Intelligence

National Cancer Action Team

Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Upper GI Measures

Version 2.1

DH INFORMATION READER BOX

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Contents

11-1A-2f - UGI SPECIFIC NETWORK BOARD MEASURES

Measure Number	Measure
11-1A-201f	Agreed Named Members and Agreed Terms of Reference for NSSG
11-1A-202f	Network/PCT Agreed Upper GI Catchment Populations and Referral Policy
11-1A-203f	Diagnostic and Local Care Team Configuration
11-1A-204f	Network Configurations of Team
11-1A-205f	Network Agreed Referral Guidelines Between Teams

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

Measure Number	Measure
11-1C-101f	NSSG Meeting
11-1C-102f	Annual Review, Work Programme and Annual Report
11-1C-103f	Network Agreed Clinical Guidelines
11-1C-104f	Network Agreed Imaging Guidelines
11-1C-105f	Network Agreed Pathology Guidelines
11-1C-106f	Agreed Minimum Dataset
11-1C-107f	Network Audit
11-1C-108f	Discussion of Clinical Trials
11-1C-109f	Agreed NSSG Three Year Service Delivery Plan
11-1C-110f	Chemotherapy Treatment Algorithms
11-1C-111f	The TYACN Pathway for Initial Management
11-1C-112f	The TYA Pathway for Follow Up on Completion of First Line Treatment

11-2F-1 - DIAGNOSTIC AND DIAGNOSTIC/LOCAL CARE UPPER GI MULTIDISCIPLINARY TEAM (MDT)

Measure Number	Measure
11-2F-101	Lead Clinician and Core Team Membership
11-2F-102	Level 2 Practitioners for Psychological Support
11-2F-103	Support for Level 2 Practitioners
11-2F-104	Team Attendance at NSSG Meetings
11-2F-105	MDT Meetings
11-2F-106	MDT Agreed Cover Arrangements for Core Member
11-2F-107	Core Member (or cover) Present for 2/3 of Meetings
11-2F-108	Annual Meeting to Discuss Operational Policy
11-2F-109	Policy for All New Patients to be Reviewed by MDT
11-2F-110	MDT Agreement to Network Guidelines fro the Management Upper GI Cancer
11-2F-111	Policy for Communication of Diagnosis to GP
11-2F-112	MDT Agreement to Network Follow Up Guidelines
11-2F-113	Operational Policy for Named Key Worker
11-2F-114	Core Histopathology Member(s) Participating in EQA Scheme
11-2F-115	Core Nurse Member Completed Specialist Study
11-2F-116	Core Nurse Responsibilities
11-2F-117	Attendance at National Advanced Communication Skills Training Programme
11-2F-118	Extended Membership of MDT
11-2F-119	Extended Membership to include specialist palliative care representative and dietician
11-2F-120	Patient Permanent Consultation Record
11-2F-121	Patient Experience Exercise
11-2F-122	Provision of Written Patient Information
11-2F-123	Agree and Record Individual Patient Diagnosis and Referral
11-2F-124	MDT Agreement to Network Clinical Guidelines for the Management of Upper GI Cancer
11-2F-125	MDT Agreement to Network Referral Guidelines (diagnostic)
11-2F-126	MDT Agreement to Network Referral Guidelines (diagnostic/local care)
11-2F-127	MDT Agreement to Network Imaging Guidelines
11-2F-128	MDT Agreement to Network Pathology Guidelines
11-2F-129	Agreed Collection of Minimum Dataset
11-2F-130	Network Audit
11-2F-131	Discussion of Clinical Trials

Measure Number	Measure
11-2F-132	Joint Treatment Planning for TYAs

11-2F-2 - SPECIALIST UPPER GI OG MULTIDISCIPLINARY TEAM (MDT)

Measure Number	Measure
11-2F-201	Lead Clinician and Core Team Membership
11-2F-202	Level 2 Practitioners for Psychological Support
11-2F-203	Support for Level 2 Practitioners
11-2F-204	Team Attendance at NSSG Meetings
11-2F-205	MDT Meetings
11-2F-206	MDT Agreed Cover Arrangements for Core Member
11-2F-207	Core Member (or Cover) Present for 2/3 of Meetings
11-2F-208	Annual Meeting to Discuss Operational Policy
11-2F-209	Policy for All New Patients to be Reviewed by MDT
11-2F-210	Policy for Communication of Diagnosis to GP
11-2F-211	MDT Agreement to Network Specialist Team Policy for Referral Discussion
11-2F-212	MDT Meeting with Referring Teams/Collaborative Audit
11-2F-213	MDT Agreement to Network Follow Up Guidelines
11-2F-214	24-Hour On-Call Consultant Specialist Surgical Cover
11-2F-215	Intensive Care (ITU) and High Dependency Unit (HDU) in Host Hospital
11-2F-216	Single Site Surgery and Post Operative Care
11-2F-217	Operational Policy for Named Key Worker
11-2F-218	Histopathology Core Members Participating in EQA Scheme
11-2F-219	Core Nurse Member Completed Specialist Study
11-2F-220	Core Nurse Responsibilities
11-2F-221	Attendance at National Advanced Communication Skills Training Programme
11-2F-222	Extended Membership of MDT
11-2F-223	Patient Permanent Consultation Record
11-2F-224	Patient Experience Exercise
11-2F-225	Provision of Written Patient Information
11-2F-226	Individual Patient Treatment Plans
11-2F-227	MDT Agreement to Network Guidelines for the Management of Upper GI Cancer
11-2F-228	MDT Agreement to Network Referral Guidelines Between Teams/Diagnosis & Assessment
11-2F-229	MDT Agreement to Network Imaging Guidelines Diagnosis/Assessment
11-2F-230	MDT Agreement to Network Pathology Guidelines

Measure Number	Measure
	Diagnosis/Assessment
11-2F-231	Agreed Collection of Minimum Dataset
11-2F-232	Network Audit
11-2F-233	Discussion of Clinical Trials
11-2F-234	Joint Treatment Planning for TYAs

11-2F-3 - SPECIALIST UPPER GI PANCREATIC MULTIDISCIPLINARY TEAM (MDT)

Measure Number	Measure
11-2F-301	Lead Clinician and Core Team Membership
11-2F-302	Level 2 Practitioners for Psychological Support
11-2F-303	Support for Level 2 Practitioners
11-2F-304	Team Attendance at NSSG Meetings
11-2F-305	MDT Meetings
11-2F-306	MDT Agreed Cover Arrangements for Core Member
11-2F-307	Core Member (or cover) Present for 2/3 of Meetings
11-2F-308	Annual Meeting to Discuss Operational Policy
11-2F-309	Policy for All New Patients to be Reviewed by MDT
11-2F-310	Policy for Communication of Diagnosis to GP
11-2F-311	MDT Agreement to Network Specialist Team Policy for Referral Discussion
11-2F-312	MDT Meeting with Referring Teams/Collaborative Audit
11-2F-313	MDT Agreement to Network Follow Up Guidelines
11-2F-314	24-Hour On-Call Consultant Specialist Surgical Cover
11-2F-315	Intensive Care (ITU) and High Dependency Unit (HDU) in Host Hospital
11-2F-316	Single Site Surgery and Post Operative Care
11-2F-317	Operational Policy for Named Key Worker
11-2F-318	Histopathology Core Members Participating in EQA Scheme
11-2F-319	Core Nurse Member Completed Specialist Study
11-2F-320	Core Nurse Responsibilities
11-2F-321	Attendance at National Advanced Communication Skills Training Programme
11-2F-322	Extended Membership of MDT
11-2F-323	Patient Permanent Consultation Record
11-2F-324	Patient Experience Exercise
11-2F-325	Provision of Written Patient Information
11-2F-326	Agree and Record Individual Patient Treatment Plans
11-2F-327	MDT Agreement to Network Guidelines for the Management of Upper GI

Measure Number	Measure
	Cancer
11-2F-328	MDT Agreement to Network Referral Guidelines Between Teams
11-2F-329	MDT Agreement to Network Imaging Guidelines
11-2F-330	MDT Agreement to Network Pathology Guidelines
11-2F-331	Agreed Collection of Minimum Dataset
11-2F-332	Network Audit
11-2F-333	Discussion of Clinical Trials
11-2F-334	Joint Treatment Planning for TYAs

11-2F-4 - ADDITIONAL MEASURES FOR SPECIALIST PANCREATIC MDT WHICH IS BEING PUT FORWARD FOR REVIEW ALSO AS A LIVER RESECTION MDT

Measure Number	Measure
11-2F-401	Team Attendance at NSSG Meetings
11-2F-402	MDT Agreed Follow Up Policy
11-2F-403	Named Hospital for Mastastectomies With ITU and HDU Facilities On Site
11-2F-404	MDT Oncology Agreement
11-2F-405	Provision of Written Patient Information
11-2F-406	Agreed Clinical Guidelines
11-2F-407	MDT Agreement to Network Referral Guidelines
11-2F-408	Agreed List of Approved Trials

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

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.

