would be acceptable to the reviewers. Thus, a change of regimen or order of regimens may no longer comply with a previous treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply.

Chemotherapy Treatment Algorithms

11-1C-114i The NSSG, in consultation with the Network Chemotherapy Group (NCG) should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.

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 NSSG should produce the algorithms for its compliance with this measure and the chemotherapy multi-professional team should produce a compatible list of algorithms for the NSSG's cancer site for their own service (measure 11-3S-122).*
- *The chemotherapy multi-professional team should agree lists with all the NSSGs 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 NSSG agreed list.

- *This exercise should include oral chemotherapy.*
- *This measure is assessed as part of the responsibility of each NSSG, but from the NCG'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.*

Compliance: The algorithms in place prior to the self assessment/peer review visit agreed by the Chair of the NSSG, and the Chair of the NCG.

For NSSGs meeting for three or more years since the publication of the measures, the algorithms are needed from the first year, then the agreed updates every two years up to the self assessment/peer review visit.

The TYACN Pathway for Initial Management

11-1C-115i The NSSG should agree, with the chair of the relevant TYACNCG, the TYACN patient pathway for initial management, including any features specific to the NSSG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

The NSSG should distribute the pathway to the lead clinicians of the MDTs of their cancer site in their host cancer network.

Compliance: The pathway, agreed by the Chair of the NSSG and the chair of the relevant TYACNCG.

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

The TYACNCG should, for compliance with their relevant measure, produce the pathway and the NSSG, for compliance with this measure, should agree to abide by it, add local contact points and distribute it.

The TYA Pathway for Follow Up on Completion of First Line Treatment

11-1C-116i The NSSG should agree, with the chair of the relevant TYACNCG the TYACN patient pathway for follow up on completion of first line treatment including any features specific to the NSSG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

The NSSG should distribute the pathway to the lead clinicians of the MDTs of their cancer site in their host cancer network.

Compliance: The pathway, agreed by the Chair of the NSSG and the chair of the relevant TYACNCG.

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

The TYACNCG should, for compliance with their relevant measure, produce the pathway and the NSSG, for compliance with this measure, should agree to abide by it, add local contact points and distribute it.

TOPIC 11-1D-1 FUNCTIONS OF THE LOCALITY GROUP

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility for the purposes of peer review, for measures 11-1D-101i to 11-1D-108i, lies with the lead clinician of the host trust.

PROVISION OF LOCAL SUPPORT TEAMS

Introduction to the next two measures

These measures should be applied to the trusts which, according to the network agreement (topic 1A: cancer networks - head and neck specific measures), should establish local support teams in their locality. They should be applied separately for each support team in the locality.

If the trust is not agreed as providing a local support team, these measures are not applicable. If the group is agreed as having to provide a team but has not provided one, these measures should be applied but counted as non-compliant. If it has provided, say, one team for a part of the catchment area but not fulfilled the agreement to provide a second team for another part, it would be counted as non-compliant with these measures regarding the 'missing' team, but these measures should still be applied regarding the team which has been provided and compliance regarding that team should be judged accordingly.

Named Members of the Local Support Team

11-1D-101i There should be a named local support team as agreed by the Network Board, and the team should have the following named members, each of which should have responsibilities for the aftercare and rehabilitation of head and neck cancer patients in the team's geographical area, listed as part of their list of responsibilities or job description:

- clinical nurse specialist;
- speech and language therapist;
- dietician;
- nurse responsible for the management of stomas (tracheostomies and gastrostomies), nasogastric tubes and tracheo-oesophageal valves;
- dental hygienist;
- a person agreed as responsible for the psychological support of head and neck cancer patients;
- physiotherapist;
- occupational therapist;
- social worker.

Note:

- *The member's role in the team need not occupy the whole of their list of responsibilities or job description.*
- *Members may be shared between more than one team, provided this is agreed between the team member and the Locality Group Chair.*
- *The role of clinical nurse specialist should be fulfilled by a different person than the nurse responsible for stoma care.*
- *The list of responsibilities of the stoma care nurse should explicitly include all the tasks specified in the measure above.*
- *The team may choose to name additional team members, but this is not subject to assessment.*
- *The clinical nurse specialist should be a core nurse member of a UAT or UAT/thyroid MDT. They need not directly carry out specialist nursing tasks on behalf of the local support team, but they may instead, act in an advisory, teaching and co-ordinating role, delegating specialist nursing tasks to named local nurses. The latter may be named as additional local team members, if desired.*
- *The speech and language therapist and dietician, named as local team members may themselves be core members of a UAT or UAT/thyroid MDT, or they may have their role in the local support team delegated to them by the MDT member, who*

need not be in the local team.

- *Full description (for illustration, not for assessment) of the roles of clinical nurse specialist, speech and language therapist and dietician in both the MDT and the local support team may be found in the NICE IOG for head and neck cancer, pg 43, 44, 45, 93, 94 and 95.*

The named local support team should have at least two head and neck cancer patients who have agreed to have their names listed in the membership, as willing to provide support to other patients in the team's geographical area of coverage.

Note:

- *Two is the minimum number, since they will need to be a support to each other in the role.*

Compliance: The agreed network distribution of local support teams, identifying the team under review, agreed by the trust lead clinician.

The named team members for the named team agreed by the trust lead clinician.

The lists of responsibilities or job descriptions agreed by the members' line managers.

The names of the local patients for the named team agreed by the trust lead clinician.

PROVISION OF NECK LUMP CLINICS

Introduction

The same considerations regarding applicability and compliance of the measures, which are outlined in the introduction to the section on provision of local support teams, are relevant to the measure on provision of neck lump clinics. The measure applies to those trusts who should host a neck lump clinic as agreed in the network distribution of neck lump clinics (topic 1A - cancer networks - head and neck specific measures).

Provision of Neck Lump Clinics

11-1D-102i There should be a clinic in the designated hospital as agreed by the network. The clinic should fulfil the following:

It should:

i) be identified on the hospital outpatient department clinic list or timetable as a clinic for patients with neck lumps;
ii) be named, with a contact number given, as the neck lump clinic for that named designated hospital, in the network primary care referral guidelines;
iii) have bookable clinic slots specified for patients referred with neck lumps;
iv) have one or more consultant designated clinicians for UAT and one or more consultant haemato-oncologists with direct patient care sessions timetabled for the clinic;
v) offer fast-track appointments;
vi) offer a service whereby an FNA sample may be taken from the patient, and the clinic informed on the same day by the lab, that the sample is adequate or not, giving time for the sample to be repeated on the same day;
Note: The histological reporting of the sample need not be completed on the same day;
vii) be held weekly;
viii) offer flexible endoscopy as the initial investigation of isolated neck lumps.

Note:

Providing the measure is fulfilled, the clinics may physically take place as part of more general clinics.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The network agreed distribution of neck lump clinics, agreed by the trust lead clinician and identifying the clinic under review. Hospital outpatient department timetable or clinic list. The network primary care referral guidelines. Clinic booking rules. Consultant or departmental work plans or timetables. Reviewers should enquire of the working practice of the clinic.

PROVISION OF CLINICS FOR PATIENTS REFERRED WITH THYROID LUMPS

Introduction

The same consideration regarding applicability and compliance of the measures, which are outlined in the introduction to the section on provision of local support teams, are relevant to the measure on provision of thyroid lump clinics. The measure applies to those trusts who should host a clinic for referral of patients with thyroid lumps as agreed in the network distribution of thyroid clinics (topic 1A - cancer networks - head and neck specific measures).

Provision of Thyroid Clinics

11-1D-103i

There should be a regular clinic in the designated hospital for referral of patients with thyroid lumps as agreed by the network.

It should be:

Either

a neck lump clinic fulfilling the measures for the integrated clinic or non-haematological part of the parallel clinics, in addition:

i) it is listed in the outpatient department as a clinic for referral of neck lumps *including those referred as of thyroid origin;*
ii) it is named in the primary care referral guidelines as receiving referrals of neck lumps *including those referred as of thyroid origin;*
iii) the bookable slots should be specified as being for patients with neck lumps *of thyroid as well as non-thyroid origin;*
iv) it should have one or more consultant designated clinicians for thyroid cancer (who may also be designated for UAT) with direct patient care sessions timetabled for the clinic.

Or

a specialised thyroid clinic for referral of neck lumps thought only to be of thyroid origin, the clinic being listed as such in the outpatient department and the primary care referral guidelines; having bookable slots specified only for lumps suspected to be of thyroid origin and designated clinicians for thyroid cancer only; and being held at a frequency agreed with the NSSG.

Otherwise it should fulfil the rest of the measure as for the neck lump clinic.

Compliance: The network agreed distribution of thyroid clinics, agreed by the trust lead clinician and identifying the clinic under review.
Hospital outpatient department timetable or clinic list.
The network primary care referral guidelines.
Clinic booking rules.
Consultant or departmental work plan or timetable.
Reviewers should enquire of the working practice of the clinic.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

DESIGNATED CLINICIANS

Introduction

These measures apply to those trusts who hosts a designated hospital according to the network agreement. The measures should be applied once for each such hospital.

Designated Clinicians

11-1D-104i For the designated hospital there should be consultant clinicians named as designated clinicians for the diagnosis and assessment of head and neck cancer. The provision of designated clinicians should fulfil the following:

- where the hospital is specified in the primary care referral guidelines as receiving UAT referrals, there should be at least 2 designated clinicians for UAT cancer;
- where the hospital is specified as receiving thyroid referrals, there should be at least 2 designated clinicians for thyroid cancer;

Each designated clinician in the hospital should fulfil the following criteria, as relevant:

- those designated for UAT cancer diagnosis and assessment should be consultant ENT surgeons or consultant OMF surgeons;
- those designated for thyroid cancer diagnosis and assessment should be consultant thyroid surgeons (or general surgeons with a thyroid practice) or consultant endocrinologists or consultant ENT surgeons;
- all designated clinicians should be those named in the relevant parts of the network primary care referral guidelines and in the internal referral guidelines.

