National Cancer Peer Review Programme

Manual for Cancer Services:
Specialist Palliative Care Measures
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# SPECIALIST PALLIATIVE CARE MEASURES

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Introduction

1.1 Aim of the Manual for Cancer Services

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

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

National quality 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 and 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 and end of life care.

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. A revised process for peer review was implemented in April 2011 and the measures contained within this manual remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Adherence to the measures in the manual for cancer service is not mandatory for the NHS but it is used by the National Cancer Peer Review Programme as part of the 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 and palliative care services for individuals, 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 and palliative care 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 lapco, 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.
Appendix A

Interpretation of the National Manual for Cancer Services

1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes Guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive and far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated.

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

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset guidance would not inspire, lead, motivate or guide and would probably be almost unreadable. The Manual for Cancer Services has to take a different approach. It is written for and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit;
- state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous measures - 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 a certain 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 measures. 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
- **b** - Breast specific
- **c** - Lung specific
- **d** - Colorectal specific
- **e** - Gynaecology specific
- **f** - UGI specific
- **g** - Urology specific
- **h** - Haematology specific
- **i** - Head and Neck specific
- **j** - Skin specific
- **k** - Brain and CNS specific
- **l** - Sarcoma specific
- **r** - Specialist Palliative Care specific
- **s** - Chemotherapy specific
- **t** - Radiotherapy specific
- **u** - User Group specific
- **v** - Rehabilitation specific
- **w** - Complementary Therapy specific
- **x** - Psychological Support specific
- **y** - Acute Oncology
- **z** - Teenage and Young Adults 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 website at [http://www.cquins.nhs.uk](http://www.cquins.nhs.uk).
SPECIALIST PALLIATIVE CARE MEASURES

Introduction

History and Context
The revised Specialist Palliative Care (SPC) Measures are based on the requirements for SPC in Improving Supportive and Palliative Care for Adults with Cancer (2004). They have been revised from the previous measures to take a number of factors into account.

- The subsequent developments in SPC practice and network organisation.
- Developments in general supportive care which have been incorporated generically into all site specific cancer measures.
- Take account of the National End of Life care strategy 2008 and the NICE EoLC Quality Standard 2011
- Strengthening the SPC multidisciplinary team (SPCMDT) so that each one has a requirement for two consultants in palliative medicine as core members.

These changes have been undertaken in consultation with the national cancer peer review SPC reference group, and subjected to national consultation.

Cancer and Non-Cancer
Following the production of Improving Supportive and Palliative Care for Adults with Cancer (2004), as part of, and in the context of the Improving Outcomes Guidance for the treatment of cancer, SPC networks have been associated with host cancer networks and reviewed as part of such networks. This also reflects the fact that a major part of SPC practice relates to patients with cancer. It is acknowledged, however, that an increasing part of the practice relates to patients with other diseases and the measures and peer review cover the whole clinical scope of SPC practice, dealing with both malignancy and non-malignancy. The measures deal with quality issues which are fundamental and common to both areas of practice.

End of Life Care Pathway
The national end of life care strategy was published in 2008 with the aim to improve end of life care for all. This was supported by the publication of quality markers 2009 that were developed at the request and in collaboration with clinicians. In 2011 NICE published Quality Standard for end of life care. These specialist palliative care measures are a good starting point to help providers and commissioners review the current provision which is an important step in the process towards the quality statement (statement 10, NICE End of Life Care Quality Standard, End of Life Care for adults) and measures set out in the NICE quality standard for end of life care.

It is also acknowledged that SPC covers the whole patient pathway, not just the phases approaching and including the end of life. Thus, the measures and peer review cover SPC across the whole patient pathway.

The National End of Life Care Programme, gives best practice guidance covering this component of the pathway. There has been consultation with representatives of the National End of Life Care Programme Board whose feedback has been taken into account with the revised measures. The current peer review SPC measures were developed before the End of Life Care Quality Standard was finalised, thus there are no current peer review measures which cover this in entirety. This situation will be reconsidered after the first round of SPC peer review.

Shape of the Service
SPC practice can't be contained or defined by boundaries which are used for site specific cancers. For each of the latter, there is a specific clinico-pathological disease entity. This allows;

- a clear entry point to the patient pathway or to an MDT’s practice (the diagnosis of the disease);
- a boundary to the MDT’s practice (the management of the disease);
- parameters for the MDT’s viability (numbers of cases of the disease or of specific procedures related to its management);
- parameters for its coverage (minimum population determined by the incidence of the disease).
These parameters are either inappropriate or impractical if applied to SPCMDTs since there is no such clearly defined disease entity.