UPPER GI SPECIFIC MEASURES

Introduction

The Improving Outcomes Guidance (IOG) Upper GI tract cancer has further developed the concepts previously used for gynae cancer. The latter involved a simple division between centre and unit teams with instructions on distribution of work. Thus, for Upper GI (UGI) tract cancer the guidance describes a network-wide structure of team types with more detailed instructions on how these teams should relate to each other and to primary care. The specific configuration of teams in a given centre or unit may take different forms depending on the catchment population and the overall structure of the service in the network to which the centre or unit belongs. The recommended minimum catchment population is 1 million for oesophago-gastric (OG) cancer and 2 million for pancreatic cancer. These considerations have determined the format of this section of the measures and have necessitated specific measures for UGI tract cancer for the Network Board and the network site specific group. These have been incorporated into UGI-specific parts of the network measures, which have been attached to the UGI measures. The measures also move more into the areas of the diagnostic process and liaison with primary care. This has been considered necessary because the organisation of the diagnostic process has such an obvious and far-reaching effect on the overall pathway of those patients who are subsequently found to have the disease.

It is recognised that the changes necessary to achieve full compliance with these measures will take time and resources. A given network may need to take a phased approach to this (over transfer of workload for instance).

Levels of Care

There are three defined levels of care:

a) The diagnostic process

b) Local care

All patients diagnosed with UGI cancer should be individually discussed with a member of the specialist team (see references to 'teams' below), prior to any proposed treatment. Subject to this and subject to agreement in the network's own guidelines, local care may be delivered under the care of a member(s) of the local UGI team.

The treatment and procedures classed in these measures as local care are:

i) Palliative surgical bi-pass procedures
ii) Palliative stenting
iii) Other endoscopic debulking methods to clear blockage by tumour, except intraluminal radiotherapy
iv) Palliative chemotherapy
v) Palliative and supportive care, not involving active, tumour shrinking or debulking therapy.

Procedures classed as local care may also be delivered under the care of a member(s) of the specialist team.

c) Specialist Care

This should only be delivered under the care of a member(s) of the specialist team (see references to 'teams' below) and this is not subject to change by the network's own guidelines.

The treatments and procedures classed in these measures as specialist care are:

i) All tumour resective surgery, whether with curative or palliative intent. In addition to being under the care of specialist team members, this should only be carried out in the host hospital of the specialist team.
ii) The following treatments, which should be delivered under the care of a member of the specialist team but the site of delivery is subject to agreement in the network's guidelines:
iii) Chemo/radiotherapy
iv) Adjuvant chemotherapy (recommended currently only for gastric cancer)
v) Intraluminal radiotherapy.

Notes:

- *Emergency surgical procedures where the diagnosis is unforeseen and is made at the time of the operation, are not subject to these measures.*
- *Palliative external beam radiotherapy has only a limited role in the treatment of primary UGI cancer and would be delivered in the radiotherapy department. It is not mandatorily covered by these measures.*

Shape of the Service

a) The diagnostic process should be carried out by a defined diagnostic team which liaises with primary care over the "guidelines for urgent referral for suspected cancer". The team refers cancer patients to other teams providing local care or specialist care.

It can be foreseen that some small hospitals far from other services would host a diagnostic team in isolation. However, by applying an underlying principle of the IOG Upper GI tract guidance, i.e. consolidation of services for a group of relatively rare cancers, then in most instances the diagnostic team will also offer local care to the relevant local patients.

Following the same principle and the fact that both the diagnostic process and local care will largely be undertaken by the same personnel, it is recommended local care teams should not exist in isolation from the diagnostic process. Therefore the measures refer to diagnostic and combined diagnostic/local care teams, the latter comprising of the diagnostic team with some modifications. For the special situation where a population is served by a local hospital hosting a specialist team, there are different arrangements for the diagnostic process and local care delivery which are described later.

b) Specialist care should be provided by defined and separate specialist teams for OG cancer and pancreatic cancer. With reference to the team's catchment population, the 1 million minimum for OG means that some localities and even some smaller networks will not be able to have a team. The 2 million population minimum for pancreatic cancer means that currently, in England, no network on the basis of its own catchment population will be able to have more than one pancreatic team.

A further principle in the IOG Upper GI guidance is that the meetings, surgical operations and acute post-operative care (including HDU and ITU) of a given specialist team should all take place in one hospital. This principle, together with the minimum catchment populations and the principle of consolidation of services for a group of relatively rare cancers have the following important implications:

- In a given trust which has a specialist OG team, it should be the only OG team for that trust.
- In a given trust which has a specialist pancreatic team it should be the only pancreatic team for that trust.

The exact boundaries of what constitutes a team and what does not, as outlined in the introduction to MDTs, is especially important here.

c) The diagnostic process and the delivery of local care for the local population of a hospital hosting a specialist team will now be considered. It is important to ensure that the specialist team experiences the management of the whole spectrum of severity of its cancer type. This and again the principle of consolidation of services for a group of relatively rare cancers means that specialist teams should also provide the local care for the secondary referral (local) catchment population of the locality to which they belong unless this imposes excessive travel requirements on frail patients. Furthermore this means that in a locality with only a specialist OG team this team should provide local care for pancreatic as well as OG cancer. A locality with a pancreatic team will also be large enough for an OG team so each will provide local care for its own cancer type. In a locality with a specialist team working in accordance with the guidance entirely in a single hospital, there may therefore be other hospitals classed as part of that locality which provide diagnostic teams which refer directly to the specialist team for both specialist and local care.

The principles outlined above mean that a unified agreement over the service configuration is needed across the whole of each network and possibly (particularly in the case of pancreatic specialist teams) between neighbouring networks involving inter-network referrals.

Configurations

These implications of the guidance lead to the following possible service configurations within a given locality which may be offered for assessment having first been agreed by the relevant Network Board. (See relevant parts of topic 1A). Their agreement is the overall responsibility of the Chair of the Network Board and their establishment is reviewed under topic 1A.

- **Locality (>2m) with specialist teams for pancreatic and OG cancer, and diagnostic team(s).**

a) Single specialist/local care team for pancreatic cancer; and

b) Single specialist/local care team for OG cancer; and

c) One or more diagnostic teams conforming to the referral agreement between the Network Board and local PCTs for the secondary referral catchment population of the locality.

Note:

It is recommended that local care for the locality's secondary catchment population is provided by the specialist teams. In exceptional circumstances where this produces excessive travelling for frail patients, the extension of named diagnostic teams to provide local care in named locations should be agreed by the Network Board (see topic 1A).

- **Locality (>1m; <2m) with specialist team for OG and diagnostic team(s).**

a) Single specialist team giving OG specialist care and local care for both OG and pancreatic.

b) One or more diagnostic teams conforming to the referral agreement between the network management group and local PCTs for the secondary referral catchment population of the locality.

Note:

It is recommended that local care for the locality's secondary catchment population is provided by the specialist team. In exceptional circumstances where this produces excessive travelling for frail patients, the extension of named diagnostic teams to provide local care in named locations should be agreed by the Network Board (see topic 1A).

- **Locality (<1m) with no specialist teams.**

a) A single diagnostic/local care team.

Note:

In exceptional circumstances where this produces excessive travelling for frail patients, the establishment of more than one named diagnostic/local care team in named locations should be agreed by the Network Board (see topic 1A).