Notes:

- *Consultant ENT surgeons may be designated for both UAT and thyroid cancer.*
- *It may be seen that whatever the combination of specialties, a minimum of two designated clinicians are needed per hospital to fulfil the measure.*
- *A clinician may act as a designated clinician for more than one hospital.*

Compliance: The named designated hospital with its designated clinicians and their named specialties, agreed by the trust lead clinician.

The network primary care referral guidelines.

The internal referral guidelines.

PROVISION OF FACILITIES IN DESIGNATED OPERATING HOSPITALS

Introduction

These measures apply only to a locality group whose locality contains a designated operating hospital as agreed in measure 11-1A-201i. Each measure should be applied once for each such hospital in the locality if there is more than one.

HDU and ITU on Site

11-1D-105i The designated operating hospital should have a high dependency unit (HDU) and intensive therapy unit (ITU) on site in the hospital.

Compliance: The reviewers should enquire of the hospital's facilities.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Written Policy for a Named Specialist Head and Neck Ward	
11-1D-106i	The designated operating hospital should have a written policy whereby inpatients receiving care for head and neck cancer, when not on HDU or ITU, should be nursed on a named ward where it is agreed as part or all of the ward's regular activity and to which such patients are admitted in preference to other wards. This ward is referred to as the specialist head and neck cancer ward. There should only be one specialist head and neck cancer ward per hospital. *Note:* *Wards with stricter ward use policies, e.g. wards reserved exclusively for head and neck cancer patients, are also considered compliant with this measure.*
Compliance:	The policy, naming the ward, agreed by the trust lead clinician and the relevant hospital manager. *Note:* *The reviewers should verify that there is only one such ward.*
Registered Nurse Staffing	
11-1D-107i	The designated operating hospital's specialist head and neck ward should have a nursing establishment which allows, when up to establishment, for the ward to have at least one grade 5 registered nurse, trained in the care of tracheostomies, on duty at all times. *Note:* *The concept of nursing establishment is used since sick leave and maternity leave etc, precludes a spot check of staff on duty at a visit, being used to judge compliance.*
Compliance:	The staffing rota of the specialist head and neck ward naming the relevant nurses, agreed by the trust lead clinician and the relevant nurse manager. The reviewers should enquire of the training of the nurses so identified.
Named Speech and Language Therapist	
11-1D-108i	The designated operating hospital's specialist head and neck ward should have time specifically allocated to the care of its patients in the list of duties or timetable of at least one speech and language therapist (SLT) core member of a UAT MDT associated with the hospital. *Note:* *The actual amount of time is not subject to review, neither is the total possible number of SLTs.*
Compliance:	The timetable of the named SLT agreed by the trust lead clinician and the SLT's line manager.
Named Dietician	
11-1D-109i	The designated operating hospital's specialist head and neck ward should have time specifically allocated to the care of its patients in the list of duties or timetable of at least one dietician core member of a UAT MDT associated with the hospital. *Note:* *The actual amount of time is not subject to review, neither is the total possible number of dieticians.*
Compliance:	The timetable of the named dietician agreed by the trust lead clinician and the dietician's line manager.

TOPIC 11-2I-1 - UAT & UAT/THYROID MDT

Section 2I-1 - Upper Aero-Digestive Tract (UAT) and combined UAT and Thyroid Multidisciplinary Team

Introduction

An individual measure will relate to the UAT and thyroid practice of the team except where some are labelled 'relating to UAT cancer' and a separate section at the end is headed 'measures specific to thyroid cancer'.

When is a Team a Team, and when is it not a Team?

The measures review a variety of aspects of the team, both structure and function, but the key question which underlies all this is who exactly constitutes the MDT, from the point of view of the peer review? Which group of people should be put forward for review against these measures, and who is it who is held compliant or not compliant?

This is best answered from the patient's point of view. If you were a patient who would you consider to be your MDT?

Primarily it is that group of people of 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. They constitute that patient's MDT.

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 specific situation where a separate "diagnostic" meeting of a particular subset of the MDT membership filters out cases with benign conditions is dealt with where relevant by a specific measure. For some cancer types the IOG had laid down detailed requirements over how the diagnostic process should be incorporated into the MDT system and this has also been translated into the measures where applicable.

Two or more groups of people who may have declared an alliance to form a so-called "combined" MDT but who do not all meet together to collectively contribute to the decisions on a given patient as specified above, do not constitute an MDT from the point of view of peer review. Such alliances have been attempted in order to achieve, for instance, a minimum caseload or catchment population. This is not appropriate. Each separate group, meeting as specified above, should be assessed separately against such criteria.

In general the measures should be applied to that defined group, but there are some functions for which MDTs may combine in a way which is appropriate. Then, the evidence put forward to demonstrate their compliance with the relevant measures may serve as common evidence across the MDTs but it is applied separately and compliance is awarded separately to each of them.

The main examples of this are as follows:

- a combined operational policy meeting but the policies are agreed on behalf of each MDT by its lead clinician;
- network-wide clinical, referral, imaging and pathology guidelines, but each MDT agrees to abide by them;
- the same network-wide project for network audit, but each MDT agreeing to participate;
- a common minimum dataset but each MDT agrees to collect its portion of it;
- a network list of approved trials but each MDT agrees to enter patients;
- an individual health professional being a member of more than one MDT, but a particular defined and named set of people make up a given MDT.

As well as meeting to make the combined multidisciplinary decisions about patients, the members of some types of MDTs are required by the measures to carry out another key function in company with other specified personnel. Thus, some of the more complex surgical procedures should all be performed by the same group

of professionals - surgeon, anaesthetist and skilled theatre and aftercare staff. This is ensured by requiring services to be organised for that MDT so that all cases of a given procedure are performed in the same hospital. The people will largely be a different set of people from those who meet to make the diagnostic and treatment decisions (the MDT as defined in the measures) but they will directly relate to that MDT and be specified by it because at least one key functionary, the surgeon, will be a core member of that MDT.

In requiring all the complex procedures to be performed in the same hospital of the MDT, this ties in the referral catchment population of the MDT to that hospital. This provides a direct link between the referring catchment population for MDT **discussion,** and the **treatment caseload** of the treatment team and its hospital facilities.

UAT AND COMBINED UAT/THYROID MDT

MDT STRUCTURE

The responsibility for review purposes for measures 11-2I-101 lies with the lead clinician of the host trust.

Lead Clinician and Core Team Membership

11-2I-101

There should be a single named lead clinician for the MDT who should then be a core team member.

The lead clinician of the MDT should have agreed the responsibilities of the position with the lead clinician of the host trust.

Note:

The role of lead clinician of the MDT should not itself imply chronological seniority, superior experience or superior clinical ability.

The MDT should provide the names of core team members.

The core team specific to the UAT team should include:

- at least three surgeons;

  Notes:

  These would normally be drawn from the ENT, OMFS or plastic surgery specialities, to fit the case mix of the team. The exact combination is not subject to review but it should be noted that, regarding the case mix of the MDT, the team should be the only UAT MDT for its catchment area.

  There is a requirement for the skill of microvascular technique to be offered by at least one core or extended team member. This is logically dealt with by measure 11-2I-122.
- 2 clinical oncologists;
- medical oncologist (if the clinical oncologist does not undertake the responsibility for chemotherapy);

  Note: The MDT may also choose to have a medical oncologist as a core or extended team member when the clinical oncologist does have some responsibility for chemotherapy. This is not mandatory.
- histopathologist;
- cytopathologist;

  Note: The above two roles may be fulfilled by one person.
- radiologist;
- clinical nurse specialist;

Note:

For the purpose of peer review, compliance with this measure regarding the clinical nurse specialist is awarded if there is a nurse core MDT member who is put forward for review against the 'MDT nurse specialist' measures.

- head and neck cancer ward member of nursing staff at level of sister or charge nurse;

  Note:

  The nurse MDT member from the staff of the head and neck ward need not be put forward against the 'MDT nurse specialist measures'.
- speech and language therapist;
- dietician;
- MDT co-ordinator/secretary;
- 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 is integrated into the

function of the MDT.

Notes:

- *Each clinical core member should have sessions specified in the job plan for the care of patients with head and neck cancer and attendance at MDT meetings.*
- *The presence of a restorative dentist as a core member of the team is dealt with entirely separately in measure 11-2I-102. This issue is not relevant to compliance with this measure.*
- *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.*
- *The coordinator/secretary role needs different amounts of time depending on team workload. See appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial roles may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description.*
- *There may be additional core members agreed for the team besides those listed above.*

Compliance: Named lead clinician for the MDT agreed by the lead clinician of the host trust.

The written responsibilities agreed by the lead clinician of the MDT and lead clinician of the host trust.

Note:

See appendix 2 for an illustration of the responsibilities of this role.

Name of each core team member agreed by the lead clinician of the MDT.

Notes:

The reviewers should record in their assessment, each case where the post(s) needed to provide the minimum core membership for a given listed role in the measure, is unfilled or non-existent, or existing posts cannot provide the service. This does not refer to mere holiday or sickness absence, or less than 67% attendance, and it refers only to the core member roles listed in the measure, not additional roles that the MDT has decided locally to include as core members, e.g. From the list in the 'extended MDT' measure. The reviewers should identify particular missing roles and identify the particular MDT in the report.

These remarks do not apply to the presence or absence of a restorative dentist on the team, which is dealt with entirely separately in measure 11-2I-102.

Restorative Dentist Core Team Member

11-2I-102 The core team specific to the MDT should include a consultant restorative dentist.

Compliance: The named restorative dentist.

Note:

The attendance and 'cover' measures apply to this core member as for the rest of the team.