This state of affairs, combined with the extremely minimal required membership of an SPCMDT in the previous measures, resulted in a large proliferation of 'teams' being put forward for review, which was not foreseen, or of value. The review was curtailed and this revision of the measures, carried out.

It is acknowledged that especially, but not exclusively, in community based SPC practice there are many patient care decisions which do not need the formal input of an SPCMDT as specified in the measures. Also, this area of care may commonly be carried out by various groups of health professionals which may designate themselves as 'teams.' The composition of such teams will be locally agreed, whether formally or informally and may or may not contain a consultant in palliative medicine. As far as the peer review is concerned there is no problem with such arrangements and they are outside the measures or the review. However, it is necessary for there to be a minimum nationally consistent organisational framework within which SPC services should operate. Otherwise it would be difficult to apply quality measures to the service and to add any value thereby. Therefore, what the peer review does require is that there are also, formal SPCMDTs, specified and constrained according to the measures. The area of SPC practice which should be subject to formal input from such MDTs is left to the network to decide, agree and include in network guidelines.

There is a requirement for all the inpatient hospital and hospice SPC services to be covered by a named SPCMDT, which is put forward for review against the SPCMDT measures. Any other SPC services (which may or may not involve other groups of staff who refer to themselves as a team), should be associated for the purpose of referral for formal multidisciplinary team input, with one of the named and peer reviewed SPCMDTs. The following 'ground rules for networking' apply, to enable a rational network to exist and to function without destructive competition or uncontrolled practice.

- All SPC in-patient services in the network should be covered by one SPCMDT or other and any one SPCMDT should be the only one for a given in-patient service.
- All out-patient/community/day care services should be associated with one or other SPCMDT and any one SPCMDT should be the only one for a given service.
- All consultants in palliative medicine in the network should be core members of an SPC MDT.

Note:
The previous organisational infrastructures, known as 'localities' and palliative care 'areas' are no longer a requirement for peer review, but of course, may be retained by networks if desired for their convenience.

Reviewing the Specialist Palliative Care Network

The establishment and location of SPC services and MDTs and the establishment of the network SPC group are the responsibility for peer review purposes of the Chair of the Network Board and are reviewed under topic 1A - cancer networks - Specialist Palliative Care measures, compliance counting towards the review of the Network Board.

Functions of the Network Specialist Palliative Care Group (NSPCG), are the responsibility for peer review purposes of the Chair of the NSPCG and are reviewed under topic 1C Functions of NSPCG, compliance counting towards the review of the NSPCG.

Functions of the specialist palliative care provider organisation are the responsibility of the medical director or nominated representative of the provider organisation and are reviewed under topic 1D Functions of the Specialist Palliative Care Service Provider Organisation, compliance counting towards the review of the provider organisation.

Functions of the SPC MDT are the responsibility for peer review purposes of the lead clinician of the MDT and is reviewed under topic 2L the SPC MDT, compliance counting towards the review of the SPC MDT.
**MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE**

### NETWORK CONFIGURATION OF SERVICES AND TEAMS (Measures 12-1A-301r to 12-1A-302r)

#### The Network Configuration of Specialist Palliative Care Services

**12-1A-301r**

The Network Board in consultation with the Network Specialist Palliative Care Group (NSPCG) and the CEs of the relevant statutory bodies (acute trusts and PCTs) and independent organisations should agree a list of those hospices, hospitals, and community specialist palliative care services (defined and declared by their PCTs) which will constitute the services of the cancer network’s palliative care network, for the purposes of peer review.

The list should include day hospices and hospice at home services.

**Notes:**

*Those establishments and communities referring to more than one network for the rest of cancer services should agree to be either wholly associated with this palliative care network for review, and therefore on this list or be wholly associated for review with a neighbouring network.*

**Compliance:**

The list, agreed by the Chair of the Network Board and the Chair of the NSPCG.

#### THE NETWORK CONFIGURATION OF SPECIALIST PALLIATIVE CARE MDTs

To be read in conjunction with the introduction to the SPC measures.