Building the UGI Cancer Network

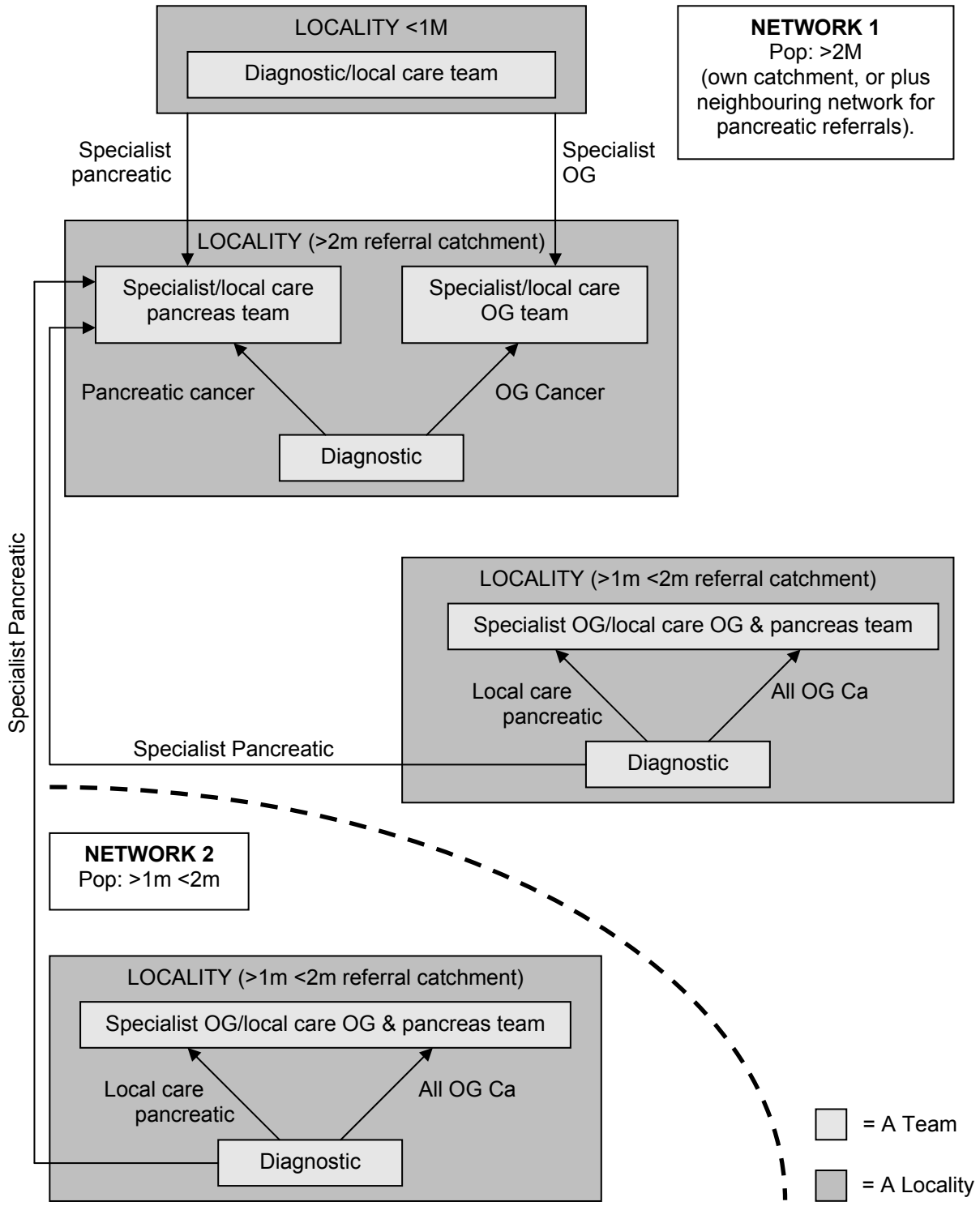
The measures assign the responsibility for establishing the UGI cancer network arrangements to the Network Board, acting in agreement with the network site-specific group and the PCTs.

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

i) Agree the identity and location of diagnostic UGI teams for the network.
ii) Agree the referral arrangements between PCTs and diagnostic teams.
iii) Find the referring catchment population of each diagnostic team from the numbers associated with its referring PCTs.
iv) Agree the configuration of diagnostic/local care/specialist teams for the network.
v) Agree the specific referral guidelines between teams across the network and if necessary between neighbouring networks.
vi) Confirm the referring catchment populations of each specialist team by adding the populations of the teams own referring diagnostic teams.

How the configurations work

The following figure illustrates examples of the configurations and how a typical group of localities would relate, according to the measures, within and across networks.



TOPIC 11-1A-2f - UGI 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 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-201f to 11-1A-205f lies with the Chair of the Network Board.	
Agreed Named Members and Agreed Terms of Reference for NSSG	
11-1A-201f	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 NSSG member responsible for ensuring 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 being recognised for its particular cancer site as:

- the board's primary source of clinical opinion on issues relating to upper GI 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, 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 found in appendix 2.*
- *Where a separate HPB NSSG is in existence this measure applies to both groups. For compliance both groups should meet the specific requirements of the measure.*

The network board should agree, with PCT leads for the catchment population of their network, a policy that their primary care practitioners will refer all patients defined by the 'urgent, suspicious of cancer' guidelines for UGI cancer to the contact point of a single named diagnostic or diagnostic/local care team on the list agreed in measure 11-1A-202f.

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.

The written policy agreed by the chair of the network board and PCT leads.

PRIMARY CARE REFERRAL POLICY

Network/PCT Agreed Upper GI Catchment Populations and Referral Policy

11-1A-202f

The Network Board should agree, with PCT leads for the catchment population of their network, a policy that their primary care practitioners will refer all patients defined by the 'urgent, suspicious of cancer' guidelines for UGI cancer to the contact point of a single named diagnostic or diagnostic/local care team on the list agreed in measure 11-1A-203f.

Compliance: The written policy agreed by the Chair of the Network Board and PCT leads.

Diagnostic and Local Care Team Configuration

11-1A-203f

The Network Board should agree, with PCT leads and the NSSG for UGI cancer:

- the location of named diagnostic and diagnostic/local care teams in the network;
- the named PCTs or named individual practices which will refer patients (defined by

the 'urgent, suspicious of cancer' guidelines for UGI cancer) to the named diagnostic or diagnostic/local care team; one practice referring to only one team.

Notes:

- *This includes specialist teams acting in their capacity as local teams for their own local (secondary) catchment population.*
- *The principles of a given primary care practice or PCT stating that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of local and specialist MDTs can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations are counted once, for planning purposes . It is accepted that individual patients will, on occasion, be referred to different teams depending on specific circumstances.*

The Network Board should calculate the referring catchment population of each named diagnostic or diagnostic/local care team. No individual primary care practice's population should count more than once.

Compliance: The list of named teams of which named type, hosted by which named hospital, together with each team's named referring PCTs or individual practices and catchment populations agreed by the Chair of the Network Board, Chair of the NSSG for UGI cancer and network PCT leads.

Network Configurations of Team

11-1A-204f The Network Board should agree, in consultation with the NSSG and lead clinicians of each trust in the network, the configuration of the teams in each locality in the network, complying with the following:

i) the configurations should conform to one or other of those described in the introduction to UGI measures;
ii) all diagnostic and diagnostic/local care teams should be included in the configuration of one or other locality.

The Network Board should agree, in consultation with the NSSG and lead clinician of each specialist team in the network, the catchment populations for referral for specialist care to named specialist teams. This should be a minimum of 1 million for OG teams and 2 million for pancreatic teams. The population should be estimated, in each case, from the catchment populations of their respective referring diagnostic and diagnostic/local care teams.

Note:

All specialist teams should be offered for review against this measure.

Compliance: The agreed configurations of each locality in the network, agreed by the Chair of the Network Board, Chair of the NSSG and the relevant lead clinician for each locality.

The configuration should name each team of named type hosted by named hospitals.

A list of each named specialist team in the network with the relevant catchment population agreed by the Chair of the Network Board, Chair of NSSG and relevant MDT lead clinician.

Notes:

When specialist teams receive referrals from other networks the catchment populations of the referring diagnostic and diagnostic/local care teams from the other networks should be counted towards the total catchment populations of the receiving specialist team in the receiving network.

The population of diagnostic and diagnostic/local care teams should count once and in only one network for each of the two cancer groups, OG and pancreatic. If, for example, a team refers, say, OG patients to an OG specialist team in their own network, but pancreatic patients to a pancreatic specialist team in another network, its catchment population counts once for OG cancer to their own network's OG team, and once for pancreatic cancer to the other receiving network pancreatic team.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
*For compliance with this measure, a Network Board should have in their network **EITHER** a specialist team **OR** teams each with at least the minimum referral catchment population **OR** no specialist teams. This can be achieved by the* network *having agreed to refer patients for specialist care for one or both of the cancer groups (OG and pancreatic) to the relevant team in another receiving network, if the original (referring) network is unable to provide the specialist teams serving the minimum population. This should be agreed as part of the network's 'referral guidelines between teams'.*
REFERRAL GUIDELINES BETWEEN TEAMS
In view of (a) the various possible configurations of service and (b) the need to have agreed the particular group of configurations for the network, the responsibility for review purposes for referral guidelines lies with the lead clinician of the MDT, the Chair of the NSSG and the Chair of the Network Board. For compliance, the Network Board in consultation with the NSSG, should produce agreed guidelines and the individual MDT, for their compliance, should agree to them. The measures count towards the review of the Network Board and the individual team.
Network Agreed Referral Guidelines Between Teams
11-1A-205f The Network Board should agree, in consultation with the NSSG, referral guidelines for each named team in the network, complying with the contents specified in the 'referral guidelines between teams' measures for each team type. *Notes:* • *Diagnostic teams and teams dealing with local care may make referrals to specialist teams in another network and specialist teams may receive referrals from another network, all on the grounds of minimum catchment populations.* • *These agreed arrangements should be stated, naming teams and their host hospitals as in the referral guidelines in topic 2F. For these inter-network arrangements the responsibility for review lies with the Network Board and MDT lead clinician from the referring network.* *Compliance:* The referral guidelines for each named team in the network, agreed by the Chair of the Network Board and the Chair of the NSSG.

