NHS
National Cancer Action Team

National Cancer Peer Review Programme

Manual for Cancer Services 2008:
Lung Measures

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INTRODUCTION

1.1 Aim of the Manual of Cancer Services 2008

This revised Manual of Cancer Services is an integral part of the NHS Cancer Plan, Cancer Reform Strategy and modernisation of cancer services. It will support quality assurance of cancer services and enable quality improvement.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and user representation, provides important information about the quality of cancer services across the country. Between 2004 and 2008 peer reviews of cancer services were carried out in each cancer network in England.

Development of this Manual of Cancer Services 2008 and the continuation of a revised peer review process has been supported by the service and agreed by strategic health authorities following a review of all national programmes in 2007. An independent evaluation of the National Cancer Peer Review Programme also demonstrated strong support for the programme to continue, but recommended that the programme should be modified. A new process will therefore be implemented during 2008 but the measures contained within this manual will remain an integral part of the review process.

The manual has not been centrally imposed.

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 2007 the Cancer Reform Strategy was published with aims to: save more lives; improve patients' quality of life; reduce inequalities; build for the future; enable cancer care to be delivered in the best place at the right time and achieve maximum value for money.

The Cancer Reform Strategy acknowledges that national guidance will continue to play a vital role as cancer services develop over the next five years. Much of this guidance has been developed by the NICE and predecessor bodies.

Improving Outcomes Guidance (IOG) for cancer services now covers the vast majority of all cancers. Implementation of this guidance, which involves the establishment of multidisciplinary teams and reconfiguration of some complex services is now well advanced for many cancers and is scheduled to be complete for less common cancers by 2010. The revised manual has therefore been drawn up to incorporate the recommendations contained within such guidance including the new guidelines published by NICE. It identifies the characteristics of service that are likely to have a significant impact on health outcomes. It is intended that those characteristics should help those involved in planning, commissioning, organising and providing cancer services to identify gaps in provision and check the appropriateness and quality of existing services. The measures provide a ready specification for the commissioning of cancer services within a given locality.

Changes have also been made as a result of feedback from the use of measures in the manual published in 2004 and following the most recent independent evaluation of peer review published in December 2007.

There has been a clear commitment to the establishment of an active and positive relationship with the Healthcare Commission and information gathered from the National Cancer Peer Review Programme has been shared with the commission. The Healthcare Commission and in future the Care Quality Commission will play an important role in assessing the quality of cancer services and peer review continues to be committed to working in partnership with that organisation.

1.3 Measures within the National Cancer Peer Review Manual

At present peer review focuses largely on measures of structure and process. Over time, as reliable measures of outcome become available, there will be a shift in emphasis.

To date, the measures have been confined to adult cancer services, except where they relate incidentally to children, for example, a radiotherapy department would normally treat adults and children. However, measures are currently being developed that specifically address the provision of services for children and young adults with cancer.

The development of cancer measures is an ongoing process in order to:

- reflect new NICE guidance and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Cancer Reform Strategy, including action required to develop world class commissioning of cancer services.

1.4 Reviewing the Measures

The National Cancer Peer Review 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 new National Cancer Peer Review Programme has taken into account comments received during the 2004 – 2008 review programme and will focus more on annual self-assessment, completed by individual teams and services and signed off by the relevant provider CEO and by the cancer network. Targeted and a random sample of self-assessments will be externally verified by zonal teams on an annual basis. Some external visits will continue but this will become the exception rather than the rule once a team has demonstrated a high level of compliance with the measures. Peer review data will continue to be published to assist commissioners and promote transparency on service performance.

The relationship between NICE Improving Outcomes Guidance and the quality measures within the Manual for Cancer Services is explained in more detail in **appendix A.**

Appendix A

Interpretation of the National Manual of Cancer Services 2008

1.1 Guidance Compared to Cancer Measures

The NICE IOG 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 of 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 to whom the results could be attributed. 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 enquires by peer reviewers when a peer review visit is undertaken. When self-assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

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 (i.e. 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 STRUCTURE OF THE MEASURES

The general layout of the measures is illustrated in the diagram in appendix B.

Each measure has a three part number e.g**. 08-1A- 201j**

- The first part indicates the year the measure was first issued e.g. 08.
- The second part relates to a particular topic (see below) e.g. 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 e.g. 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
r - Specialist Palliative Care specific
s - Chemotherapy specific
t - Radiotherapy specific
u - User Group specific

Index of Topics

Topic 1 covers the management and organisation of the whole cancer network.

Within topic 1:

Section 1A covers the establishment of the network board and its functions.

Section 1B covers co-ordination of cancer commissioning for service developments.

Section 1C covers the functions of the network site specific groups (NSSGs).