#### The Network Configuration of Specialist Palliative Care MDTs

**12-1A-302r**

The Network Board in consultation with the NSPCG should agree the configuration of Specialist Palliative Care MDTs (SPCMDTs) for the network. The list should include:

- the number and names of the SPCMDTs;
- the named hospital and/or hospice in-patient facilities which each SPCMDT covers;
- the named outpatient or community or day care services which are associated with each SPCMDT for the purposes of referral for multidisciplinary input.

The above configuration should comply with the following ground rules for networking:

- All SPC in-patient services in the network (both those where beds are under the care of consultants in palliative medicine, and those parts of such a consultant's in-patient practice which are advisory, covering beds which are under the care of other specialties) should be covered by an MDT.
- All out-patient/community/day services in the network should be associated with a SPCMDT for the purposes of patient referral.

**Note on coverage by SPCMDTs:**

*For all the above services, any given service should be covered by or associated with no more than one SPCMDT. This is compatible, however, with any given SPCMDT covering more than one service.*

All consultants in palliative medicine in the network should be core members of an SPC MDT.

**Compliance:**

The list of named SPCMDTs with the in-patient facilities they cover and the outpatient/community/day services with which they are associated, agreed by the Chair of the Network Board.

Reviewers should check whether the configuration complies with the ground rules for networking.
Establishment of Network Specialist Palliative Care Group

12-1A-303r

There should be a single Network Specialist Palliative Care Group (NSPCG), having membership fulfilling the following:

- the lead clinician from each SPCMDT in the network;
- at least one nurse core member of an SPC MDT in the network;
- there should be a named chair drawn from the above membership;
- two patients'/carers’ representatives;
- healthcare professional representation from
  - social care,
  - primary care,
  - rehabilitation services
- healthcare professional representation from all the specialist palliative care settings which occur in the network including each of the following if they occur;
  - inpatient
  - day services
  - community

Note: All care settings referred to include those offered by the NHS and also by the independent sector.

- one of the SPCMDT members from the network should be nominated as having specific responsibility for patient/carers issues and information for patients and carers;
- a member of the NSPCG responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the NSPCG;
- named secretarial/administrative support.

Notes:

A given individual may represent more than one category of stakeholder or setting.

It is recommended that the membership reflects the balance in the network between the NHS and the independent sector.

There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.

If the local patients'/carers’ group do not wish, or are unable, to nominate a patients'/carers’ representative, but there is an agreed mechanism for obtaining patients'/carers’ advice, then the measure will be deemed to have been complied with.

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

- The NSPCG being recognised as the board’s primary source of clinical opinion on issues relating to specialist palliative care for the network;
- The NSPCG being recognised as the group with corporate responsibility, delegated by the board, for co-ordination and consistency across the network for specialist palliative care policy, practice guidelines, clinical guidelines, audit, research and service improvement;
- Consulting with the relevant "site specific" and "cross cutting" network groups on specialist palliative care issues.

Notes:

There may be additional points in the agreed terms of reference, recommendations may be found in appendix 2.

Compliance: The named members and NSPCG 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 NSPCG.
# Network Training and Education Strategy

**12-1A-304r** The Network Board, in consultation with the NSPCG should produce a network training and education strategy which fulfils the following:

- it should specify the key education and training requirements in palliative care for health and social care professionals outside specialist palliative care services;
- it should be set over a defined three years, with a start and an end date;
- it should identify priority groups for training;
- it should finally express the training and education needs in terms of numbers of places per year, on named local, regional or national programmes.

**Compliance:** The network palliative care training and education strategy agreed by the Chair of the Network Board and Chair of the NPCG. The reviewers should enquire as to how it was produced and verify that it fulfills the points above.
MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

GENERAL ACTIVITIES

Network Specialist Palliative Care Group Meetings

12-1E-101r The NSPCG should meet regularly and record attendance.

Note:
The attendance of SPCMDT representatives is reviewed in the measure for each SPCMDT.

Compliance: A list of meetings and attendance records in the last 12 months.

Annual Review, Work Programme and Annual Report

12-1E-102r The Chair of the NSPCG should have an annual review with the network lead clinician and/or appropriate member of the Network Board.

The NSPCG should have agreed an annual work programme with the board.

The NSPCG 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 NSPCG 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.

NETWORK GUIDELINES (measures 12-1E-103r to 12-1E-105r).