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

PSYCHOLOGICAL SUPPORT

Level 2 Practitioners for Psychological Support

11-2I-103 At least one clinical core member of the team should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	• *The relevant discipline 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.* • *The definition of the levels may be found in appendix 1 of the Psychological support measures.*
Compliance:	The named member. Written confirmation of completion of training agreed by the lead clinician of the MDT.
Support for Level 2 Practitioners	
11-2I-104	The level 2 practitioner(s) should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month.
Compliance:	Reviewers should enquire to ascertain that this is taking place.
Team Attendance at NSSG Meetings	
11-2I-105	The lead clinician of the MDT or representative should attend at least two thirds of the NSSG meetings.
Compliance:	The attendance record of the NSSG.
MDT Meeting	
11-2I-106	The MDT should hold its meetings weekly, and record core members' attendance, and have a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (Guidance only - e.g. letters, emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting). *Note:* *For combined UAT/thyroid cancer MDTs, thyroid cancer cases should be discussed at the weekly meetings as and when they are referred.*
Compliance:	Attendance records of the meetings. Written procedure agreed by the lead clinician of the MDT.
MDT Agreed Cover Arrangements for Each Core Member	
11-2I-107	The MDT should agree named cover arrangements for each core member. *Notes:* • *This refers to the nominating of staff who should **in general** be expected to provide cover for core members e.g. a specialist trainee or non-consultant career grade on a consultant's team or core members of the same discipline providing cover for each other. It does not refer to the member having to provide a person to cover for each and every absence. This aspect is dealt with by the attendance measure above.* • *Where a medical specialty is referred to, the cover for a core member need not be a consultant, but should be a specialist trainee or non-consultant career grade.*
Compliance:	Written arrangements agreed by the lead clinician of the MDT.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Core Members (or Cover) Present for 2/3 of Meetings

11-2I-108 Core members or their arranged cover should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT.

The reviewers should identify the particular roles where attendance is below the requirements of this measure.

Notes:

The intention is that core members of the team should be personally committed to it, reflected in their personal attendance at a substantial proportion of the meetings, not relying instead on their cover arrangements. Reviewers should use their judgement on this matter and should highlight in their report where this commitment is lacking.

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2I-109 Besides the regular meetings to discuss individual patients, the team should meet at least annually to discuss, review, agree and record at least some operational policies.

Compliance: Written confirmation of at least one meeting agreed by the lead clinician of the MDT to illustrate the recording of at least some operational policies.

Policy for All New Patients to be Reviewed by MDT

11-2I-110 There should be an operational policy for the team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan.

The policy should specify at what other stages in the patient pathway patients are referred back for discussion.

Compliance: The written policy agreed by the lead clinician of the MDT.

Policy for Communication of Diagnosis to GP

11-2I-111 The MDT should have agreed a policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis by the end of the following working day.

The MDT should have completed an audit against this policy of the timeliness of notification to GPs of the diagnosis of cancer.

Compliance: The written policy agreed by the lead clinician of the MDT.

The written results of the audit.

Operational Policy for Named Key Worker

11-2I-112 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 above policy should have been implemented for patients who came under the MDT's care after publication of these measures and who are under their care at the time of the peer review visit or annual self assessment.

Notes:

- *For information: according to the NICE palliative care guidance, a key worker is a person who, with the patient's consent and agreement, takes a key role in coordinating the patient's care and promoting continuity e.g. ensuring the patient knows who to access for information and advice. This is not intended to have the same connotation as the key worker in social work.*

- *It may be necessary to agree a single key worker across both a cancer site specific MDT and the specialist palliative care MDT for certain patients.*

Compliance: The written policy agreed by the lead clinician of the MDT.
Reviewers should spot check some of the relevant patients' case notes.

Operational Policy for Principal Clinician

11-2I-113

There should be an operational policy for the team whereby:

- at any one stage in the patient's journey, they should have a named clinical member of the MDT who is agreed as the principal clinician for the patient and to whom the patient primarily relates with regard to decision-making for their clinical management;
- the identity of the principal clinician should be made clear to the patient and their GP and recorded in their case notes.

The policy should have been implemented for patients who came under the MDT's care after publication of these measures and who are under their care at the time of the peer review visit or annual self assessment.

Notes:

- *It is expected that the principal clinician would be a consultant member of the MDT.*
- *The role of the principal clinician relates to that of key worker in that it would be a major part of the key worker's duties to ensure that the named principal clinician is identified and made known at each stage of the patient's journey.*

Compliance: The written policy agreed by the lead clinician of the MDT.
The reviewers should spot check some of the relevant patient's care notes.

Core Histopathology Member taking part in Histopathology EQA

11-2I-114

The core histopathologist member(s) of the MDT should be taking part in an EQA scheme, either a specialist scheme for the cancer site(s) of the team or a general EQA scheme which has a section covering the cancer site(s) of the team.

Compliance: Documentary evidence to show that they are taking part in a relevant EQA.
Note:
Their actual performance against the requirements of the EQA is not subject to peer review.

MDT NURSE SPECIALIST MEASURES

Introduction

Why are there currently "nursing measures" for MDTs, but no similar requirements for other MDT members?

The modern change to MDT working has created and then highly developed the specific role of nurse MDT members, with its related activities which, in full measure, go to make up the role of cancer nurse specialist. The roles of the medical specialties in the MDT have not been so profoundly influenced or so extensively developed by their MDT membership itself, compared to that of the MDT nurse specialists. The role definitions and training requirements of nurse MDT specialists are not "officially" established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were head and neck surgeons and palliative care physicians, before there were established head & neck MDTs and specialist palliative care teams).

Therefore a particularly strong need was perceived for using the measures to define more clearly the role of the nurse member and to set out minimum training requirements for nursing input into MDTs.

This is in order to establish these roles more firmly in the NHS infrastructure, and to avoid the situation where MDTs can comply with measures by having generalist nurses who "sit in" on MDT meetings and sign attendance forms but play no defining role in the team's actual dealings with its patients.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Core Nurse Member Completed Specialist Study

11-2I-115 Each core nurse specialist should have successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent.

Compliance: Confirmation of successful completion of the course/module.

Agreed List of Responsibilities for Core Nurse Members

11-2I-116 The MDT should have agreed a list of responsibilities, with each of the core nurse specialists of the team, which includes the following:

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings;
- providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice;
- involvement in clinical audit;
- leading on patient and carer communication issues and co-ordination of the patient pathway for patients referred to the team - acting as the key worker or responsible for nominating the key worker for the patient's dealings with the team.
- ensuring that results of patients' holistic needs assessment are taken into account in the decision making;
- contributing to the management of the service (see note below);
- utilising research in the nurse's specialist area of practice.

Notes:

- *"Management" in this context does not mean clerical tasks involving the documentation on individual patients i.e. this responsibility does not overlap with the responsibility of the MDT co-ordinator.*
- *A list of responsibilities containing all the elements in this measure and the previous measure would encompass all of the four domains of specialist practice required for the role of cancer nurse specialist.*
- *Additional responsibilities may be agreed.*

Compliance: The list of responsibilities agreed by the lead clinician of the MDT and the core nurse specialist(s).

Attendance on the National Advanced Communication Skills Training Programme

11-2I-117 At least those core members of the team who have direct clinical contact with patients should have attended the national advanced communications skills training.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *Also, it applies only with regard to members which are in place i.e. if a team lacks a given core member from that list, it should still be counted as compliant with this measure provided those members which are in place comply.*
- *The relevant disciplines include medical, surgical, nursing and allied health professionals.*
- *The reviewers should record which core members of those relevant are non-compliant.*

Compliance: Written confirmation of the MDT members who have attended the national advanced communications skills training programme.

Operational Policy Specifying Discharge Criteria

11-2I-118 There should be a policy agreed between the MDT and the local support teams it deals with, specifying the discharge criteria to be met before the patient is discharged from hospital. The criteria should include:

- an individually tailored rehabilitation plan, jointly agreed between the MDT and the relevant local support team, for each patient;
- the identification of a single named contact person for each patient, from the local support team, to act as the patient's own rehabilitation co-ordinator.

Compliance: The written policy agreed by the lead clinician of the MDT and a representative of each of the local support teams it deals with.

Note:

The MDT and the support teams may agree additional points for the policy. These are not subject to review.

Aftercare and Rehabilitation Protocol

11-2I-119 The MDT should agree a protocol with the local support teams specifying:

- which items of care for patients will be provided by the support teams and which by the MDT, and for which parts of the patient journey;
- indications for referral back to the care of members of the MDT, from the support team.

Compliance: The written protocol agreed by the lead clinician of the MDT and a representative of each of the local support teams it deals with.

Note:

The MDT and the support teams may agree additional points for the policy. These are not subject to review.

Clinical Follow Up Protocol

11-2I-120 The MDT should agree a protocol with its referring designated hospitals, specifying:

- who is responsible for follow up of patients between MDT members and designated clinicians who are not MDT members;
- which is the setting for follow up between the hospital hosting the head and neck ward and the referring designated hospitals.

Notes:

The follow up arrangements may be specific to individual cancer sites.

Compliance: The written protocol agreed by the lead clinician of the MDT and a representative, designated clinician from each of the designated hospitals.

Core Consultant Member spend 50% of Time on Care of UAT Cancer

11-2I-121 Each of the core consultant members of the MDT should spend 50% or more of their direct patient care sessions on the care of UAT cancer.

Note:

Where members treat UAT cancer and thyroid cancer, any direct patient care sessions devoted to thyroid cancer may count towards the 50%.

Compliance: The timetables or job plans of the consultant core members of the MDT.

Agreed Service Specification for Rescue of Reconstructive Surgical Flap Failure

11-2I-122 The MDT should agree a service specification and provide the service for the rescue of reconstructive surgical flap failure. The service specification should stipulate:

- it should be available 24 hours/day, 7 days/week, 365 days/year;
- it should be provided by consultant surgeons with training in microvascular surgical technique;
- the cover surgeons may be non-resident but should undertake to be available to operate as soon as the theatre staff and facilities are available;
- it is provided at the hospital where the MDT performs curative resections and where the specialist head and neck ward is sited.

