Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Lung Measures

Version 2.1

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For Recipient's Use	

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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.

TOPIC 11-1A-2c - LUNG SPECIFIC NETWORK BOARD MEASURES

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 for 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 GROUP (NSSG)
The responsibility for review purposes for measure 11-1A-201c lies with the Chair of the Network Board.
Agreed Named Members and Terms of Reference of NSSG

11-1A-201c 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 lung 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.

TOPIC 11-1C-1c - 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'.

The responsibility for review purposes for measures dealing with the function of NSSGs lies with the chair of the group.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
GENERAL ACTIVITIES	
NSSG Meeting	
11-1C-101c	The NSSG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed as part of each MDT measures.*
Compliance:	A list of meeting dates and attendance records in the last 12 months.
Annual Review, Work Programme and Annual Report	
11-1C-102c	The Chair of the NSSG should have an annual review with the network lead clinician and/or an 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.
Compliance:	Documentation sufficient to show that a review meeting took place with the network lead clinician and/or appropriate member of the Network Board. The annual work programme agreed by the Chair of the Network Board. The annual report agreed by the Chair of the NSSG and the Chair of the Network Board. *Note:* *This meeting should be face to face. An email is not an acceptable mechanism for the review.*
CLINICAL GUIDELINES	
Introduction For their compliance with this measure the NSSG should, in consultation with the MDTs, the network chemotherapy group and radiotherapy head of service, produce the network-wide clinical guidelines. Each individual MDT, for their compliance with the relevant measure on clinical guidelines in the MDT section, should agree to them. Network guidelines should be reviewed at least every 3 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-103c	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). *Note:* *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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

REFERRAL GUIDELINES

Introduction

For their compliance with this measure the NSSG should, in consultation with the MDTs, produce the network-wide referral guidelines. Each individual MDT, for their compliance with the relevant measure on referral guidelines in the MDT section, should agree to them.

Network Agreed Referral Guidelines

11-1C-104c The NSSG should agree network-wide referral guidelines (the indications for referral of the patient to another MDT, within or outside the network).

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

IMAGING GUIDELINES

Introduction

For their compliance with this measure the NSSG should, in consultation with the MDTs and the network cancer imaging group produce the network-wide imaging guidelines. Each individual MDT, for their compliance with the relevant measure on imaging guidelines in the MDT section, should agree to them.

Network Agreed Imaging Guidelines

11-1C-105c The NSSG should agree network-wide imaging guidelines for diagnosis and review. The guidelines should address:

- imaging modalities;
- their specific indications.

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

PATHOLOGY GUIDELINES

Introduction

For their compliance with this measure the NSSG should, in consultation with the MDTs and the network cancer pathology group, produce the network-wide cancer pathology guidelines. Each individual MDT, for their compliance with the relevant measure on pathology guidelines in the MDT, should agree to them.

Network Agreed Pathology Guidelines

11-1C-106c The NSSG should agree network-wide pathology guidelines for diagnosis and assessment. The guidelines should address:

- laboratory and histopathological/histochemical investigations;
- their specific indications.

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

Agreed Minimum Dataset

11-1C-107c 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 all appropriate 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.

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

11-1C-108c The NSSG should agree at least one network audit project with the Network Board.

Notes:

- *See appendix 1 for audit.*
- *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.

Discussion of Clinical Trials

11-1C-109c 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Network Agreed Three Year Service Delivery Plan

11-1C-110c The NSSG should agree proposed service developments for its cancer site, for 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.

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 the 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-111c 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.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
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-112c	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-113c	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 11-2C-1 - LUNG MULTIDISCIPLINARY TEAM (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 that 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. For some cancer types the IOG has 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 team.

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 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 treating team and its hospital facilities.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
The responsibility, for review purposes, for measure 11-2C-101 lies with the lead clinican of the host trust
MDT STRUCTURE
Lead Clinician and Core Team Membership

11-2C-101 There should be a single named lead clinician for the lung 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 of 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 lung MDT should include:

- designated respiratory physician(s);
- designated thoracic surgeon(s);
- clinical oncologist;
- medical oncologist (where the responsibility of chemotherapy is not undertaken by the clinical oncologist core member);
- imaging specialist;
- histopathologist;
- designated cytologist;
- lung nurse specialist;
- a core member of the specialist palliative care team;
- 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 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 lung 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 medically qualified core member(s) depend on the cancer site of the MDT.*
- *The co-ordinator/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 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.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	Named lead clinician for the lung MDT agreed by the lead clinician of 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 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 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.	
Level 2 Practitioners for Psychological Support	
11-2C-102	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.* • *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	
11-2C-103	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	
11-2C-104	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	
11-2C-105	The team should hold its meetings at least fortnightly, 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

MDT Agreed Cover Arrangements for Core Members

11-2C-106 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 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 below.*
- *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-career grade.*

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

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

11-2C-107 Core members or their arranged cover (see measure 11-2C-102 and 11-2C-106) should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT.

Note:

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 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.

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

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2C-108 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

11-2C-109 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

11-2C-110 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Operational Policy for Named Key Worker

11-2C-111

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.

Notes:

- *For information: according to the NICE supportive and 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 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 patient's case notes.

Core Histopathology Member Taking Part in Histopathology EQA

11-2C-112

The core histopathology 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 member, 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 specialist. The role definitions and training requirements of nurse MDT members are not very well "officially" established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were thoracic surgeons and palliative care physicians before there were established lung 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 specialist 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

11-2C-113

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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Agreed Responsibilities for Core Nurse Members

11-2C-114 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 at National Advanced Communication Skills Training Programme

11-2C-115 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 communication skills training programme.