Introduction

For compliance with these measures, the NSPCG, in consultation with the SPCMDTs, should produce the guidelines and for compliance with their relevant measures in topic 3R, the SPCMDTs should agree to abide by them and add local information where required.

Referral, Admission and Discharge Criteria

12-1E-103r The NSPCG, in consultation with the SPCMDTs should agree network wide guidelines for core specialist palliative care services, specifically:

- inpatient specialist palliative care services (hospital and hospice);
- day services (where applicable);
- outpatient clinics in any setting;
- community based services.

For each specified service the guidelines should address the following, as relevant:

- patient referral criteria;
- admission criteria;
- discharge criteria.

The guidelines should be distributed to primary care practices, acute trusts and NSSGs (for distribution on to MDTs) within the network.

Compliance: The written guidelines agreed by the Chair of the NSPCG

The reviewers should enquire of the distribution process

Note:
Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.
### Criteria for Referral to the Specialist Palliative Care MDT

**12-1E-104r** The NSPCG should, in consultation with the SPCMDTs, agree network-wide guidelines specifying the criteria which should prompt a referral of a patient to a SPCMDT.

**Compliance:** The written guidelines agreed by the Chair of the NSPCG.

### Network Agreed Clinical Guidelines

**12-1E-105r** The NSPCG should agree network-wide guidelines for the palliative care of a given patient in at least the following situations:

- control of specific named symptoms;
- palliative interventions for common named symptom emergencies;
- identification of patients in the last phase of life;
- care of dying patients and their carers.

The guidelines should be distributed to primary care practices, acute trusts and NSSGs (for distribution on to MDTs) within the network.

**Note:**

*The network may agree network-wide clinical guidelines additional to those listed above.*

**Compliance:** The written guidelines agreed by the Chair of the NSPCG.

The reviewers should enquire of the distribution process.

**Note:**

*Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.*

### Network Palliative Care Directory

**12-1E-106r** The NSPCG should agree a single network-wide directory of specialist palliative care services. This should include:

1. A list of all specialist palliative care facilities, including:
   - inpatient, day care services or outpatient clinics within NHS hospitals where the hospital also offers services other than palliative care;
   - specialist NHS palliative care hospitals or hospices, inpatient, day care services and outpatient clinics;
   - specialist independent sector inpatient hospices, day care services and outpatient clinics;
   - community based services, NHS and independent sector.
2. A list of SPCMDTs, stating the catchments and palliative care setting(s) for which they are responsible and in which they offer palliative care or advice.
3. The referral criteria for each service.
4. The contact details for each of the facilities and teams identified above.

**Notes:**

- *The directory may contain additional information to that outlined above.*
- *The directory may be part of a larger document but the information outlined above should be in one discrete section.*

**Compliance:** The directory, showing the information outlined above, agreed by the Chair of the NSPCG.

### 24 Hour On Call Service

**12-1E-107r** The NSPCG should:

1. Agree the minimum specification of the service which should stipulate:
   - that it is available 24 hours a day, 7 days a week, for telephone advice on specialist palliative care;
   - who will be providing the telephone advice;
   - the categories of staff which are intended to have access to the service;
MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

• whether it is available to patients and / or carers;
• that it covers the whole network. (If more than one contact number and / or rota is used to cover the network, the hospitals and communities for which each one is applicable should be stated.).

2) Produce referral guidelines for the service covering the areas of patient and / or carer needs and clinical problems for which the service is available.

3) Agree a policy detailing clinical governance safeguards, which includes the minimum qualifications and /or competencies needed for staff to take part in providing the service.

Notes:
The NSPCG should produce the specification for its compliance with this measure and the individual SPCMDTs for their compliance with their relevant measure in topic 3R, should agree to it and provide the relevant staff members.

Compliance:
The minimum service specification agreed by the Chair of the NSPCG.
The referral guidelines agreed by the Chair of the NSPCG.
The clinical governance safe-guard policy including the minimum qualifications and/or competencies.

Reviewers should examine the service specification and the guidelines.

Note:
The qualifications and competencies of the people providing the telephone advice are a matter of judgment by the network, but they should be agreed and stated in the policy.

7 Day Visiting Service for Direct Assessment

12-1E-108r The NSPCG should:

1) Agree the minimum service specification which should stipulate that:
• it is available from 0900 - 1700 hrs, 7 days a week, to provide visits on request, to patients at home or in hospital for direct review by specialist palliative care staff;
• it is staffed at any one time by at least a nurse that meets the SPC core member specialist training requirements (measure 12-3R-111), or a consultant or NCCG in palliative medicine or ST3, or above, in palliative medicine;
• it covers the whole network. (If more than one contact number and / or rota is used to cover the network, the hospitals and communities for which each one is applicable should be stated.)