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

Introduction

The measures in this section should be applied separately to each NSSG in the network.Where there is a seperate HPB NSSG a duplicate set of measures should be applied.

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 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
GENERAL ACTIVITIES	
NSSG Meeting	
11-1C-101f	The NSSG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed as part of each MDT 's measures.*
Compliance:	A list of meetings and attendance records in the last 12 months.
Annual Review, Work Programme and Annual Report	
11-1C-102f	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.
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	
For their compliance with this measure, the NSSG should, in consultation with the MDTs, 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 Agreed Clinical Guidelines	
11-1C-103f	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.* • *See further instructions on clinical guidelines for UGI cancer.*
Compliance:	The clinical guidelines agreed by the Chair of the NSSG and the Chair of the Network Board.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

IMAGING GUIDELINES

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-104f 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

For 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-105f 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-106f 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-107f 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.

Discussion of Clinical Trials

11-1C-108f 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 of 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.

Agreed NSSG Three Year Service Delivery Plan

11-1C-109f 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 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-110f 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-111f 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
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-112f	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 11-2F-1 - DIAGNOSTIC AND DIAGNOSTIC/LOCAL CARE UPPER GI MULTIDISCIPLINARY TEAM (MDT)

Introduction

The diagnostic process should be carried out by a defined diagnostic team which liaises with primary care over the "guidelines for urgent referral for suspected cancer". The team refers cancer patients to other teams providing local care or specialist care.

It can be foreseen that some small hospitals far from other services would host a diagnostic team in isolation. However, by applying an underlying principle of the IOG upper GI tract guidance, i.e. consolidation of services for a group of relatively rare cancers, then in most instances the diagnostic team will also offer local care to the relevant local patients. Following the same principle and the fact that both the diagnostic process and local care will largely be undertaken by the same personnel, it is recommended local care teams should not exist in isolation from the diagnostic process. Therefore the measures refer to diagnostic and combined diagnostic/local care teams, the latter comprising of the diagnostic team with some modifications. For the situation where a population is served by a local hospital hosting a specialist team, there are different arrangements for the diagnostic process and local care delivery which are described later.

UPPER GI DIAGNOSTIC TEAM AND DIAGNOSTIC/LOCAL CARE TEAM

This set of measures should be applied to both types of team, except where more specific applications are stated for certain measures.

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 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 reviewed 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 as 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	
MDT STRUCTURE	
The responsibility, for review purposes, for measure 11-2F-101 lies with the lead clinician of the host trust (see topic 1A).	
Lead Clinician and Core Team Membership	
11-2F-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 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 UGI cancer diagnostic or diagnostic/local care team should include: • one or more clinicians (physicians or surgeons) specialising in gastroenterology; • endoscopist of any discipline, who could be one of the other team members; • histopathologist; • radiologist; • clinical oncologist; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member); • upper GI nurse specialist; • MDT co-ordinator/secretary; • a core member of the specialist palliative care team. • 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 MDT nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the MDT. *Notes:*

- *Each clinical core member should have sessions specified in the job plan for the care of patients with upper GI 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 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 with their role, agreed by the lead clinician of the MDT.

Note:

The reviewers should record in their reports 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.

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

Level 2 Practitioners for Psychological Support

11-2F-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

11-2F-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

11-2F-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 Meetings

11-2F-105 The team should hold its meetings at least weekly, 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 Core Member

11-2F-106 The MDT should agree named cover arrangements for each core member (see 11-2F-101).

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 if not should be a specialist trainee or non-consultant career grade.*

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

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

11-2F-107 Core members or their arranged cover (see measures 11-2F-101 and 11-2F-106) 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.

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.

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2F-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

11-2F-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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
MDT Agreement to Network Guidelines fro the Management Upper GI Cancer	
11-2F-110	The MDT should have agreed a policy whereby all patients diagnosed with UGI cancer are discussed with a member of the relevant specialist team prior to referral to the specialist team or prior to proposed local care. The date at which the discussion took place should be recorded in the case notes.
Compliance:	The written policy, agreed by the lead clinician of the MDT.
Policy for Communication of Diagnosis to GP	
11-2F-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 the policy of the timeliness of notification to general practitioners of the diagnosis of cancer.
Compliance:	The written policy agreed by the lead clinician of the MDT. The written results of the audit.
Measures 11-2F-112 and 11-2F-113 apply to the diagnostic/local care team only.	
MDT Agreement to Network Follow Up Guidelines	
11-2F-112	Follow up arrangements between the specialist team and the referring diagnostic/local care team(s) may vary locally according to circumstances, but written follow up guidelines should be agreed between the specialist team and the referring team(s). The arrangements should include those for patients who are referred to the specialist team but are found to be unsuitable for specialist care.
Compliance:	Follow up guidelines agreed by the lead clinician of the specialist MDT and the Chair of the NSSG.
Operational Policy for Named Key Worker	
11-2F-113	There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s). The policy should have been implemented 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 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 patients' case notes.
Core Histopathology Member(s) Participating in EQA Scheme	
11-2F-114	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 MDT member with its related activities which, in full measure, go to make up the role of the 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 UGI surgeons and palliative care physicians before there were established UGI 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

11-2F-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.

Core Nurse Responsibilities

11-2F-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).

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
Attendance at National Advanced Communication Skills Training Programme
11-2F-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 communication skills training programme.
The following measure applies to the diagnostic team only
Extended Membership of MDT
11-2F-118 The MDT should provide the names of members of the extended team for named roles in the team. *Notes:* • *The MDT may choose to have no extended team. This should be stated in writing.* *Compliance:* Name of each extended team member with their role, or written agreement to have no extended team, agreed by the lead clinician of the MDT. Name of each extended team member and their role, agreed by lead clinician of the MDT.
The following measure applies to the diagnostic/local care team only
Extended Membership to include specialist palliative care representative and dietician
11-2F-119 If they are not already offered as core team members, the named team for the extended MDT should include: • core member of the specialist palliative care team; • dietician. Note: • The MDT may wish 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 and their role, agreed by lead clinician of the MDT.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

PROVIDING PATIENT CENTRED CARE

Patient Permanent Consultation Record

11-2F-120

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 examples of anonymised 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

11-2F-121

The MDT should have undertaken (or be undertaking) 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

11-2F-122

The MDT should provide patients and carers written material 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 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 named extended team for the MDT should include:

- *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 facilitates 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.

DIAGNOSTIC REFERRAL DECISION

The following measure applies to the diagnostic/local care team only.

Agree and Record Individual Patient Diagnosis and Referral

11-2F-123 The core MDT at their regular meetings should agree and record patients' diagnosis and subsequent referral. The record should include:

- the identity of patients discussed;
- the diagnosis, at the time of making the referral decision;
  (i) benign
  (ii) malignant (with histological confirmation)
  (iii) malignant (without histological confirmation)
- type of cancer (pancreatic or OG);
- referral decision (which should be updated if necessary after the discussion of the case with a specialist team member);
  (i) retained for local care by diagnostic/local care team
  (ii) to which specialist team (named if more than one is possible from the relevant configuration)
- in the case of patients referred for specialist care to another team in the network, the team to which they are referred should be named.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: Anonymised examples of the record of a meeting 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 proforma as well as in individual patients' notes.

CLINICAL GUIDELINES

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

MDT Agreement to Network Clinical Guidelines for the Management of Upper GI Cancer

11-2F-124

a) The MDT should agree network-wide clinical guidelines for patients diagnosed with UGI cancer with the NSSG. The guidelines should state the parameters of disease stage and patient fitness which determine when each of the treatments/ procedures classified as local care or specialist care, in the introduction, are indicated.

b) The diagnostic/local care team should agree with each of its specialist teams and the NSSG:

- which of the treatments/procedures classified as local care in the introduction may be delivered by the local care team, subject to each case being discussed with a member of the specialist team prior to the proposed treatment.