Extended Membership of MDT

11-2C-116 The MDT 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 lung MDT should include:

- psychologist/psychiatrist;
- chaplain/pastoral care worker;
- bereavement care worker.

Notes:

- *The MDT may choose to name additional extended team members.*

- *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.*

Compliance: 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

11-2C-117

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

11-2C-118

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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Provision of Written Patient Information

11-2C-119

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 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.

Agree and Record Individual Patient Treatment Plans

11-2C-120

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, or supportive care or combinations of the same, that are to be referred 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 peer 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

CLINICAL GUIDELINES

The responsibility for review purposes for clinical guidelines lies with the lead clinician of the MDT and the chair of the NSSG. For compliance the NSSG, in consultation with the MDTs, should produce the agreed network-wide clinical guidelines. The individual MDTs, for their compliance with this measure, should agree to them.

MDT Agreement to Network Clinical Guidelines

11-2C-121

The MDT should agree specified network-wide clinical guidelines* with the NSSG for that cancer site. Where there are agreed national clinical guidelines the network and the MDT should accept these.

* i.e. how a given patient should be clinically managed (usually at the level of which modality of treatment is indicated for a given set of clinical circumstances, rather than detailed regimens or details of surgical techniques, etc).

Notes:

- *More details of regimens and techniques may be agreed if desired.*
- *See 11-1C-103c.*

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

REFERRAL GUIDELINES

The responsibility for review purposes for referral guidelines lies with the lead clinician of the MDT and the chair of the NSSG. For compliance the NSSG, in consultation with the MDTs, should produce the agreed network-wide referral guidelines. The individual MDTs, for their compliance with this measure, should agree to them.

MDT Agreement to Network Referral Guidelines

11-2C-122

The MDT should agree referral guidelines* with the NSSG.

* i.e. the indicators for referral of the patient to another MDT within or outside the network.

Notes:

- *For compliance the NSSG should produce an agreed guideline and the individual MDT for their compliance, should agree to abide by it.*
- *See 11-1C-104c.*

Compliance: The referral guidelines agreed by the lead clinician of the MDT and the Chair of the NSSG and Chair of the Network Board.

IMAGING GUIDELINES

The responsibility for review purposes for imaging guidelines lies with the lead clinician of the MDT and the chair of the NSSG. For compliance the NSSG, in consultation with the MDTs, should produce the agreed network-wide imaging guidelines. The individual, for their compliance with this measure, should agree to them.

MDT Agreement to Network Imaging Guidelines

11-2C-123

The MDT should agree imaging guidelines for diagnosis and assessment. The guidelines should address:

- imaging modalities;
- their specific indications.

Note:

See 11-1C-105c.

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

PATHOLOGY GUIDELINES

The responsibility for review purposes for pathology guidelines lies with the lead clinician of the MDT and the chair of the NSSG. For compliance the NSSG, in consultation with the MDTs, should produce the agreed network-wide pathology guidelines. The individual MDTs, for their compliance with this measure, should agree to them.

MDT Agreement to Network Pathology Guidelines

11-2C-124

The MDT should agree pathology guidelines for diagnosis and assessment. The guidelines should address:

- laboratory and histopathology/histochemical investigations;
- their specific indications.

Note:

See 11-1C-106c.

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

MDT Agreement to Network Collection of Minimum Dataset

11-2C-125

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 record of 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

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

11-2C-126

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.

Discussion of Clinical Trials

11-2C-127

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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
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.

Joint Treatment Planning for TYAs

11-2C-128

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.

MDT WORKLOAD

There is no definite evidence base for a minimum viable workload in the *'Improving Outcomes Guidance'* for lung cancer, so it is not incorporated into measures for this MDT.

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

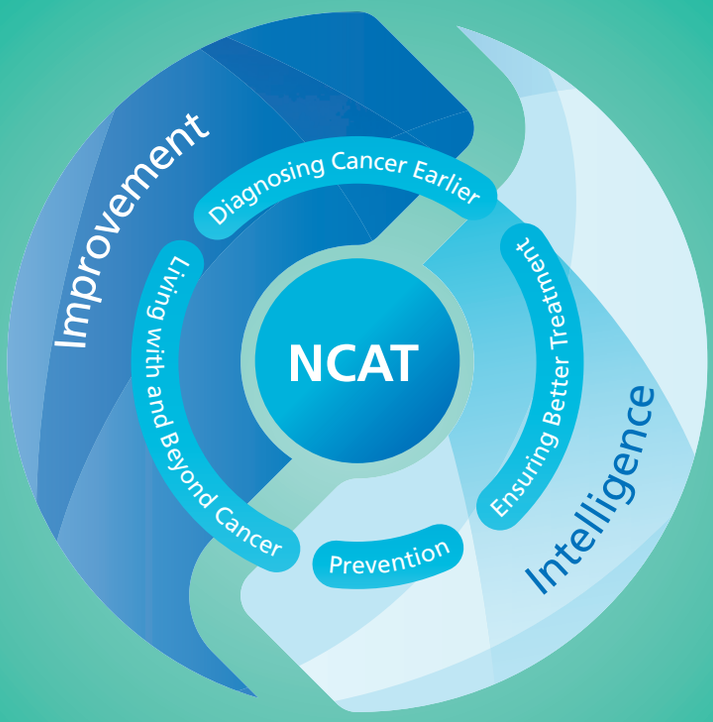
- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met:
    - to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's 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-109c	Revised research measure
11-1C-111c	Chemotherapy Algorithm generic measure for NSSGs
11-1C-112c	The TYACN Pathway for Initial Management
11-1C-113c	The TYA Pathway for Follow Up on Completion of First Line Treatment
11-2C-127	Revised research measure
11-2C-128	Joint Treatment Planning for TYAs



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