Note: It may additionally be offered outside the hours of 0900 - 1700.

2) Produce referral guidelines for the service covering:
• the categories of staff which are intended to request the service;
• the areas of patient needs and clinical problems for which the service is available.

3) Distribute the relevant contact numbers on paper or electronically to the users of the service as defined above, covering the whole network.

Notes:
The NSPCG should produce the specification for its compliance with this measure and the individual SPCMDTs for their compliance with their relevant measure in topic 3R, should agree to it and provide the relevant staff members.

Compliance:
The minimum service specification agreed by the Chair of the NSPCG.
The referral guidelines agreed by the Chair of the NSPCG.
The reviewers should enquire of the distribution process.

Note:
Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.
# MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

## NETWORK AUDIT

### Introductory notes

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

The minimum progress needed for the NSPCG's compliance with this measure (since audit is a long and multistage process) is that the NSPCG, in consultation with the SPCMDTs, agrees at least one network audit project with the Network Board, usually within trust audit programmes. The individual SPCMDTs, for compliance with their relevant SPCMDT measure, should agree to participate in the audit.

### Network Audit

**12-1E-109r** The NSPCG should agree at least one network audit project with the Network Board.

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

*Note:*

- It is expected that the National Council for Palliative Care dataset should be part of the network audit programme.
- Additional projects may be agreed.

**Compliance:**

The audit agreed by the Chair of the NSPCG and the Chair of the Network Board. Written confirmation of annual review sufficient to show compliance with the measure.

### Discussion of Clinical Trials

**12-1E-110r** The NSPCG should discuss at least annually a report from each of its SPCMDTs (see relevant MDT measures).

The following should be present at the discussion:

- the Chair of the NSPCG or a nominated representative;
- the NSPCG research lead;
- the lead clinician of the SPCMDT or a nominated representative from that SPCMDT;
- 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 discussion regarding trials sufficient to show compliance with the measure including those present.

The programme for improvement agreed by the lead clinicians of the SPCMDTs and the clinical lead of the research network.

*Note:*

The discussion with various individual SPCMDTs may take place at different meetings of the NSPCG.
### Proposals for Service Development

The NSPCG, in consultation with the SPC provider organisations, should undertake a needs assessment for network wide palliative care services. This should include:

- an assessment of the aggregate needs of the population;
- a mapping of current services;
- an assessment of current services compared with need;
- identification of service gaps in provision.

**Note:**

*The assessment should be expressed as the service required for each SPC provider organisation the network.*

Based on the assessment, the NSPCG should, in consultation with the SPC provider organisations, recommend to, and agree with the Network Board, the following:

- prioritisations for service development and/or reconfiguration;
- prioritisations for workforce development;
- any development of network operational policies.

**Note:**

*The above recommendations make up the so-called ‘proposals for service development’.*

The assessment should be reviewed and updated every three years and updated proposals for service development generated as above.

**Note:**

*The assessment should form the basis of the proposals for service developments for specialist palliative care, for the three subsequent contracting years, as advice to the board, for the network proposed service delivery plan.*

#### Compliance

The assessment and proposals for service development (updated, as required), agreed by the Chair of the Network Board, and the Chair of the NSPCG.
## INTRODUCTION

This section is applicable to the host provider organisation (hospital site, hospice or PCT) of the inpatient, outpatient, community or day services declared in the network configuration. The responsibility for the purpose of peer review for compliance with the measures in this section lies with the medical director or nominated representative of the organisation.

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| **Contribution to the Proposals for Service Development** |
| **12-1D-102r** | The SPC provider organisation should contribute to the network needs assessment and proposals for service development for consideration by the NSPCG. |
| **Note:** | Proposals for service development, for example, may include; |
| | • prioritisation for service development and/or reconfiguration; |
| | • prioritisation for workforce development; |
| | • any development of network operational policies. |
| **Compliance:** | The assessment and proposals for service development updated as required, agreed by the medical director or nominated representative of the provider organisation and the Chair of the NSPCG. |
There should be a single named lead clinician for the named SPCMDT who should then be a core team member.