Notes:

- *This would require a minimum of three consultant surgeons with microvascular skills staffing the cover rota.*
- *There may be additional points agreed in the specification, but these are not subject to review save as per the measure.*

Compliance: The service specification and the cover rota with named surgeons agreed by the lead clinician of the MDT.

The reviewers should enquire of the working practice of the hospital and of the training of the surgeons regarding microvascular skills.

Agreed Policy for Patient to Discuss Treatment Options

11-2I-123

The MDT should agree and be practising a policy that when the MDT's advice is that the patient has an open choice between different options for their initial treatment, those options should be presented to the patient in a multidisciplinary way i.e. the specialist responsible for each treatment modality - surgery, radiotherapy, chemotherapy, should make the case to the patient for their own modality as it is relevant to the treatment options, rather than one specialist presenting all the modalities. A clinical nurse specialist should be present.

Note:

'Clinical nurse specialist' is defined as in the notes in measure 11-2I-101.

Compliance: The policy agreed by the lead clinician of the MDT.

The reviewers should enquire of the working practice of the MDT.

Extended Membership of MDT

11-2I-124

The team should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members.

The named extended team for the MDT should include:

- anaesthetist;
- a health professional agreed as being the contact person for a specified gastrostomy and tube feeding service;
- ophthalmologist;
- consultant pain specialist;
- therapeutic radiographer;
- maxillo-facial or dental technician;
- dental hygienist;
- person agreed as providing benefits advice;
- health professional(s) agreed as providing psychological support to patients and carers;
- physiotherapist;
- occupational therapist;
- a core member of the specialist palliative care team.

Notes:

- *The anaesthetist should be the regular anaesthetist of one of the surgical members of the core MDT.*
- *The tube feeding service should be specified - by named hospital.*
- *Although there is not a requirement to have a named social worker as part of the extended team, there should be arrangements in place to access a social worker when required.*
- *The MDT may wish to name additional extended team members. This is not subject to review.*

Compliance: The name of each extended team member with their role agreed by the lead clinician of

the MDT.

PROVIDING PATIENT CENTERED CARE.

Patient Permanent Consultation Record

11-2I-125

The MDT should be giving 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:

- diagnosis;
- treatment options and plan;
- relevant follow up (discharge) arrangements.

Note:

The MDT may, in addition, offer a permanent record of consultations undertaken at other stages of the patient's journey.

The record of consultation should identify areas discussed during consultation and include a diagram where appropriate which supports the consultation discussion.

The consultation record provides a permanent summary of the discussion between the doctor and the patient and should always be offered to the patient unless specifically declined by the patient;

A record should be kept in the notes.

Compliance: The reviewers should enquire of the working practice of the team and see anonymised examples of records given to patients.

Note:

It is recommended that they are 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.

Patient Experience Exercise

11-2I-126

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.

The exercise should at least ascertain whether patients were offered:

- 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.

Notes:

- *The exercise may consist of a survey, questionnaire, focus group or other method.*
- *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.*

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.

Compliance: The results of the exercise.

A report for the action taken.

Provision of Written Patient Information for UAT Cancer

11-2I-127

The MDT should provide written material for patients and carers which includes:

- 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 sevices available to support the effects of living with cancer and dealing with its emotional effects.

It is recommended that the information and its delivery to patients and careers follow the principles of the NHS Information Prescription project.(www.informationprescription.info).

Notes:

- *The information prescription should be tailored to the patients/careers needs based on an information needs assessment. information may be generated and dispenced outside of the clinic environments within an information centre where where a clear operational policy between the clinic and information center are appropriate to providing such service.*
- *The information prescription should be composed to information from the national pathways supplemented with national and local accredited information.*

Compliance: The written, (visual and audio if used - see note below) material.

Note:

It is recommended that it 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.

For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.

Pre-treatment Assessment Sessions

11-2I-128 The MDT should have at its disposal sessions in the work programmes or timetables of its relevant staff (see below), identified as sessions when they are available for head and neck cancer patients to be seen and assessed in a multidisciplinary way, prior to the delivery of their initial definitive treatment.

The sessions should fulfil the following:

(i) They should be identified as pre-assessment sessions and should all be timetabled on the same half day or days for the specialists below:

- at least one surgical core member of the MDT;
- at least one oncology core member of the MDT;
- an SLT core member of the MDT;
- a dentist core member of the MDT;
- a dietician core member of the MDT;
- a clinical nurse specialist core member of the MDT;
- a member of the core or extended MDT who is the agreed person responsible for the psychological support of patients.

(ii) The sessions should be regular and at an agreed frequency.

(iii) The MDT should have at its disposal a venue for the pre-assessment of head and neck cancer patients as in the previous measure, where the time allotted, according to the time specified in the previous measure, is identified as such in the ward or department's timetable.

Notes:

- *Here, for the purposes of peer review, the clinical nurse specialist is defined as a core nurse member of the MDT who is put forward for review against the minimum MDT nurse specialist measures.*

- *There may be sessions from other specialists in addition; this is not subject to review.*
- *Multidisciplinary assessment may take place before or after MDT discussions or at other stages in the patient journey as well; this is not subject to review.*
- *There are no measures regarding the attendance frequency of individuals, but they should be available according to their normal timetable as above, when required.*
- *The sessions may be in an outpatient clinic or ward or other department. This is not subject to review.*

Compliance: The frequency of the pre-assessment session agreed by the lead clinician of the MDT.

The timetables or work programmes of the above specialists agreed by the lead clinician of the MDT and the line manager of the specialist.

The venue timetable agreed by the lead clinician of the MDT and the relevant hospital manager.

The reviewers should enquire of the working practice of the MDT.

Agree and Record Individual Patient Treatment Plans

11-2I-129 The core MDT at their regular meetings should agree and record patients' diagnoses and subsequent treatment plans or referral. The record should include:

- the patient's identity;
- the diagnosis including the primary site of the cancer;
- at which stage in the patient's journey the MDT discussion is taking place (e.g. for illustration only: newly diagnosed, pre-initial treatment; newly diagnosed, post-op; newly recurrent);
- the multidisciplinary treatment planning decision; i.e. to which modalities of care (surgery, radiotherapy, chemotherapy, endocrine therapy - in the case of thyroid cancer - or other) they are to be referred for consideration;
- in the case of patients with salivary gland cancer and UAT cancer involving the skull base, for an MDT which does not deal with these cancers and which is referred a patient, the named MDT which the patient is to be referred on to should be recorded.

Compliance: Anonymised examples of the record of a meetings and individual anonymised treatment plans.

Notes:

Only exactly what is required in the list above is necessary for evidence.

Detailed minutes of the content of discussions over patients are not required for evidence.

For review purposes patient specific information should be anonymised.

It is recommended that this essential information is recorded on an MDT decision proforma as well as in individual patient's notes.

REFERRAL GUIDELINES FROM THE DIAGNOSTIC AND ASSESSMENT SERVICE

Introduction

See the network measures relating to these guidelines in conjunction with this MDT measure.

MDT Agreement to Network Guidelines for Referral from Diagnosis and Assessment Service

11-2I-130 The MDT should agree the network-wide guidelines for referral from the diagnosis and assessment service to the MDTs.

Note:

This includes both UAT and thyroid cancer referral.

Compliance: The network guidelines, specifying which designated hospitals should refer to the MDT under review, and to which MDTs patients with thyroid cancer, salivary gland cancer and UAT cancer involving the skull base, should be referred: agreed by the lead clinician of the MDT.

Note:

The MDT under review may be the MDT agreed as receiving thyroid, salivary gland and skull base referrals.

Single Named Designated Hospital for Surgical Procedure

11-2I-131 The MDT should perform all of its curative surgical procedures in a single, named, designated operating hospital, with a specialist head and neck ward, in accordance with measure 11-1A-210i.

Note:

- *This measure does not **mandatorily** apply to simple, complete excision biopsies performed by the diagnostic and assessment service for the diagnosis of T_1 lesions and which are thought to be sufficient for cure.*
- *Similarly this measure does not **mandatorily** apply to thyroidectomies for thyroid cancer. However, simple excision of T_1 lesions and thyroidectomies **may be** carried out in the hospitals designated for surgical treatment deliver.*

Compliance: The named hospital agreed by the lead clinician of the MDT.

The network distribution of designated operating hospitals.

The reviewers should enquire of the working practice of the MDT.

GUIDELINES FOR UAT CANCER

Introduction

See the measures relating to these guidelines in topic 1C 'function of the network site specific group', in conjunction with these MDT measures.

MDT Agreement to Network Imaging Guidelines for UAT Cancer

11-2I-132 The MDT should agree the network imaging guidelines for the diagnosis and assessment of UAT cancer.

Compliance: The network imaging guidelines agreed by the lead clinician of the MDT and the Chair of the NSSG.

MDT Agreement to Network Pathology Guidelines for UAT Cancer

11-2I-133 The MDT should agree the network pathology guidelines for the assessment of UAT cancer.

Compliance: The network pathology guidelines agreed by the lead clinician of the MDT and the Chair of the NSSG.

MDT Agreement to Network Clinical Guidelines for Treatment of UAT Cancer

11-2I-134 The MDT should agree the network clinical guidelines for the treatment of UAT cancer.

Compliance: The network clinical guidelines agreed by the lead clinician of the MDT and the Chair of the NSSG.

Agreed Collection of Minimum Dataset

11-2I-135 The MDT should agree the same minimum dataset (MDS) with other MDTs of the same cancer site(s) across the network (network-wide MDS). The MDS should include the data items required for:

- the cancer waiting times monitoring, including Going Further on Cancer Waits in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Services;

- the Cancer Registration Dataset as specified in the National Contract for Acute Services.

The MDS must include all items required for the national contract, any additional items should use definitions and codes taken from National Cancer Dataset and the NHS Data Dictionary.

Notes:

- *The network MDS may include additional data items.*

The MDT should have started to record the MDS or their portion of the MDS for each patient on proformas and/or in an electronically retrievable form.

Compliance: The MDS agreed by the lead clinician of the MDT and the Chair of the NSSG.