Note:

A diagnostic-only team would usually refer all patients directly to a specialist team.

Compliance: The clinical guidelines agreed by the lead clinician of the diagnostic/local care team and the Chair of the NSSG.

REFERRAL GUIDELINES BETWEEN TEAMS

In view of (a) the various possible configurations of the service and (b) the need to have agreed the particular group of configurations for the network, the responsibility for review purposes for referral guidelines lies with the lead clinician of the MDT, the Chair of the NSSG, and the Chair of the Network Board. For compliance the Network Board, in consultation with the NSSG, should produce agreed guidelines and the individual MDT for their compliance should agree them. The measures count towards the review of the Network Board and the individual teams.

The following measure applies to the diagnostic team only.

MDT Agreement to Network Referral Guidelines (diagnostic)

11-2F-125

The MDT should agree referral guidelines which include the following:

- to what extent and in what circumstances the diagnostic team may further investigate a patient after the diagnosis of malignancy and before referral to other teams;
- that patients who need specialist care are referred to teams offering specialist care with the names of the teams and their host hospitals;
- that patients who need local care are referred to a team offering local care with the name of the team and their host hospitals.

Notes:

- *Specialist care and local care are defined in the introduction to the UGI measures.*
- *It is strongly recommended that when patients are referred for care to another team all members of the referring MDT refer patients with a given cancer type to the same*

named team.

- *Referral agreements between PCTs and the diagnostic team are dealt with in topic 1A.*

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

Note:

Diagnostic and diagnostic/local care teams may make referrals to specialist teams in another network on the grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (receiving) network, with their host hospitals.

The following measure applies to the diagnostic/local team only.

MDT Agreement to Network Referral Guidelines (diagnostic/local care)

11-2F-126

The MDT should agree referral guidelines which include the following:

- to what extent and in what circumstances the diagnostic team may further investigate a patient after the diagnosis of malignancy and before referral to other teams;
- that patients who need specialist care are referred to teams offering specialist care with the names of the teams and their host hospitals.

Notes:

- *Specialist care and local care are defined in the introduction to the UGI measures.*
- *It is strongly recommended that when patients are referred for care to another team all members of the referring MDT refer patients with a given cancer type to the same named team.*

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

Note:

Diagnostic and diagnostic local care teams may make referrals to specialist teams in another network on the grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (receiving) network, with their host hospitals.

IMAGING GUIDELINES

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

MDT Agreement to Network Imaging Guidelines

11-2F-127

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

- imaging modalities;
- their specific indications.

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

PATHOLOGY GUIDELINES

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

MDT Agreement to Network Pathology Guidelines

11-2F-128 The MDT should agree pathology guidelines for diagnosis and review. The guidelines should address:

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

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

Agreed Collection of Minimum Dataset

11-2F-129 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

11-2F-130 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:

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	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	
11-2F-131	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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Joint Treatment Planning for TYAs	
11-2F-132	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 11-2F-2 - SPECIALIST UPPER GI OG MULTIDISCIPLINARY TEAM (MDT)

Introduction

Specialist care should be provided by defined and separate specialist teams for OG cancer and pancreatic cancer. With reference to the team's catchment population, the 1 million minimum for OG means that most cancer centres and some larger cancer units will potentially be able to host a team. Some smaller centres and even some smaller networks will not be able to have a team however. The 2 million population minimum for pancreatic cancer means that no cancer units and only some centres will be able to have a team. Also the 2 million minimum means that currently, in England, no network on the basis of its own catchment population will be able to have more than one pancreatic team.

A further principle in the IOG upper GI guidance is that the meetings, surgical operations and acute post-operative care (including HDU and ITU) of a given specialist team should all take place in one hospital. This principle, together with the minimum catchment populations and the principle of consolidation of services for a group of relatively rare cancers have the following important implications:

- in a given single locality which has a specialist OG team, it should be the only OG team for that locality;
- in a given locality which has a specialist pancreatic team it should be the only pancreatic team for that locality.

The exact boundaries of what constitutes a team and what does not, as outlined in the introduction to MDTs is especially important here. This set of measures should be applied to both types of team (OG and pancreatic).

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 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 as 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

MDT STRUCTURE

The responsibility, for review purposes, for measure 11-2F-201 lies with the lead clinician of the host trust (see topic 1A).

Lead Clinician and Core Team Membership

11-2F-201

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

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

Note:

The role of the 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 defined roles in the team.

The core team specific to the specialist OG MDT should include:

- two or more surgeons;

Note to the above point:

OG or thoracic surgeons may count as core team surgeons.

It is recommended that these are not also hepato-pancreatico-biliary surgeons.

In order to achieve measure 11-2F-214 a 24-hour surgical on-call rota - at least three specialist consultant surgeons per team would be needed.

- physician gastroenterologist;
- clinical oncologist;
- medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member);
- dietician;
- histopathologist;
- imaging specialist;
- OG 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 that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT;
- at least one of the core team radiologists should be an interventional radiologist;
- there should be a core team member trained in endoscopic ultrasonography.

Notes:

- *Each clinical core member should have sessions specified in the job plan for the care of patients with upper GI 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 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 may not occupy the whole of an individual's job description.*

The MDT may choose to name additional core members.

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 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.

Level 2 Practitioners for Psychological Support

11-2F-202 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

11-2F-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

11-2F-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.

MDT Meetings

11-2F-205 The team should hold its meetings at least weekly, 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).

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	Attendance records of the meetings. Written procedure agreed by the lead clinician of the MDT.
MDT Agreed Cover Arrangements for Core Member	
11-2F-206	The MDT should agree named cover arrangements for each core member (see 11-2F-201). *Notes:* • *This refers to the nominating of staff who should in general be expected to provide cover for core members e.g. 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 if not should be a specialist trainee or non-consultant career grade.*
Compliance:	Written arrangements agreed by the lead clinician of the MDT.
Core Member (or Cover) Present for 2/3 of Meetings	
11-2F-207	Core members or their arranged cover (see measures 11-2F-201 and 11-2F-206) should attend at least two thirds of the number of meetings.
Compliance:	Attendance record of the MDT or audit results. 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 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.* *Compliance with this measure also confers compliance with measure 11-2F-206.*
OPERATIONAL POLICIES	
Annual Meeting to Discuss Operational Policy	
11-2F-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 illiustrate the recording of at least some operational policies.
Policy for All New Patients to be Reviewed by MDT	
11-2F-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	
11-2F-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 the policy of the timeliness of notification to GPs of a diagnosis of cancer.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The written policy agreed by the lead clinician of the MDT. The written results of the audit.

The next measure applies to specialist teams referring some cancer types to another specialist team elsewhere in the network or neighbouring network.

MDT Agreement to Network Specialist Team Policy for Referral Discussion

11-2F-211 The MDT should have agreed a policy whereby all patients diagnosed with the relevant cancer type are discussed with a member of the relevant specialist team prior to referral to that specialist team or prior to proposed local care. The date at which the discussion took place should be recorded in the case notes.

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

For the following measure, the specialist team should comply with either section (a) or section (b).

MDT Meeting with Referring Teams/Collaborative Audit

11-2F-212 a) During the year prior to the peer review visit, the specialist MDT should have held a meeting at which at least one core member representative of the specialist team met with at least one core member representative of each of its referring diagnostic, diagnostic/local care teams, and any specialist referring teams, to review all the cases during the previous year diagnosed as having cancer (with or without histological confirmation). At the meeting they should have ascertained whether all cases diagnosed with UGI cancer, relevant to that specialist team, were discussed with them prior to referral or to proposed local care, and whether referrals were consistent with the network clinical and referral guidelines.

b) During the year prior to the peer review visit the specialist team, with any other specialist teams in the network, should have carried out as one of the agreed network audit projects the following:

- an audit of cases (over at least the previous year) diagnosed as having cancer by its referring diagnostic and diagnostic/local care teams (with or without histological confirmation);
- cases referred for specialist care and local care should be audited for consistency with the clinical and referral guidelines;
- the audit should also ascertain whether all cases diagnosed with UGI cancer relevant to that specialist team were discussed with them prior to referral or to proposed local care.

Notes:

- *The meeting should include a representative of any specialist team referring a certain cancer type to the team in question, whether from within the network or from a neighbouring network.*
- *For sections a) and b) of this measure, compliance or non-compliance count towards the specialist MDT.*
- *In section b), completion of the relevant audit project would provide compliance for this measure as well as compliance for part of the network audit.*

Compliance: Written confirmation, including attendance list of the meeting and the results of the audit as applied to the specialist team in question.