The lead clinician of the SPCMDT should have agreed the responsibilities of the position with the lead clinician of the host organisation.

Note:
- The role of lead clinician of the SPCMDT should not of itself imply chronological seniority, superior experience or superior clinical ability.

The SPCMDT should provide the names of core team members.

The core team specific to specialist palliative care should include:
- two consultants in palliative medicine;
- two specialist palliative care nurse specialists;
- an AHP representative for rehabilitation support services - applicable only to MDTs where coverage includes inpatient services having beds under the care of consultants in palliative medicine;
- SPCMDT co-coordinator/secretary;
- a core team member should be nominated as having specific responsibility for patients'/carers' issues and information for patients and carers;
- a member of the core team should be nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the SPCMDT;
- each clinical core member should have sessions specified in the job plan for the care of patients with specialist palliative care needs and attendance at MDT meetings.

Notes:
- The co-ordinator/secretary role needs different amounts of time depending on team workload. See appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial role may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description.
- Clinical sessions should be defined as relevant to their professional group.
- There may be additional core members agreed for the team besides those listed above.

Compliance:
- Named lead clinician for the SPCMDT agreed by the lead clinician of the host organisation.
- The written responsibilities, agreed by the lead clinician of the SPCMDT and lead clinician of the host organisation.

Note:
- See appendix 2 for an illustration of the responsibilities of the role.
- Name of each core team member agreed by the lead clinician of the SPCMDT.

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, are 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 SPCMDT has decided locally to include as core members, e.g. from the list in the 'extended SPCMDT' measure. The reviewers should identify particular missing roles and identify the particular SPCMDT in the report.
## Level 2 Practitioners for Psychological Support

**12-3R-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

**12-3R-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.

## Attendance at NSPCG Meetings

**12-3R-104** The lead clinician of the SPCMDT or representative should attend at least two thirds of the NSPCG meetings.

**Compliance:** The attendance record of the NSPCG meeting.

## SPCMDT Meeting

**12-3R-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 management decision before the next scheduled meeting.

**Note:**
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 SPCMDT.

## SPCMDT Agreed Cover Arrangements

**12-3R-106** The SPCMDT should agree named cover arrangements for each core member.

**Notes:**
- This refers to the nominating of staff who should in general be expected to provide cover for the core members. It does not refer to the member having to provide a person to cover for each and every absence. This aspect is dealt with by the attendance measure below.
- Where a medical specialty is referred to, the cover for a core member need not be a consultant but should be a specialist trainee or non-career grade.

**Compliance:** Written arrangements agreed by the lead clinician of the SPCMDT.

## Core member (or cover) present for 2/3 of meetings

**12-3R-107** Core members or their arranged cover (see measures 12-3R-101 and 12-3R-106) should attend at least two thirds of the number of meetings.
### MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

**Compliance:** Attendance record of the SPCMDT.

**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 judgment on this matter and should highlight in their report where this commitment is lacking.*
- *The reviewers should identify the particular roles where attendance is below the requirements of this measure.*

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**Annual Meeting to Discuss Operational Policy**

**12-3R-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 SPCMDT to illustrate the recording of at least some operational policies.

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**Operational Policy for MDT Discussion**

**12-3R-109** There should be an operational policy for the SPCMDT specifying for patients already under its care;

- at what stages of the patient pathway and/or what clinical circumstances they should be discussed at the weekly team meeting;
- which aspects of their care should be discussed and decided upon.

**Note:**
*See measure 12-1E-104r for the criteria for new patient referrals to the SPCMDT.*

**Compliance:** The policy, agreed by the lead clinician of the SPCMDT.

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**Operational Policy for Key Worker**

**12-3R-110** 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 SPCMDT 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 SPCMDT member(s).

The above policy should have been implemented for patients who came under the SPCMDT'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 for certain patients to agree a single key worker across both a cancer site specific MDT and the SPCMDT.*

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

Reviewers should spot check some of the relevant patients' case notes.

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**MDT NURSE SPECIALIST MEASURES** (Measures 12-3R-111 and 12-3R-112)

**Introduction**

Why are there currently "nursing measures" for the SPCMDTs, but no similar requirements for other SPCMDT 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 the nurse MDT members are not “officially” established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were breast surgeons and palliative care physicians, before there were established breast MDTs and SPCMDTs).