Note:

For compliance, the NSSG should produce the agreed MDS and the individual MDT for their compliance with this measure, should agree to collect it.

Anonymised of the record data for individual patients.

Note:

For the purpose of self-assessment the team should confirm that they started to record the MDS in compliance with the details of the measure.

NETWORK AUDIT

Introductory Notes

For review purposes a network audit project is an audit project related to the cancer site or sites of the NSSG and the activities of its MDTs. The same project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified. The individual MDTs, for compliance with their relevant MDT measure, should agree to participate in the audit. See appendix 1 for audit.

Network Audit

11-2I-136

The MDT should agree to participate in the network audit project agreed by the NSSG.

The MDT should annually review the progress of the project or present the results of the completed network audit project to the NSSG for discussion at one of their meetings.

Notes:

For MDTs which have previously been peer reviewed the project should have been completed since that previous peer review.

Compliance: The audit agreed by the lead clinician of the MDT and the Chair of the NSSG.

Written confirmation of review of progress of audit sufficient to show compliance with the measure.

CANCER RESEARCH NETWORK UAT CANCER

Introductory Note:

Because of the different cancer types dealt with by some teams for UAT cancer, not every team may be able to enter patients into a given trial on the list.

Discussion of Clinical Trials for UAT

11-2I-137

The MDT should produce a report at least annually on clinical trials, for discussion with the NSSG. The report should include;

- 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 NSSG.

The MDT should agree a final programme for improvement at the NSSG discussion

meeting.

Note:

For compliance with this measure the MDT should produce a proposed programme for improvement and, at the discussion with the NSSG, settle on a mutually agreed programme between the participants of the meeting.

In addition, applicable only to MDTs dealing with the following cancer sites:

- Leukaemia
- Lymphoma
- Germ cell malignancy
- Bone and/or soft tissue sarcoma
- Brain and CNS malignancy
- Malignant melanoma

The MDT should produce a report on clinical trials, covering the above points, for TYA patients, for discussion at the teenage and young adults' cancer network co-coordinating group (TYACNCG).

The MDT should agree a final programme for improvement for TYA clinical trials with the TYACNCG.

Note:

The TYACNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.

Compliance: The report, agreed by the lead clinician of the MDT. The reviewers should check that the contents fulfil the points above.

The programme for improvement, agreed by the lead clinician of the MDT and the clinical lead for the cancer research network.

Where relevant, the clinical trials report for TYA patients, agreed by the lead clinician of the MDT, and the programme for improvement agreed by the lead clinician of the MDT, Chair of the TYACNCG and the clinical lead for the cancer research network.

MDT to Discuss at Least 100 New Cases per Year

11-2I-138 The MDT should discuss at least 100 separate cases per year of squamous carcinoma of the UAT, newly presenting to the MDT for the first time.

Compliance: The number of cases, averaged over the two years prior to the peer review visit or self-assessment.

MEASURES SPECIFIC TO THYROID CANCER

Introduction

The following are measures additional to 11-2I-101 to 11-2I-138, which should be applied to combined UAT/thyroid MDTs. The responsibility for review purposes for these measures lies with the lead clinician of the MDT.

MDT STRUCTURE

Named Core Team Members for Thyroid Cancer

11-2I-139

The MDT should provide the names of the following core team members:

- endocrinologist;
- nuclear medicine specialist.

Notes:

- *If any of the core MDT disciplines of surgery, oncology, nursing, histopathology and imaging, do not have a UAT member named in measure 11-2I-101 who is also responsible for thyroid cancer, then a separate core member of the relevant discipline, with responsibility for thyroid cancer, should be named for this measure.*
- *The team may agree additional core team members. This is not subject to review.*
- *The responsibility for ^{131}I treatment may be taken by an oncologist or a nuclear medicine specialist or both.*
- *The above core members should be consultants. Their cover need not be a consultant.*
- *The measures relating to core members attendance 11-2I-107 and 11-2I-108 apply to the additional core members above, as well as the rest of the core combined UAT/thyroid MDT.*

Compliance: The name of each core member as above with their role, agreed by the lead clinician of the MDT.

Note:

The note regarding compliance applies as for measure 11-2I-101.

Extended Membership of MDT for Thryroid Cancer

11-2I-140

The MDT may agree additional members for the extended team, specifically for its thyroid cancer practice, in which case they should be named, with their named roles.

Or, the MDT may agree to have no additional members for the extended team, in which case this should be declared.

Compliance: The name of each extended team member with their role, agreed by the lead clinician of the MDT, together with their respective roles or the decision to have none, agreed by the lead clinician of the MDT.

Note:

The name of the role is all that is required, not long role descriptions.

NETWORK GUIDELINES FOR THYROID CANCER

Introduction

See the measures relating to these guidelines in Topic 1C 'functions of the network site specific group' in conjunction with these MDT measures.

MDT Agreement to Network Imaging Guidelines for Thyroid Cancer

11-2I-141

The MDT should agree the network imaging guidelines for the diagnosis and assessment of thyroid cancer.

Compliance: The network imaging guidelines agreed by the lead clinician of the MDT and Chair of the the NSSG.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

MDT Agreement to Network Pathology Guidelines for Thyroid Cancer

11-2I-142 The MDT should agree the network pathology guidelines for the diagnosis and assessment of thyroid cancer.

Compliance: The network pathology guidelines agreed by the lead clinician of the MDT and Chair of the NSSG.

MDT Agreement to Network Clinical Guidelines for Thyroid Cancer

11-2I-143 The MDT should agree the network clinical guidelines for the diagnosis and assessment of thyroid cancer.

Compliance: The network clinical guidelines agreed by the lead clinician of the MDT and Chair of the NSSG.

AGREED NETWORK AUDIT

Introductory Notes

For review purposes a network audit project related to the cancer size or sites of the NSSG and the activities of its MDTs. The same audit project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified.

The individual MDTs for compliance with this measures should agree to participate in the audit. See appendix 1 for audit.

Network Audit for Thyroid Cancer

11-2I-144 The MDT should agree to participate in the network audit project with the necessary funding, the project agreed with the NSSG.

The MDT should annually review the progress of the project or present the results of the completed network audit project to the NSSG for discussion at one of their meetings.

Note:

For MDTs which have previously been peer reviewed the project should have been completed since that previous peer review.

Compliance: The project agreed by the lead clinician of the MDT and the Chair of the NSSG.

Written confirmation of review of progresss of audit sufficient to show compliance with the measure.

Discussion of Clinical Trials for Thyroid Cancer

11-2I-145 The MDT should produce a report at least annually on clinical trials, for discussion with the NSSG. The report should include;

- 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 NSSG.

The MDT should agree a final programme for improvement at the NSSG discussion meeting.

Note:

For compliance with this measure the MDT should produce a proposed programme for improvement and, at the discussion with the NSSG, settle on a mutually agreed programme between the participants of the meeting.

In addition, applicable only to MDTs dealing with the following cancer sites:

- Leukaemia
- Lymphoma
- Germ cell malignancy
- Bone and/or soft tissue sarcoma

- Brain and CNS malignancy
- Malignant melanoma

The MDT should produce a report on clinical trials, covering the above points, for TYA patients, for discussion at the teenage and young adults' cancer network co-coordinating group (TYACNCG).

The MDT should agree a final programme for improvement for TYA clinical trials with the TYACNCG.

Note:

The TYACNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.

Compliance: The report, agreed by the lead clinician of the MDT. The reviewers should check that the contents fulfil the points above.

The programme for improvement, agreed by the lead clinician of the MDT and the clinical lead for the cancer research network.

Where relevant, the clinical trials report for TYA patients, agreed by the lead clinician of the MDT, and the programme for improvement agreed by the lead clinician of the MDT, Chair of the TYACNCG and the clinical lead for the cancer research network.

OPERATIONAL POLICY ON NECK NODE DISSECTION

Introduction

See measure relating to this in topic 1C 'functions of the network site specific group'.

MDT Agreement to Network Surgeon Authorised to Perform Lymph Node Resections

11-2I-146

The MDT in consultation with any other MDTs in the network (UAT or combined UAT/thyroid or thyroid) should agree with the NSSG which of it's members if any are authorised to perform lymph node resections on thyroid cancer patients.

Notes:

i) *Any members so authorised should be core surgical members of the MDT.*
ii) *This measure does not apply to the simple excision of lymph nodes for diagnosis.*

Compliance: The named members agreed by the lead clinician of the MDT and the Chair of the NSSG, or the agreement that no members are so authorised.

Provision of Written Patient Information for Thyroid Cancer

11-2I-147

The MDT should provide written material for patients and carers which includes:

- information specific to that MDT about local provision of the services offering treatment for thyroid cancer;
- 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 emotional effects.

It is recommended that the information and its delivery to patients and carers follow the principles of the NHS Information Prescription project. (www.informationprescription.info).

Notes:

- *The information prescription should be tailored to the patients/carers needs based on an information needs assessment. Information may be generated and dispensed*

outside of the clinic environments within an information centre where a clear operational policy between the clinic and information centre is in place which identifies how clinic records are updated and that facilities and resources within the information centre are appropriate to providing such a service.

- *The information prescription should be composed of information from the national pathways supplemented with national and local accredited information*

Compliance: The written (visual and audio if used - see note below) material.

Notes:

*It is **recommended** that it 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.*

For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.

Joint Treatment Planning for TYAs

11-2I-148

For each patient in the TYA age group, the MDT should agree the following decisions with the TYA MDT and record them as part of that patient's joint treatment planning decision:

- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment-surgery, radiotherapy, chemotherapy, biological therapy or supportive care, or combinations of the same, they are to be referred to for consideration);
- the named consultant in charge of each modality of definitive treatment and the named person in charge of organising arrangements for the age-appropriate support and care environment including those when the treatment is delivered outside the PTC facility.

For those in the age range 19 to the end of their 24th birthday, the MDT should record the choice of treatment location, made by the patient, in particular, whether it is the TYA facility or which of the named designated hospitals for TYAs.