MDT Agreement to Network Follow Up Guidelines

11-2F-213 Follow up arrangements between the specialist team and the referring diagnostic/local care team(s) may vary locally according to circumstances, but written follow up guidelines should be agreed between the specialist team and the referring team(s).

The arrangements should include those for patients who are referred to the specialist team but are found to be unsuitable for specialist care.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	Follow up guidelines agreed by the lead clinician of the specialist MDT and the Chair of the NSSG.
24-Hour On-Call Consultant Specialist Surgical Cover	
11-2F-214	There should be 24-hour on-call consultant specialist surgical cover for post operative care. *Note:* *To achieve this measure at least three specialist consultant surgeons per team would be needed.*
Compliance:	24-hour on-call rota staffed by core team surgical members.
Intensive Care (ITU) and High Dependency Unit (HDU) in Host Hospital	
11-2F-215	There should be intensive care (ITU) and high dependency unit (HDU) facilities available in the hospital hosting the specialist MDT.
Compliance:	Reviewers to view the facilities. *Note:* *For the purpose of self-assessment the facilities should be confirmed within the teams' operational policy.*
Single Site Surgery and Post Operative Care	
11-2F-216	The treatment planning meetings, operations and acute post-operative care activities of the MDT should all be carried out in the same hospital.
Compliance:	Reviewers to view the facilities and enquire of team working arrangements.
Operational Policy for Named Key Worker	
11-2F-217	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 these measures and who are under their care at the time of the peer review visit. *Notes:* • *For information - according to the NICE IOG guidance palliative and supportive care guidance the 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 patients case notes.
Histopathology Core Members Participating in EQA Scheme	
11-2F-218	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 MDT member, with its related activities which, in full measure, go to make up the role of the 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 UGI surgeons and palliative care physicians before there were established UGI 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

11-2F-219 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 the certificate of successful completion of the course/module.

Core Nurse Responsibilities

11-2F-220 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).

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Attendance at National Advanced Communication Skills Training Programme

11-2F-221

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

11-2F-222

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 MDT should include:

- cytopathologist;
- core member of the specialist palliative care team;
- anaesthetist/intensivist.

Notes:

- *The anaesthetist/intensivist should at least represent this specialty at MDT operational policy meetings and co-ordinate this aspect of the MDT's activities.*
- *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 CENTRED CARE

Patient Permanent Consultation Record

11-2F-223

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

11-2F-224

The MDT should have undertaken (or be undertaking) 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

11-2F-225

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.

Individual Patient Treatment Plans

11-2F-226 The core MDT, at their regular meetings, should agree and record individual patient's treatment plans. A record is made of the treatment plan. The record should include:

- the identity of patients discussed;
- the multidisciplinary treatment planning decision i.e. to which modalities of specialist care, or local care (surgery, radiotherapy, chemotherapy, combinations or supportive care) they are to be referred for consideration;
- in the case of patients referred for specialist care to another specialist team in the network, or in a neighbouring network, the named specialist team to which they are referred.

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 a meeting 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 proforma as well as in individual patients' notes.

CLINICAL GUIDELINES

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

MDT Agreement to Network Guidelines for the Management of Upper GI Cancer

11-2F-227 a) The MDT should agree network-wide clinical guidelines for patients diagnosed with UGI cancer with the NSSG. The guidelines should state the parameters of disease stage and patient fitness which determine when each of the treatments/procedures classified as local care or specialist care, in the Introduction and relevant to the specialists team's cancer type are indicated.

b) The specialist team should agree with each of its referring teams and the NSSG:

- which of the treatments/ procedures, classified as local care in the introduction and relevant to the specialist team's cancer type, may be delivered by that local team subject to each case being discussed with a member of the specialist team prior to the proposed treatment;
- which sites may be used by specialist team members to deliver those 'specialist classified' treatments which may be carried out, outside the specialist team's host hospital.

Notes:

- *A diagnostic-only team would usually refer all patients directly to a specialist team.*

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

Note:

It is recommended that this essential information is recorded on an MDT proforma as well as in individual patients notes.

REFERRAL GUIDELINES

The format of these measures and related measures in topic 1A is specific to UGI cancer. In view of (a) the various possible configurations of the service and (b) the need to have agreed the particular group of configuration for the network, the responsibility for assessment purposes for referral guidelines lies with the lead clinician of the MDT, the Chair of the NSSG, and the Chair of the Network Board. For compliance the Network Board, in consultation with the NSSG, should produce agreed guidelines and the individual MDT, for their compliance should agree them. The measures count towards the assessment of the Network Board and individual teams.

MDT Agreement to Network Referral Guidelines Between Teams/Diagnosis & Assessment

11-2F-228 The MDT should agree referral guidelines which includes the following:

- to what extent and in what circumstances the referring diagnostic teams may further investigate a patient after the diagnosis of malignancy and before referral to the specialist team;
- that patients who need specialist care are referred to (name of team being reviewed) from the (name of referring diagnostic and diagnostic/local care teams);
- that patients who need local care are referred to (name of team being reviewed) from the (name of diagnostic teams referring for local care), (applies to specialist teams also providing local care);
- that patients who need specialist care in another network, are referred to (name of team in the other network) from the (name of the team being reviewed).

Notes:

- *Specialist care and local care are defined in the introduction to the UGI measures.*
- *It is strongly recommended that when patients are referred for care to another team all members of the referring MDT refer patients with a given cancer type to the same named team.*
- *Referral agreements between PCTs and UGI teams are dealt with in topic 1A.*

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

Note:

Specialist teams may receive referrals from diagnostic and diagnostic/local care teams in other networks on grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (referring) networks with their host hospitals.

IMAGING GUIDELINES

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

MDT Agreement to Network Imaging Guidelines Diagnosis/Assessment

11-2F-229 The MDT should agree imaging guidelines for diagnosis and review. The guidelines should address:

- imaging modalities;

- their specific indications.

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

PATHOLOGY GUIDELINES

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

MDT Agreement to Network Pathology Guidelines Diagnosis/Assessment

11-2F-230 The MDT should agree pathology guidelines for the diagnosis and assessment. The guidelines should address:

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

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

Agreed Collection of Minimum Dataset

11-2F-231 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 the 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

11-2F-232

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

11-2F-233

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	
11-2F-234	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 11-2F-3 - SPECIALIST PANCREATIC MULTIDISCIPLINARY TEAM (MDT)

Introduction

Specialist care should be provided by defined and separate specialist teams for OG cancer and pancreatic cancer. With reference to the team's catchment population, the 1 million minimum for OG means that most cancer centres and some larger cancer units will potentially be able to host a team. Some smaller centres and even some smaller networks will not be able to have a team however. The 2 million population minimum for pancreatic cancer means that no cancer units and only some centres will be able to have a team. Also the 2 million minimum means that currently, in England, no network on the basis of its own catchment population will be able to have more than one pancreatic team.

A further principle in the IOG upper GI guidance is that the meetings, surgical operations and acute post-operative care (including HDU and ITU) of a given specialist team should all take place in one hospital. This principle, together with the minimum catchment populations and the principle of consolidation of services for a group of relatively rare cancers have the following important implications:

- in a given single locality which has a specialist OG team, it should be the only OG team for that locality;
- in a given locality which has a specialist pancreatic team it should be the only pancreatic team for that locality.

The exact boundaries of what constitutes a team and what does not, as outlined in the introduction to MDTs is especially important here. This set of measures should be applied to both types of team (OG and pancreatic).

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 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 as 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	
MDT STRUCTURE	
The responsibility, for review purposes, for measure 11-2F-301 lies with the lead clinician of the host trust (see topic 1A).	
Lead Clinician and Core Team Membership	
11-2F-301	There should be a single named lead clinician for the specialist Pancreatic MDT who should then be a core team member. The lead clinician of the MDT should have agreed responsibilities of the position with the lead clinician of the host trust. *Note:* *The role of the 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 specialist pancreatic MDT should include: • two or more hepato-pancreatico-biliary surgeons; *Note to the above point:* *It is recommended that these do not function as OG surgeons.* *In order to achieve measure 08-2F-314 - a 24-hour surgical on-call rota - at least three specialist consultant surgeons per team would be needed.* • physician gastroenterologist; • clinical oncologist; • medical oncologist (where the responsibility for chemotherapy is not undertaken by

the clinical oncologist core member);
- histopathologist;
- UGI nurse specialist;
- endoscopist of any discipline - who could be one of the other team members;
- 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;
- a core member nominated responsible for ensuring recruitment into clinical trials and other well designed studies is integrated into the function of the MDT;
- at least one of the core team radiologists should be an interventional radiologist;
- there should be a core team member trained in endoscopic ultrasonography.