Therefore a particularly strong need was perceived for using the measures to define more clearly the role of the nurse member and to set out minimum training requirements for nursing input into MDTs. This is in order to establish these roles more firmly in the NHS infrastructure and to avoid the situation where MDTs can comply with measures by having generalist nurses, who “sit in” on MDT meetings and sign attendance forms but play no defining role in the team’s actual dealings with its patients.

### Specialist Training for Core Nurse Members

**12-3R-111** 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 1st degree level or equivalent.

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

### Agreed Responsibilities for Core Nurse Members

**12-3R-112** The SPCMDT 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’s 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 SPCMDT co-coordinator.
- Additional responsibilities to those in this measure may be agreed.

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

### Attendance at Advanced Communications Training Programme

**12-3R-113** At least those core members of the team who have direct clinical contact with patients should have attended the national advanced communication skills training.

**Notes:**

- This measure applies only to those disciplines which have direct clinical contact and which are named in the SPCMDT structure measure for core and extended 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 measures provided those members which are in place comply.
- The relevant disciplines include medical, nursing and allied health professionals.
- The reviewers should record which core members of those relevant are non-compliant.
## Extended Membership of SPCMDT

**12-3R-114** The SPCMDT 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 SPCMDT should include the person agreed as a contact point for each of the following:

- psychological support services;
- social support services;
- rehabilitation support services;
- spiritual support services;
- bereavement services;
- pharmacy support;
- pain specialists with expertise in nerve blocking and neuromodulation techniques.

*Note:*

The MDT may choose to name additional extended team members.

**Compliance:** Name of each extended team member with their role agreed by the lead clinician of the SPCMDT.

## PROVIDING PATIENT CENTRED CARE

### Patient's Permanent Consultation Record

**12-3R-115** The SPCMDT should be giving patients the opportunity of a permanent record or summary of at least a consultation between the patient and the health care professional when the following are discussed:

- management options and plan;
- relevant follow up arrangements.

*Note:*

The SPCMDT may, in addition, offer a permanent record of consultations undertaken at any stage of the patient's journey.

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

**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 / Carer Experience Exercise

**12-3R-116** The SPCMDT should have undertaken or be undertaking an exercise during the previous two years prior to review to obtain feedback on patients'/carers' experience of the services offered.

*Notes:*

- The exercise may consist of a survey, questionnaire, focus group or other method.

The exercise should have been presented and discussed at an SPCMDT meeting and the team should have implemented at least one action point arising from the exercise.

**Compliance:** The results of the exercise.

A report of the action taken.
### Provision of Written Patient Information

12-3R-117

The SPCMDT should provide patients and carers with written material which includes:

- information specific to specialist palliative care about local provision of specialist palliative care services;
- information about patient and carer involvement groups and patient and carer self-help groups;
- information about the services offering psychological, social and spiritual/cultural support, if available;
- information specific to specialist palliative care about management and care options (including names and functions/roles of the team treating them).

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](http://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.

### Management Planning Decision

12-3R-118

The core SPCMDT at their regular meetings should agree and record individual patient's management plans.

The record should include:

- the identity of patients discussed;
- the multidisciplinary management planning decision;

**Compliance:**

Anonymised examples of the record of a meeting and anonymised management plans.

**Notes:**

- Only exactly what is required in the list above is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence.
- For peer review purposes patient specific information should be anonymised.
- It is recommended that this essential information is recorded on an SPCMDT decision proforma as well as in individual patient’s notes.
### MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

**NETWORK GUIDELINES** (measures 12-3R-119 to 12-3R-120)

**Introduction**
For compliance with their relevant measures in topic1E the NSPCG, in consultation with the SPCMDTs, should produce the guidelines and for compliance with these measures, the SPCMDTs should agree to abide by them and add local information where required.

#### SPCMDT Agreement to Network Guidelines on Criteria for Referral to a Specialist Palliative Care MDT

**12-3R-119** The SPCMT should agree the network wide guidelines with the NSPCG for criteria for referral to a SPCMT.

- The SPCMT should add local contact points and distribute the guidelines to its referring site specialised MDTs.

**Compliance:**
- The network guidelines with local contact points agreed by the lead clinician of the SPCMDT and the Chair of the NSPCG.
- The reviewers should enquire as to the distribution process.