Notes:

Patients in the age range 16 to the end of their 18th birthday should be treated in the PTC.

The date of joint agreement to the planning and of the patient's choice of treatment place may be later than the date of the initial treatment planning discussion by the MDT.

Compliance: The reviewers should ask to see examples of the treatment planning decision record of patients from the TYA age group. Evidence of joint agreement should be by individual TYA patient decision records of the site-specific MDT being authorised by a core member of the TYA MDT.

Note:

If the MDT has had no such patients referred since the last assessment/review this part of the measure is considered to have been complied with. The overall compliance depends then, only on the non-TYA aspects of this measure.

TOPIC 11-2I-2 - THYROID ONLY MDT

When is a Team a Team, and when is it not a Team?

The measures review a variety of aspects of the team, both structure and function, but the key question which underlies all this is who exactly constitutes the MDT, from the point of view of the peer review? Which group of people should be put forward for review against these measures, and who is it who is held compliant or not compliant?

This is best answered from the patient's point of view. If you were a patient who would you consider to be your MDT?

Primarily it is that group of people of 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. They constitute that patient's MDT.

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 specific situation where a separate "diagnostic" meeting of a particular subset of the MDT membership filters out cases with benign conditions is dealt with where relevant by a specific measure. For some cancer types the IOG had laid down detailed requirements over how the diagnostic process should be incorporated into the MDT system and this has also been translated into the measures where applicable.

Two or more groups of people who may have declared an alliance to form a so-called "combined" MDT but who do not all meet together to collectively contribute to the decisions on a given patient as specified above, do not constitute an MDT from the point of view of peer review. Such alliances have been attempted in order to achieve, for instance, a minimum caseload or catchment population. This is not appropriate. Each separate group, meeting as specified above, should be assessed separately against such criteria.

In general the measures should be applied to that defined group, but there are some functions for which MDTs may combine in a way which is appropriate. Then, the evidence put forward to demonstrate their compliance with the relevant measures may serve as common evidence across the MDTs but it is applied separately and compliance is awarded separately to each of them.

The main examples of this are as follows:

- a combined operational policy meeting but the policies are agreed on behalf of each MDT by its lead clinician;
- network-wide clinical, referral, imaging and pathology guidelines, but each MDT agrees to abide by them;
- the same network-wide project for network audit, but each MDT agreeing to participate;
- a common minimum dataset but each MDT agrees to collect its portion of it;
- a network list of approved trials but each MDT agrees to enter patients;
- an individual health professional being a member of more than one MDT, but a particular defined and named set of people make up a given MDT.

As well as meeting to make the combined multidisciplinary decisions about patients, the members of some types of MDTs are required by the measures to carry out another key function in company with other specified personnel. Thus, some of the more complex surgical procedures should all be performed by the same group of professionals - surgeon, anaesthetist and skilled theatre and aftercare staff. This is ensured by requiring services to be organised for that MDT so that all cases of a given procedure are performed in the same hospital. The people will largely be a different set of people from those who meet to make the diagnostic and treatment decisions (the MDT as defined in the measures) but they will directly relate to that MDT and be specified by it because at least one key functionary, the surgeon, will be a core member of that MDT.

In requiring all the complex procedures to be performed in the same hospital of the MDT, this ties in the referral catchment population of the MDT to that hospital. This provides a direct link between the referring catchment population for MDT **discussion,** and the **treatment caseload** of the treatment team and its hospital facilities.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility for review purposes for measures 11-2I-201 lies with the lead clinician of the host trust.

MDT STRUCTURE

Single Named Lead Clinician with Agreed Responsibilities

11-2I-201

There should be a single named lead clinician for the MDT who should then be a core team member.

The lead clinician of the MDT should have agreed the responsibilities of the position with the lead clinician of the host trust.

Note:

The role of lead clinician of the MDT should not in itself imply chronological seniority, superior experience or superior clinical ability.

The MDT should provide the names of core team members for named roles in the team.

The core team specific to the cancer MDT should include:

- endocrinologist;
- surgeon;
- clinical oncologist;
- radiologist;
- nuclear medicine specialist;
- histopathologist;
- cytopathologist;
- clinical nurse specialist;
- MDT co-ordinator/secretary;
- 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 is integrated into the function of the MDT.

Notes:

- *Each clinical core member should have sessions specified in the job plan for the care of patients with head and neck cancer and attendance at MDT meetings.*
- *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.*
- *The co-ordinator/secretary role needs different amounts of time depending on team workload. See the appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial role may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description.*
- *There may be additional core members agreed for the team besides those listed above.*
- *The responsibility for treatment may be taken by an oncologist or a nuclear medicine specialist, or both.*
- *The roles of histopathologist and cytopathologist may be fulfilled by one person.*

Compliance: Named lead clinician for the MDT agreed by the lead clinician of the host trust.

The written responsibilities agreed by the lead clinician of the MDT and lead clinician of the host trust.

Note:

See appendix 2 for an illustration of the responsibilities of this role.

Name of each core team member with their role, agreed by the lead clinician of the host

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
trust. *Notes:* *The reviewers should record in their assessment each case where the post(s) needed to provide the minimum core membership for a given listed role in the measure is unfilled or non-existent, or existing posts cannot provide the service. This does not refer to mere holiday or sickness absence, or less than 67% attendance, and it refers only to the core member roles listed in the measure, not to additional roles that the MDT has decided locally to include as core members, e.g. from the list in the 'extended MDT' measure. The reviewers should identify the particular missing roles and identify the particular MDT in the report.*
The responsibility, for review purposes, for the subsequent measures lies with the lead clinician of the MDT.
PSYCHOLOGICAL SUPPORT.
Level 2 Practitioners for Psychological Support
11-2I-202 At least one clinical core member of the team should have completed the training necessary to enable them to practice at least level 2 for the psychological support of cancer patients and carers. *Notes:* • *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.* • *The relevant discipline 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.* • *The definition of the levels may be found in appendix 1 of the Psychological support measures.* *Compliance:* The named member. Written confirmation of completion of training agreed by the lead clinician of the MDT.
Support for Level 2 Practitioners
11-2I-203 The level 2 practitioner(s) should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month. *Compliance:* Reviewers should enquire to ascertain that this is taking place.
Team Attendance at NSSG Meetings
11-2I-204 The lead clinician of the MDT or representative should attend at least two thirds of the NSSG meetings. *Compliance:* The attendance record of the NSSG.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

MDT Meeting

11-2I-205 The team should hold its meetings at an agreed frequency, record core members' attendance and have a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (Guidance only - e.g. letters, emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting).

Compliance: Attendance records of the meetings.
Written procedure agreed by the lead clinician of the MDT.

MDT Agreed Cover Arrangements for each Core Member

11-2I-206 The MDT should agree named cover arrangements for each core member.

Notes:

- *This refers to the nominating of staff who should **in general** be expected to provide cover for core members e.g. a specialist trainee or non-consultant career grade on a consultant's team or core members of the same discipline providing cover for each other. It does not refer to the member having to provide a person to cover for each and every absence. This aspect is dealt with by the attendance measure above.*
- *Where a medical specialty is referred to, the cover for a core member need not be a consultant, but it should be a specialist trainee or non-consultant career grade.*

Compliance: Written arrangements agreed by the lead clinician of the MDT.

Core Members (or cover) Present for 2/3 of Meetings

11-2I-207 Core members or their arranged cover should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT.

Notes:

The intention is that core members of the team should be personally committed to it, reflected in their personal attendance at a substantial portion of the meetings, not relying instead on their cover arrangements. Reviewers should use their judgement on this matter and should highlight in their report where this committment is lacking.

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2I-208 Besides the regular meetings to discuss individual patients, the team should meet at least annually to discuss, review, agree and record at least some operational policies.

Compliance: Written confirmation of at least one meeting agreed by the lead clinician of the MDT to illustrate the recording of at least some operational policies.

Policy for All New Patients to be Reviewed by MDT

11-2I-209 There should be an operational policy for the team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan.

The policy should specify at what other stages in the patient pathway patients are referred back for discussion.

Compliance: The written operational policy agreed by the lead clinician of the MDT.

Policy for Communication of Diagnosis to GP

11-2I-210 The MDT should have agreed a policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis by the end of the following working day.

The MDT should have completed an audit against this policy of the timeliness of notification to GPs of the diagnosis of cancer.

Compliance: The written policy agreed by the lead clinician of the MDT.
The results of the audit.

Operational Policy for Named Key Worker

11-2I-211

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 members 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 above policy should have been implemented for patients who came under the MDT's care after publication of these measures and who are under their care at the time of the peer review visit or annual self assessment.

Notes:

- *For information: according to the NICE palliative care guidance, a key worker is a person who, with the patient's consent and agreement, takes a key role in co-ordinating the patient's care and promoting continuity e.g. ensuring the patient knows who to access for information and advice. This is not intended to have the same connocation as the key worker in social care.*
- *It may be necessary to agree a single key worker across both a cancer site specific MDT and the specialist palliative care MDT for certain patients.*

Compliance: The written policy agreed by the lead clinician of the MDT.
Reviewers should spot check some of the relevant patients' case notes.

Operational Policy for Principal Clinician

11-2I-212

There should be an operational policy for the team whereby:

- at any one stage in the patient's journey, they should have a named clinical member of the MDT who is agreed as the principal clinician for the patient and to whom the patient primarily relates with regard to decision-making for their clinical management;
- the identity of the principal clinician should be made clear to the patient and their GP and recorded in their case notes.

The above policy should have been implemented for patients who came under the MDT's care after publication of these measures and who are under their care at the time of the peer review visit or annual self assessment.

Notes:

- *It is expected that the principal clinician would be a consultant member of the MDT.*
- *The role of the principal clinician relates to that of key worker in that it would be a major part of the key worker's duties to ensure that the named principal clinician is identified and made known at each stage of the patient's journey.*

Compliance: The written policy agreed by the lead clinician of the MDT.
The reviewers should spot check some of the relevant patient's case notes.