Notes:

- Each clinical core member should have sessions specified in the job plan for the care of patients with pancreatic 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 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 with their role, agreed by the lead clinician of the host 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.

Level 2 Practitioners for Psychological Support

11-2F-302 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

11-2F-303 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

11-2F-304 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 Meetings

11-2F-305 The team should hold its meetings at least weekly, 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 Core Member

11-2F-306 The MDT should agree named cover arrangements for each core member (see 11-2F-301).

Notes:

- *This refers to the nominating of staff who should in general be expected to provide cover for core members e.g. 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 if not should be a specialist trainee or non-consultant career grade.*

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

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

11-2F-307 Core members or their arranged cover (see measures 11-2F-301 and 11-2F-306) should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT or audit results.
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 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.

Compliance with this measure also confers compliance with measure 11-2F-306.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2F-308 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

11-2F-309 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

11-2F-310 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 the policy of the timeliness of notification to GPs of a diagnosis of cancer.

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

The next measure applies to specialist teams referring some cancer types to another specialist team elsewhere in the network or neighbouring network.

MDT Agreement to Network Specialist Team Policy for Referral Discussion

11-2F-311 The MDT should have agreed a policy whereby all patients diagnosed with the relevant cancer type are discussed with a member of the relevant specialist team prior to referral to that specialist team or prior to proposed local care. The date at which the discussion took place should be recorded in the case notes.

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

For the following measure the specialist team should comply with either section (a) or section (b).

MDT Meeting with Referring Teams/Collaborative Audit

11-2F-312 a) During the year prior to the peer review visit, the specialist MDT should have held a meeting at which at least one core member representative of the specialist team met with at least one core member representative of each of its referring diagnostic, diagnostic/local care teams, and any specialist referring teams, to review all the cases during the previous year diagnosed as having cancer (with or without histological confirmation). At the meeting they should have ascertained whether all cases diagnosed with Pancreatic cancer, relevant to that specialist team, were discussed with them prior to referral or to proposed local care, and whether referrals were consistent with the network clinical and referral guidelines.

b) During the year prior to the peer review visit the specialist team, with any other specialist teams in the network, should have carried out as one of the agreed network audit projects the following:

- an audit of cases (over at least the previous year) diagnosed as having cancer by its referring diagnostic and diagnostic/local care teams (with or without histological

confirmation);

- cases referred for specialist care and local care should be audited for consistency with the clinical and referral guidelines;
- the audit should also ascertain whether all cases diagnosed with Pancreatic cancer relevant to that specialist team were discussed with them prior to referral or to proposed local care.

Notes:

- *The meeting should include a representative of any specialist team referring a certain cancer type to the team in question, whether from within the network or from a neighbouring network.*
- *For sections a) and b) of this measure, compliance or non-compliance count towards the specialist MDT.*
- *In section b), completion of the relevant audit project would provide compliance for this measure as well as compliance for part of the network audit.*

Compliance: Written confirmation, including attendance list of the meeting and the results of the audit as applied to the specialist team in question.

MDT Agreement to Network Follow Up Guidelines

11-2F-313 Follow up arrangements between the specialist team and the referring diagnostic/local care team(s) may vary locally according to circumstances, but written follow up guidelines should be agreed between the specialist team and the referring team(s).

The arrangements should include those for patients who are referred to the specialist team but are found to be unsuitable for specialist care.

Compliance: Follow up guidelines agreed by the lead clinician of the specialist MDT and the Chair of the NSSG.

24-Hour On-Call Consultant Specialist Surgical Cover

11-2F-314 There should be 24-hour on-call consultant specialist surgical cover for post operative care.

Note:

To achieve this measure at least three specialist consultant surgeons per team would be needed.

Compliance: 24-hour on-call rota staffed by core team surgical members.

Intensive Care (ITU) and High Dependency Unit (HDU) in Host Hospital

11-2F-315 There should be intensive care (ITU) and high dependency unit (HDU) facilities available in the hospital hosting the specialist MDT.

Compliance: Reviewers to view the facilities.

Note:

For the purpose of self-assessment the facilities should be confirmed within the teams' operational policy.

Single Site Surgery and Post Operative Care

11-2F-316 The treatment planning meetings, operations and acute post-operative care activities of the MDT should all be carried out in the same hospital.

Compliance: Reviewers to enquire of team working arrangements.

Operational Policy for Named Key Worker

11-2F-317 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 these measures and who are under their care at the time of the peer review visit.

Notes:

- *For information - according to the NICE IOG guidance palliative and supportive care guidance the 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 patients case notes.

Histopathology Core Members Participating in EQA Scheme

11-2F-318 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 MDT member, with its related activities which, in full measure, go to make up the role of the 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 UGI surgeons and palliative care physicians before there were established UGI 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

11-2F-319 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.

Core Nurse Responsibilities

11-2F-320 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 carers' communication issues and co-ordination of the patient pathway for patients referred to the team - acting as the keyworker or responsible for nominating the keyworker 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 to those in this and the previous measure may be agreed.

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

Attendance at National Advanced Communication Skills Training Programme

11-2F-321 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

11-2F-322 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 team for the extended MDT should include:

- cytopathologist;
- core member of the specialist palliative care team;
- anaesthetist/intensivist.

Notes:

- *The anaesthetist/intensivist should at least represent this specialty at MDT operational policy meetings and co-ordinate this aspect of the MDT's activities.*
- *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.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	Name of each extended team member with their role agreed by the lead clinician of the MDT.

PROVIDING PATIENT CENTRED CARE

Patient Permanent Consultation Record

11-2F-323

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

11-2F-324

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 information for patients (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 covered. 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Provision of Written Patient Information

11-2F-325

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

11-2F-326

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

- the identity of patients discussed;
- the multidisciplinary treatment planning decision i.e. to which modalities of specialist care, or local care (surgery, radiotherapy, chemotherapy, combinations or supportive care) they are to be referred for consideration;
- in the case of patients referred for specialist care to another specialist team in the network, or in a neighbouring network, the named specialist team to which they are referred.

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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: Anonymised examples of the record of a meeting 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 proforma as well as in individual patients' notes.

CLINICAL GUIDELINES

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

MDT Agreement to Network Guidelines for the Management of Upper GI Cancer

11-2F-327

a) The MDT should agree network-wide clinical guidelines for patients diagnosed with UGI cancer with the NSSG. The guidelines should state the parameters of disease stage and patient fitness which determine when each of the treatments/procedures, classified as local care or specialist care, in the introduction and relevant to the specialists team's cancer type are indicated.

b) The specialist team should agree with each of its referring teams and the NSSG:

- which of the treatments/procedures classified as local care in the introduction and relevant to the specialist team's cancer type, may be delivered by that local team subject to each case being discussed with a member of the specialist team prior to the proposed treatment;
- which sites may be used by specialist team members to deliver those 'specialist classified' treatments which may be carried out, outside the specialist team's host hospital.

Notes:

- *A diagnostic-only team would usually refer all patients directly to a specialist team.*

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

Note:

It is recommended that this essential information is recorded on an MDT proforma as well as in individual patients notes.

REFERRAL GUIDELINES

The format of these measures and related measures in topic 1A is specific to UGI cancer. In view of (a) the various possible configurations of the service and (b) the need to have agreed the particular group of configuration for the network, the responsibility for assessment purposes for referral guidelines lies with the lead clinician of the MDT, the Chair of the NSSG, and the Chair of the Network Board. For compliance the Network Board, in consultation with the NSSG, should produce agreed guidelines and the individual MDT, for their compliance should agree them. The measures count towards the assessment of the Network Board and individual teams.

MDT Agreement to Network Referral Guidelines Between Teams

11-2F-328

The MDT should agree referral guidelines which includes the following:

- to what extent and in what circumstances the referring diagnostic teams may further investigate a patient after the diagnosis of malignancy and before referral to the specialist team;
- that patients who need specialist care are referred to (name of team being reviewed) from the (name of referring diagnostic and diagnostic/local care teams);
- that patients who need local care are referred to (name of team being reviewed)

from the (name of diagnostic teams referring for local care), (applies to specialist teams also providing local care);
- that patients who need specialist care in another network, are referred to (name of team in the other network) from the (name of the team being reviewed).