Section 1D covers the functions of the locality groups, each of which is responsible for the management and organisation of one of the localities that have been defined and established by the board.

Section 1E covers the functions of the following groups: palliative care, chemotherapy, network users' group.

Topic 2 deals with service delivery by multidisciplinary teams rather than network management and organisation. It covers the establishment and functions of the MDTs for a particular cancer site or related group of cancers.

The sections in topic 2 cover each of the tumour sites. The letter indicating the tumour site e.g. 2B – breast multidisciplinary team.

Topic 3 deals with services, which are not specific to a particular cancer site. They cover specialist palliative care MDTs, cancer imaging, chemotherapy, cancer pathology and radiotherapy.

The sections in topic 3 cover each of the cross cutting services. The letter indicating the particular service e.g. 3T – chemotherapy service.

Topic 4 covers Cancer Registries.

Topic 5 covers Cancer Research Networks.

Topic 6 covers Primary Care Trusts.

Topic 7 covers Children's Cancer.

Some themes, such as service improvement, patient centred care, general supportive and palliative care and data collection are addressed at various places within the Manual of Cancer Services.

Each network will be made up of several localities 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 National Cancer 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 of Cancer Services On-line

To assist cancer networks to navigate round the measures - and to help individuals focus on the measures of interest to them – an on-line version of the Manual of 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.

Appendix B

Provider and Commissioner Cancer Network Structure and the Cancer Measures

Topic 1 Cancer Network
Sections:

- 1A Network Board
- 1B Commissioning
- 1C Network Site Specific Groups
- 1D Locality Groups
- 1E Network Cross-Cutting Services

Topic 2 Multidisciplinary Teams (MDT)
Sections:

- 2B Breast MDT
- 2C Lung MDT
- 2D Colorectal MDT
  - 2D-2 Local
  - 2D-3 Liver
- 2E Gynaecology MDT
  - 2E-1 Local
  - 2E-2 Specialist
- 2F UGI MDT
  - 2F-1 Local
  - 2F-2 Specialist OG
  - 2F-3 Specialist Pancreatic
  - 2F-4 Additional Liver
- 2G Urology MDT
  - 2G-1 Local
  - 2G-2 Specialist
  - 2G-3 Testicular
  - 2G-4 Penile
- 2H Haematology MDT
- 2I Head & Neck MDT
  - 2I-1 UAT/ Thyroid Combined
  - 2I-2 Thyroid
- 2J Skin MDT
  - 2J-1 Local
  - 2J-2 Specialist
  - 2J-3 Malignant Melanoma
  - 2J-4 T-Cell Cutaneous Lymphoma

Topic 3 Cross-Cutting Services
Sections:

- 3R Specialist Palliative Care MDT
- 3S Chemotherapy
  - 3T-1 Clinical Chemotherapy
  - 3T-2 Oncology Pharmacy
  - 3T-3 Intrathecal Chemotherapy
  - 3T-4 Level II Treatment Facility
  - 3T-5 Level III/IV Treatment Facility
- 3T Radiotherapy

Topic 4 Cancer Registry

Topic 5 Cancer Research Networks

Topic 6 Primary Care Trusts (PCTs)

Topic 7 Children's Cancer

TOPIC 08-1A-2c - LUNG SPECIFIC NETWORK BOARD MEASURES

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

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

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

It can be seen from the above that:

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

NOMENCLATURE

Within the network measures a number of groups have been defined. These groups each need a name for the purposes of the measures, and for data collection 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 GROUP (NSSGs)

The responsibility for review purposes for measure 08-1A-201c lies with the chair of the network.

08-1A-201c

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

- the MDT lead clinician from each MDT in the network;
- at least one nurse core member of a MDT in the network;
- a service improvement representative;
- there should be a named chair drawn from the above membership;
- two user representatives;
- one of the NHS employed members of the NSSG should be nominated as having specific responsibility for users' issues and information for patients and carers;
- a member of the NSSG 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 should be recognised as:

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

Notes:

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

Compliance: The named members and NSSG chair, agreed by the chair of the network board.

The terms of reference agreed by the chair of the network board and chair of the NSSG.