Core Histopathology Member Taking Part in Histopathology EQA

11-2I-213

The core histopathologist member(s) of the MDT should be taking part in an EQA scheme, either as a specialist scheme for the cancer site(s) of the team or a general EQA scheme which has a section covering the cancer site(s) of the team.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: Documentary evidence to show that they are taking part in a relevant EQA.

Note:

Their actual performance against the requirements of the EQA is not subject to peer review.

MDT NURSE SPECIALIST MEASURES

Introduction

Why are there currently "nursing measures" for MDTs, but no similar requirements for other MDT members?

The modern change to MDT working has created and then highly developed the specific role of nurse MDT specialist, with its related activities which, in full measure, go to make up the role of cancer nurse specialist. The roles of the medical specialists in the MDT have not been so profoundly influenced or so extensively developed by their MDT membership itself, compared to that of the MDT nurse specialist. The role definitions and training requirements of nurse MDT specialists are not "officially" established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were head and neck surgeons and palliative care physicians, before there were established head and neck MDTs and specialist palliative care teams).

Therefore a particularly strong need was perceived for using the measures to define more clearly the role of the nurse member and to set out minimum training requirements for nursing input into MDTs.

This is in order to establish these roles more firmly in the NHS infrastructure, and to avoid the situation where MDTs can comply with measures by having generalist nurses who "sit in" on MDT meetings and sign attendance forms but play no defining role in the team's actual dealings with its patients.

Core Nurse Member Completed Specialist Study

11-2I-214 Each core nurse specialist should have successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent.

Note:

It is strongly recommended that if there is more than one core nurse member in the MDT, they should all be compliant with this measure.

Compliance: Confirmation of successful completion of the course/module.

Agreed List of Responsibilities for Core Nurse Members

11-2I-215 The MDT should have agreed a list of responsibilities, with each of the core nurse specialist of the team, which includes the following:

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings;
- providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice;
- involvement in clinical audit;
- leading on patients' and carers' communication issues and co-ordination of the patient pathway for patients referred to the team - acting as the key worker or responsible for nominating the key worker for the patient's dealings with the team.
- ensuring that results of patients' holistic needs assessment are taken into account in the decision making;
- contributing to the management of the service (see note below);
- utilising research in the nurse's specialist area of practice.

Notes:

- *"Management" in this context does not mean clerical tasks involving the documentation on individual patients i.e. this responsibility does not overlap with the responsibility of the MDT co-ordinator.*
- *Additional responsibilities to those in this measure and the next measure may be agreed.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The list of responsibilities agreed by the lead clinician of the MDT and the core nurse specialist(s).

Attendance on the National Advanced Communication Skills Training Programme

11-2I-216

At least those core members of the team who have direct clinical contact with patients should have attended the national advanced communications skills training programme.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *Also, it applies only with regard to members which are in place i.e. if a team lacks a given core member from that list, it should be counted as compliant with this measure provided those members which are in place comply.*
- *The relevant disciplines include medical, surgical, nursing and allied health professionals.*
- *The reviewers should record which core members of those relevant are non-compliant.*

Compliance: Written confirmation of the MDT members who have attended the national advanced communications skills training programme.

Clinical Follow up Protocol

11-2I-217

The MDT should agree a protocol with its referring designated hospitals, specifying:

- who is responsible for follow up of patients between MDT members and designated clinicians who are not MDT members;
- which is the setting for follow up between the hospital hosting the head and neck ward and the referring designated hospitals.

Note:

The follow up arrangements may be specific to individual cancer sites.

Compliance: The written protocol agreed by the lead clinician of the MDT and a representative, designated clinician from each of the designated hospitals.

Agreed Policy for Patient to Discuss Treatment Options

11-2I-218

The MDT should agree and be practising a policy that when the MDT's advice is that the patient has an open choice between different options for their initial treatment, those options should be presented to the patient in a multidisciplinary way i.e. the specialist responsible for each treatment modality - surgery, radiotherapy, chemotherapy, should make the case to the patient for their own modality as it is relevant to the treatment options, rather than one specialist presenting all the modalities. A clinical nurse specialist should be present.

Compliance: The policy agreed by the lead clinician of the MDT.

The reviewers should enquire of the working practice of the MDT.

Extended Membership of MDT

11-2I-219

The MDT may agree additional members for the extended team, in which case they should be named, with their named roles.

Or, the MDT may agree to have no additional members for the extended team, in which case this should be declared.

Compliance: The name of each extended team member with their role agreed by the lead clinician of the MDT, together with their respective roles, or the decision to have none, agreed by the lead clinician of the MDT.

Note:

The name of the role is all that is required, not long role descriptions.

PROVIDING PATIENT CENTERED CARE

Patient Permanent Consultation Record

11-2I-220

The MDT should be giving 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:

- diagnosis;
- treatment options and plan;
- relevant follow up (discharge) arrangements.

Note:

The MDT may, in addition, offer a permanent record of consultations undertaken at other stages of the patient's journey.

The record of consultation should identify areas discussed during consultation and include a diagram where appropriate which supports the consultation discussion.

The consultation record provides a permanent summary of the discussion between the doctor and the patient and should always be offered to the patient unless specifically declined by the patient;

A record should be kept in the notes.

Compliance: The reviewers should enquire of the working practice of the team and see anonymised examples of records given to patients.

Note:

It is recommended that they are 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.

Patient Experience Exercise

11-2I-221

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.

The exercise should at least ascertain whether patients were offered:

- a key worker;
- assessment of their physical, emotional, practical, psycological 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.

Notes:

- *The exercise may consist of a survey, questionnaire, focus group or other method.*
- *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.*

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.

Compliance: The results of the exercise.

A report of the action taken.

Provision of Written Patient Information

11-2I-222

The MDT should provide written material for patients and carers which includes:

- information specific to that MDT about local provision of the services offering treatment for thyroid cancer;
- information about patient involvement groups and self-help groups;

- information about the services offering psychological social and spiritual/cultural support, if available.
- information specific to thyroid cancer 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 emotional effects.

it is recommended that the information and its delivery to patients and carers follow the principles of the NHS Information Prescription project.(www.informationprescription.info).

Notes:

- *The information prescription should be tailored to the patients carers needs based on an information needs assessment. Information may be generated and dispensed outside the clinic environments within an information centre where a clear operational policy between the clinic and information centre is in place which identifines how clinic records are updated and that facilities and resorces within the information centre are appropriate to providing such a service.*
- *The information prescription should be composed of information from the national pathways supplemented with national and local accredited information.*

Compliance: The written (visual and audio if used - see note below) material.

Notes:

It is recommended that it 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.

For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.

Agree and Record Individual Patient Treatment Plans

11-2I-223

The core MDT at their regular meetings should agree and record individual patient's treatment plans. A record should be made of the treatment plan. The record should include:

- 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 to for consideration).

Note:

A therapeutic operation may in effect form part of the initial investigation and staging procedure to render the patient suitable for discussion and for a subsequent treatment planning decision. This operation should be recorded.

Compliance: Anonymised examples of the record of meetings and individual anonymised treatment plans.

Notes:

Only exactly what is required in the list above is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence.

For review purposes, patient-specific information should be anonymised.

It is recommended that this essential information is recorded on an MDT decision proforma as well as in individual patient's notes.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

GUIDELINES

Introduction

See the network measure relating to these guidelines (measure 11-1A-218i) in conjunction with this MDT measure.

MDT Agreement to Network Guidelines for Referral from Diagnosis and Assessment Service

11-2I-224 The MDT should agree the network-wide guidelines for referral of thyroid cancer from the diagnosis and assessment service to the MDTs.

Compliance: The network guidelines specifying which designated hospitals should refer to the MDT under review, agreed by the lead clinician of the MDT and Chair of the Network Board.

NETWORK GUIDELINES THYROID CANCER

Introduction

See the measures relating to these guidelines in topic 1C 'function of the network site specific group', in conjunction with these MDT measures.

MDT Agreement to Network Imaging Guidelines for Thyroid Cancer

11-2I-225 The MDT should agree the network imaging guidelines for the diagnosis and assessment of thyroid cancer.

Compliance: The network imaging guidelines agreed by the lead clinician of the MDT and Chair of the NSSG.

MDT Agreement to Network Pathology Guidelines for Thyroid Cancer

11-2I-226 The MDT should agree the network pathology guidelines for the diagnosis and assessment of thyroid cancer.

Compliance: The network pathology guidelines agreed by the lead clinician of the MDT and Chair of the NSSG.

MDT Agreement to Network Clinical Guidelines for Treatment of Thyroid Cancer

11-2I-227 The MDT should agree the network clinical guidelines for the treatment of thyroid cancer.

Compliance: The network clinical guidelines agreed by the lead clinician of the MDT and Chair of the NSSG.

Agreed Collection of Minimum Dataset

11-2I-228 The MDT should agree the same mimimum dataset (MDS) with other MDTs of the same cancer site(s) across the network (network-wide MDS). The MDS should include the data items required for:

- the cancer waiting times monitoring, including Going Further on Cancer Waits in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Services;
- the Cancer Registration Dataset as specified in the National Contract for Acute Services.

The MDS must include all items required for the national contract, any additional items should use definitions and codes taken from the National Cancer Data Set and NHS Data Dictionary.

Notes:

- *The network MDS may include additional data items.*

The MDT should have started to record the MDS or their portion of the MDS for each patients on proformas and/or electronically retrievable form.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The MDS agreed by the lead clinician of the MDT and the Chair of the NSSG. *Note:* *For compliance, the NSSG should produce the agreed MDS and the individual MDT, for their compliance with this measure, should agree to collect it.* Anonymised examples of the record data for individual patients. *Note:* *For the purpose of self-assessment the team should confirm that they have started to record the MDS in compliance with the details of the measure.*

NETWORK AUDIT

Introductory notes

For review purposes a network audit project related to the cancer size or sites of the NSSG and the activities of its MDTs. The same audit project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified.