Notes:

- *Specialist care and local care are defined in the introduction to the UGI measures.*
- *It is strongly recommended that when patients are referred for care to another team all members of the referring MDT refer patients with a given cancer type to the same named team.*
- *Referral agreements between PCTs and UGI teams are dealt with in topic 1A.*

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

Note:

Specialist teams may receive referrals from diagnostic and diagnostic/local care teams in other networks on grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (referring) networks with their host hospitals.

IMAGING GUIDELINES

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

MDT Agreement to Network Imaging Guidelines

11-2F-329 The MDT should agree imaging guidelines for diagnosis and review. The guidelines should address:

- imaging modalities;
- their specific indications.

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

PATHOLOGY GUIDELINES

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

MDT Agreement to Network Pathology Guidelines

11-2F-330 The MDT should agree pathology guidelines for diagnosis and assessment. The guidelines should address:

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

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Agreed Collection of Minimum Dataset

11-2F-331

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

11-2F-332

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

11-2F-333

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.

Joint Treatment Planning for TYAs

11-2F-334

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	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 11-2F-4 - ADDITIONAL MEASURES FOR SPECIALIST PANCREATIC MDT WHICH IS BEING PUT FORWARD FOR REVIEW ALSO AS A LIVER RESECTION MDT

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility for review purposes for measure 11-2F-401 lies with the lead clinician of the specialist pancreatic MDT.

MDT STRUCTURE

There are no mandatory core team members for the liver resection MDT in addition to those listed for the specialist pancreatic team.

The team may wish to name additional core team members specifically for the liver resection work. This is not subject to review.

Team Attendance at NSSG Meetings

11-2F-401 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 MEETINGS

Note:

The MDT should discuss cases referred for resection of liver metastases, as and when they are referred, during the regular meetings of the specialist pancreatic MDT. There is no separate measure which deals with this.

OPERATIONAL POLICIES

MDT Agreed Follow Up Policy

11-2F-402 The MDT should agree a follow up policy with the referring colorectal MDTs in its catchment area, specifying:

- which team should follow up the patient after liver metastatectomy;
- specific indications for referral back to the liver resection MDT, if the referring colorectal MDTs are agreed as being involved in follow up, after metastatectomy.

Compliance: *The policy, agreed by the lead clinician of the liver resection MDT and the lead clinicians of the referring colorectal MDTs.*

Note:

The teams may agree additional points in the follow up policy. These are not subject to review.

Named Hospital for Mastastectomies With ITU and HDU Facilities On Site

11-2F-403 The named hospital in which the metastatectomies of the team are carried out should have an ITU and HDU on site.

Compliance: The reviewers should enquire as to the facilities of the hospital.

Note:

For the purpose of self-assessment the facilities should be confirmed within the teams' operational policy.

KEY WORKER

Note:

The patient's key worker should have been specified previously by their original colorectal MDT. There are no separate measures for this for the liver resection team.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

EXTENDED TEAM

Note:

There are no mandatory members for the extended team for liver resection, in addition to those listed for the specialist pancreatic team. The team may wish to name additional members for the extended team specifically for the liver resection work. This is not subject to review.

MDT Oncology Agreement

11-2F-404

The MDT should have a separate agreement with each referring colorectal MDT specifying that:

Either:

any chemotherapy for patients given as combination treatment with metastatectomy, is managed by an oncologist from the referring colorectal MDT, who should attend the meetings of the liver resection team at which the patient is discussed;

Or:

it is managed by a core oncology member of the liver resection MDT.

Compliance: The agreement for each referring MDT, authorised by the lead clinician of the liver resection MDT and the lead clinician of the referring MDT.

PATIENT CENTRED CARE

Provision of Written Patient Information

11-2F-405

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.

NETWORK GUIDELINES FOR THE RESECTION OF LIVER METASTASES

Introduction

Clinical Management

The development of clinical management guidelines for metastatectomy, aside from deciding the liver resection MDT and referral between teams, doesn't essentially involve questions of service reconfiguration. The responsibility for review purposes therefore for the clinical management guidelines lies with the lead clinician of the MDT and the Chair of the NSSG. For compliance with the relevant measure in topic 1C, the NSSG in consultation with the MDTs, including a representative of the liver resection MDT should produce the network-wide guidelines. The individual MDT for their compliance with the relevant measure, should agree to them.

Agreed Clinical Guidelines

11-2F-406 The MDT should agree with the **colorectal** NSSG the network-wide guidelines for the resection of liver metastases from colorectal cancer. They should cover the following:

- the indications (in terms of specific clinical and investigational parameters) for metastatectomy and for its use in combination with chemotherapy;
- the stage in the assessment process that a patient should be transferred to the care of the liver resection team and therefore, which parts of the assessment protocol should be the responsibility of the colorectal MDT and which parts the responsibility of the liver resection team.

Notes:

- *More details of techniques or regimens may be agreed if desired. They are not subject to review by this measure.*
- *See 11-1C-103f.*

Compliance: The network guidelines agreed by the lead clinician of the liver resection MDT and the Chair of the **Colorectal** NSSG.

Referral Between Teams

The decision regarding which MDT should be the liver resection MDT, and which MDTs should refer to it, may involve a degree of service reconfiguration within and between networks. The responsibility for review purposes, therefore, for the referral guidelines between teams is that of the Network Board (in consultation with the NSSG). For compliance with the relevant measure in topic 1A, the Network Board should produce the guideline and the individual MDT for their compliance with the relevant team measure, should agree it.

MDT Agreement to Network Referral Guidelines

11-2F-407 The MDT should agree with the Network Board the network-wide guidelines stating the named liver resection MDT to which the named colorectal MDTs in the network should refer patients for consideration of metastatectomy.

Note:

The referring MDTs may be from more than one network.

Compliance: The network guidelines naming the relevant MDTs, agreed by the lead clinician of the liver resection MDT under review, and the Chair of the Network Board.

Agreed List of Approved Trials

11-2F-408 The MDT should produce a written response annually to the NSSG's approved list of trials and other well designed studies, which fulfils the following:

- for each clinical trial and well designed study the MDT should agree to enter patients or state the reason why it will not be able to;
- the programme for improvement for recruitment into approved trials and other well designed studies arising from the MDT's recruitment results.

Compliance: The response including the programme for improvement agreed by the lead clinician of the MDT and Chair of the NSSG

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
MDT WORKLOAD
This is covered by the requirement for liver resection MDTs to have a catchment population of two million or more.

Appendix 1

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

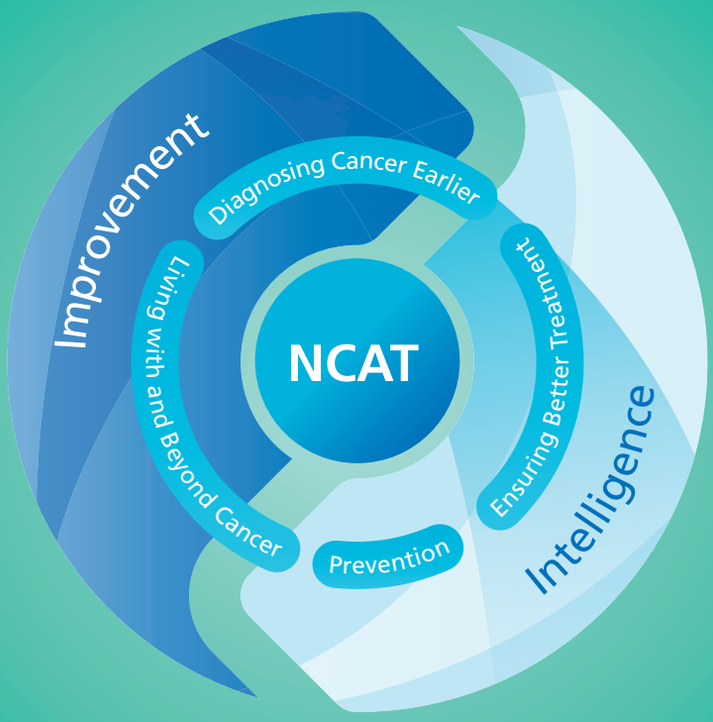
- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met:
    - to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's 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-108f	Revised research measure
11-1C-110f	Chemotherapy Algorithm generic measure for NSSGs
11-1C-111f	The TYACN Pathway for Initial Management
11-1C-112f	The TYA Pathway for Follow Up on Completion of First Line Treatment
11-2F-118	Revised measure
11-2F-131, 11-2F-233, 11-2F-333	Revised research measure
11-2F-132, 11-2F-234, 11-2F-334	Joint Treatment Planning for TYAs



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