**Note:**
*Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.*

#### SPCMDT Agreement to Network Clinical Guidelines

**12-3R-120** The SPCMDT should agree the specified network-wide clinical guidelines with the NSPCG (see 12-1E-105r).

**Compliance:**
- The written guidelines agreed by the lead clinician of the SPCMDT and the Chair of the NSPCG.

#### SPCMDT Agreement to Network 24hr Telephone Advice Service Specification

**12-3R-121** The SPCMDT should agree to the specialist palliative care network's service specification and referral guidelines for the 24 hour telephone advice service. (see 12-1E-107r).

- The SPCMDT should distribute local contact points to their relevant service users.

**Compliance:**
- The network service specification and the referral guidelines agreed by the lead clinician of the SPCMDT.
- The reviewers should enquire of the distribution process.

**Note:**
*Minor shortcomings in the completeness of distribution, should not preclude compliance with this measure. Reviewers should exercise judgement in this matter.*

#### SPCMDT Agreement to 7 Day Visiting Service Specification

**12-3R-122** The SPCMDT should agree to the palliative care network's service specification and referral guidelines for the 0900-1700 hours visiting service (see measure 12-1E-108r).

**Compliance:**
- The network service specification and the referral guidelines agreed by the lead clinician of the SPCMDT.

#### SPCMDT Agreement to Network Education and Training Plan

**12-3R-123** The SPCMDT should agree the network training and education strategy (see 12-1A-304r).

**Compliance:**
- The network training and education strategy agreed by the SPCMDT lead clinician.
**NETWORK AUDIT**

**Introductory Notes**
For review purposes here, a network audit project is an audit project agreed by the NSPCG and related to specialist palliative care the same project being carried out by all SPCMDTs in the network, each team's results being separately identified. The individual SPCMDTs, for compliance with their relevant MDT measure, should agree to participate in the audit.

**Network Audit**

<table>
<thead>
<tr>
<th>12-3R-124</th>
<th>The SPCMDT should agree to participate in the network audit project agreed by the NSPCG.</th>
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<tbody>
<tr>
<td></td>
<td>The SPCMDT should annually review the progress of the project or present the results of the completed network audit project to the NSPCG for discussion at one of their meetings.</td>
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<tr>
<td>Note:</td>
<td>• It is expected that the National Council for Palliative Care dataset should be part of the network audit programme.</td>
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<td>• Additional projects may be agreed.</td>
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</tbody>
</table>

**Compliance:**
The audit agreed by the lead clinician of the SPCMDT and the Chair of the NSPCG. Written confirmation of review of progress of audit sufficient to show compliance with the measure.

**Discussion of Clinical Trials**

<table>
<thead>
<tr>
<th>12-3R-125</th>
<th>The SPCMDT should produce a report at least annually on clinical trials, for discussion with the NSPCG. The report should include:</th>
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<tbody>
<tr>
<td></td>
<td>• details of the SPCMDT's trials portfolio including the extent of local provision of the national portfolio;</td>
</tr>
<tr>
<td></td>
<td>• the SPCMDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets;</td>
</tr>
<tr>
<td></td>
<td>• the SPCMDT's programme for improvement for the above, as proposed to the NSPCG.</td>
</tr>
</tbody>
</table>

The SPCMDT should agree a final programme for improvement at the NSPCG discussion meeting.

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

**Compliance:**
The report, agreed by the lead clinician of the SPCMDT. The reviewers should check that the contents fulfil the points above. The programme for improvement, agreed by the lead clinician of the SPCMDT and the clinical lead for the cancer research network.
APPENDIX 2

2.1 Role of the NSPCG

Membership

The NSPCG 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 SPCMDT lead clinicians in the network.

Service Planning

NSPCGs 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.

NSPCGs should:

- recommend priorities for service development to the Network Board;
- ensure decisions become integrated into constituent organisational structures and processes.

Service Improvement/Redesign

- all NSPCGs and individual SPC teams should commit to service improvements;
- process mapping and capacity and demand analyses should become part of the norm;
- NSPCGs should develop/approve high quality information for patient, for use across the network.

Service Quality Monitoring and Evaluation

NSPCGs should:

- agree on priorities for common data collection (in line with national priorities e.g. for waiting times and cancer registries) 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 actions following peer review are implemented;
- report identified risks/untoward incidents to ensure learning is spread.

Workforce Development

NDSGs should:

- consider the overall workforce requirements for the NSPCG;
- 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

NSPCGs 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

NSPCGs 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 NSPCG 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.