The individual MDTs for compliance with this measures should agree to participate in the audit. See appendix 1 for audit.

Network Audit for Thyroid Cancer

11-2I-229

The MDT should agree to participate in the network audit project agreed by the NSSG.

The MDT should annually review the progress of the project or present the results of the completed network audit project to the NSSG for discussion at one of their meetings.

Notes:

For MDTs which have previously been peer reviewed the project should have been completed since that previous peer review.

Compliance: The project agreed by the lead clinician of the MDT and the Chair of the NSSG.

Written confirmation of review of progress of audit sufficient to show compliance with the measure.

Discussion of Clinical Trials

11-2I-230

The MDT should produce a report at least annually on clinical trials, for discussion with the NSSG. The report should include;

- 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 NSSG.

The MDT should agree a final programme for improvement at the NSSG discussion meeting.

Note:

For compliance with this measure the MDT should produce a proposed programme for improvement and, at the discussion with the NSSG, settle on a mutually agreed programme between the participants of the meeting.

In addition, applicable only to MDTs dealing with the following cancer sites:

- Leukaemia
- Lymphoma
- Germ cell malignancy
- Bone and/or soft tissue sarcoma
- Brain and CNS malignancy
- Malignant melanoma

The MDT should produce a report on clinical trials, covering the above points, for TYA patients, for discussion at the teenage and young adults' cancer network co-coordinating

group (TYACNCG).

The MDT should agree a final programme for improvement for TYA clinical trials with the TYACNCG.

Note:

For compliance with this measure the MDT should produce a proposed programme for improvement with the TYACNCG and settle on a mutually agreed programme.

Note:

The TYACNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.

Compliance: The report, agreed by the lead clinician of the MDT. The reviewers should check that the contents fulfil the points above.

The programme for improvement, agreed by the lead clinician of the MDT and the clinical lead for the cancer research network.

Where relevant, the clinical trials report for TYA patients, agreed by the lead clinician of the MDT, and the programme for improvement agreed by the lead clinician of the MDT, Chair of the TYACNCG and the clinical lead for the cancer research network.

OPERATIONAL POLICY ON NECK NODE DISSECTION

Introduction

See measure relating to this in topic 1C 'functions of the network site specific group'.

MDT Agreement to Network Surgeons Authorised to Perform Lymph Node Resections

11-2I-231

The MDT in consultation with the UAT MDT(s) in the network, should agree with the NSSG which surgeons in the network are authorised to perform lymph node resections on thyroid cancer patients.

Notes:

i) *Any surgeon(s) so authorised should be a core member(s) of either a UAT or the thyroid MDT or both.*
ii) *this measures does not apply to the simple excision of lymph nodes for diagnosis.*

Compliance: The named surgeons agreed by the lead clinician of the MDT and the Chair of the NSSG.

Joint Treatment Planning for TYAs

11-2I-232

For each patient in the TYA age group, the MDT should agree the following decisions with the TYA MDT and record them as part of that patient's joint treatment planning decision:

- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment-surgery, radiotherapy, chemotherapy, biological therapy or supportive care, or combinations of the same, they are to be referred to for consideration);
- the named consultant in charge of each modality of definitive treatment and the named person in charge of organising arrangements for the age-appropriate support and care environment including those when the treatment is delivered outside the PTC facility.

For those in the age range 19 to the end of their 24th birthday, the MDT should record the choice of treatment location, made by the patient, in particular, whether it is the TYA facility or which of the named designated hospitals for TYAs.

Notes:

Patients in the age range 16 to the end of their 18th birthday should be treated in the PTC.

The date of joint agreement to the planning and of the patient's choice of treatment place

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	may be later than the date of the initial treatment planning discussion by the MDT.
Compliance:	The reviewers should ask to see examples of the treatment planning decision record of patients from the TYA age group. Evidence of joint agreement should be by individual TYA patient decision records of the site-specific MDT being authorised by a core member of the TYA MDT. *Note:* *If the MDT has had no such patients referred since the last assessment/review this part of the measure is considered to have been complied with. The overall compliance depends then, only on the non-TYA aspects of this measure.*

APPENDIX 1

This appendix is to follow

APPENDIX 2

2.1 Role of Network (Tumour) Site Specific Groups (NSSGs)

Membership

Network tumour site-specific groups 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 constituent organisations in the network.

Service Planning

NSSGs should ensure that service planning:

- is in line with national guidance/standards (including reconfiguration where necessary);
- covers the whole care pathway;
- promotes high quality care and reduces inequalities in service delivery;
- takes account of the views of patients and carers;
- takes account of opportunities for service and workforce redesign;
- establishes common guidelines, including clear referral guidelines.

NSSGs should:

- recommend priorities for service development to the network board. (In some networks this is via an advisory clinical group, consisting of membership from chairs of network groups, trust lead clinicians and the network team);
- ensure decisions become integrated into constituent organisational structures and processes.

Service Improvement/Redesign

- all NSSGs and individual cancer teams should commit to service improvements;
- process mapping and capacity and demand analyses should become part of the norm;
- requests for additional resources from NSSGs should be accompanied by evidence of involvement in service improvement/redesign;
- NSSGs should develop/approve high quality information for patient, for use across the network.

Service Quality Monitoring and Evaluation

NSSGs should:

- agree on priorities for common data collection (in line with national priorities e.g. for waiting times, registries and NCASP), but go beyond this where possible;
- 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 action plans agreed following peer review are implemented;
- report identified risks/untoward incidents to ensure learning is spread.

Workforce Development

NSSGs should:

- consider the overall workforce requirements for the NSSG;
- consider the education and training needs of teams and, where appropriate, of individuals;
- liaise with the network board and with the workforce development confederation to ensure that appropriate workforce numbers and CPD are available;
- promote links between teams through rotation of staff;
- develop common recruitment/retention strategies;
- take account of opportunities for skill mix changes.

Research and Development

- NSSGs should agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Annual Work Plan and Report

NSSGs should:

- draw the above together in an annual work plan in the context of a prioritised clinical governance development plan, for approval by the network board;
- ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training;
- provide an annual report of activity to feed health economy clinical governance reporting processes.

2.2 The Responsibilities of MDT members

Responsibilities of the MDT lead clinician

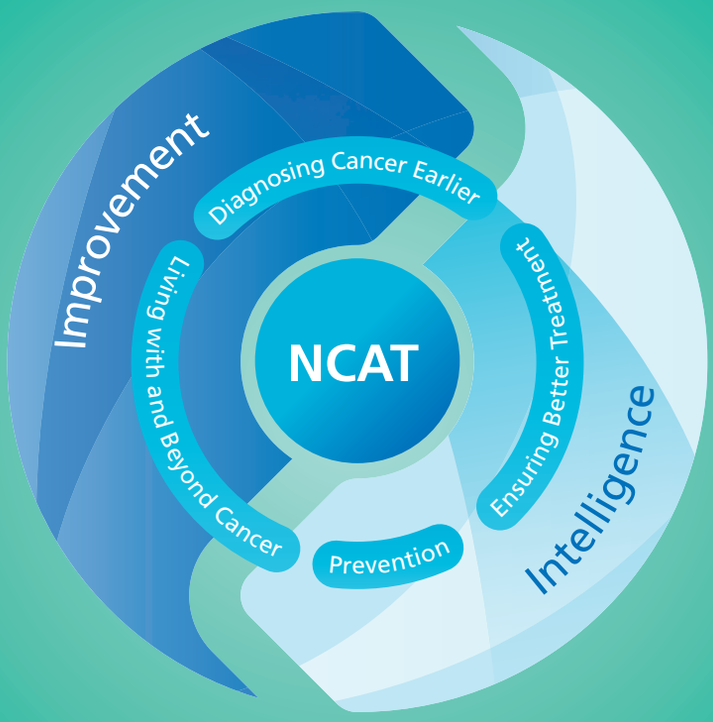
- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met:
    - to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
    - to 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;
    - to 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 MDT meeting and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- ensure that target of 100% of cancer patients discussed at the MDT is met;
- provide link to NSSG either by attendance at meetings or by nominating another MDT member to attend;
- lead on or nominate lead for service improvement;
- organise and chair annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members);
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported;
- ensure target of communicating MDT outcomes to primary care is met.

Responsibilities of the MDT Co-ordinator

- facilitate and co-ordinate the functions of the multidisciplinary team meetings;
- ensure the appropriate proportions of patients are discussed at MDTs;
- help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed. Ensuring patients' diagnoses,
- investigations, and management and treatment plans are completed and added to the patient's notes;
- managing systems that inform GP's of patient's diagnosis, decisions made at outpatient appointment etc;
- working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;
- working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;
- undertake demand and capacity studies where appropriate;
- report changes to MDTs on a monthly basis;
- data collection and recording of data;
- to manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
- keep comprehensive diary of all team meetings;
- record attendance at meetings;
- take minutes at the multidisciplinary meetings, type notes back in the required format and distribute to all concerned;
- the post holder will be expected to be instrumental in the development of databases to capture patient information and report this to the clinicians on a weekly basis;
- inform lead cancer manager of waiting times for patients when these exceed appropriate targets;
- ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
- ensure all correspondence, notes, x-rays, results, etc are available for the meetings;
- ensure action plans for patient care are produced with agreed reviews;
- assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;
- ensure members or their deputy are advised of meetings and any changes of date, venue, etc.

ADDENDUM - Amendments to measures April 2012

Measure number	Comment
11-1C-113i	Revised research measure
11-1C-114i	Chemotherapy Algorithm generic measure for NSSGs
11-1C-115i	The TYACN Pathway for Initial Management
11-1C-116i	The TYA Pathway for Follow Up on Completion of First Line Treatment
11-1D-102i	Revised wording to IV
11-2I-137, 11-2I-145, 11-2I-230	Revised research measure
11-2I-148, 11-2I-232	Joint Treatment Planning for TYAs



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