TOPIC 08-1C-1c - FUNCTIONS OF NETWORK SITE SPECIFIC GROUPS (NSSGs)

Introduction

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

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

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

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
GENERAL ACTIVITIES	
08-1C-101c	The NSSG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed as part of each MDT measures.*
Compliance:	A list of meetings dates and attendance records in the last 12 months.
08-1C-102c	The chair of the NSSG should have an annual review with the network lead clinician and/or an appropriate member of the network board. The NSSG should have agreed an annual work programme with the board. The NSSG should have produced an annual report for the board.
Compliance:	Documentation sufficient to show that a review meeting took place with the network lead clinician and/or appropriate member of the network board. The annual work programme agreed by the chair of the network board. The annual report agreed by the chair of the NSSG and the chair of the network board. *Note:* *This meeting should be face to face. An email is not an acceptable mechanism for the review.*
CLINICAL GUIDELINES	
Introduction For their compliance with this measure the NSSG should, in consultation with the MDTs, the network chemotherapy group and radiotherapy head of service, produce the network-wide clinical guidelines. Each individual MDT, for their compliance with the relevant measure on clinical guidelines in the MDT section, should agree to them. Network guidelines should be reviewed at least every 3 years, or when new guidance is available. The measures count towards the review of the NSSG and the individual team.	
08-1C-103c	The NSSG should agree network-wide clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques). *Note:*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

More details of regimens and techniques may be agreed if desired.

Compliance: The clinical guidelines agreed by the chair of the NSSG and the chair of the network board.

REFERRAL GUIDELINES

Introduction

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

08-1C-104c The NSSG should agree network-wide referral guidelines (the indications for referral of the patient to another MDT, within or outside the network).

Compliance: The referral guidelines agreed by the chair of the NSSG and the chair of the network board.

IMAGING GUIDELINES

Introduction

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

08-1C-105c The NSSG should agree network-wide imaging guidelines for the diagnosis and review of the cancer site or sites of the group. The guidelines should address:

- imaging modalities;
- their specific indications.

Compliance: The imaging guidelines agreed by the chair of the NSSG and the chair of the network board.

PATHOLOGY GUIDELINES

Introduction

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

08-1C-106c The NSSG should agree network-wide pathology guidelines for the diagnosis and assessment of the cancer site or sites of the group. 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

DATA COLLECTION

08-1C-107c The NSSG should agree a network-wide minimum dataset (MDS). The MDS should include the data items required for:

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

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

Note:

The NSSG may agree additional data items.

Compliance: The MDS 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.

08-1C-108c The NSSG should agree a network-wide policy specifying:

- which team members 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 policy 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 abide by it.

NETWORK AUDIT

Introductory Notes

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

The minimum progress needed for the NSSG's compliance with this measure (since audit is a long and multistage process) is that the NSSG in consultation with the MDTs agrees at least one network audit project with the network board, with any necessary sources of funding agreed with commissioners from elsewhere. The individual MDTs, for compliance with their relevant MDT measure should agree to participate in the audit. See appendix 1 for audit.

08-1C-109c The NSSG should agree a network audit project, with any necessary resourcing, with the network board.

Notes:

- *See appendix 1 for audit.*
- *Additional projects may be agreed and funded.*

Compliance: The project agreed by the chair of the NSSG and the chair of the network board.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	Note: *An agreed summary is sufficient provided it shows compliance with the measure.*
08-1C-110c	The NSSG should annually review the progress of the network audit project or discuss the results of the completed network audit project. *Note:* *See appendix 1 for audit.*
Compliance:	*Written confirmation of an annual review sufficient to show compliance with the measures.* *Note:* *Compliance with this measure automatically confers compliance with measure 08-1C-109c, for the NSSG and any MDTs which have taken part in the audit project.*
CANCER RESEARCH NETWORK	
08-1C-111c	The NSSG should discuss at least annually a report from each of its MDTs, including the following points as related to the MDT's activity during the preceding year: • the MDT's response to the approved clinical trials and other week designed studies list; • the MDT's recruitment into clinical trials and other well designed studies. The following should be present at the discussion: • the chair of the NSSG or a nominated representative; • 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.
Compliance:	Confirmation of discussion regarding trials, sufficient to show compliance with the measure. *Note:* *The discussion with various individual MDTs may take place at different meetings of the NSSG.*
08-1C-112c	The NSSG and the clinical lead of the research network should agree remedial actions for improving recruitment into approved trials and other well designed studies with each of its MDTs, following its meeting to discuss the MDTs' recruitment.
Compliance:	The remedial actions agreed by the chair of the NSSG and the research clinical lead. *Notes:* *It is acceptable for them to agree that no remedial action is needed for a given MDT if the accrual is satisfactory.* *The outcome for each of the MDTs which relate to that NSSG should be agreed for compliance with the measure.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
PROPOSALS FOR SERVICE DEVELOPMENTS
08-1C-113c 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 group.

TOPIC 08-2C-1 - LUNG MULTIDISCIPLINARY TEAM (MDT)

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

The measures review a variety of aspects of the team, both structure and function, but the key question, which underlies all this, is who exactly constitutes the MDT, from the point of view of the peer review? Which group of people should be put forward for review against these measures, and that is it who is held compliant or not compliant? This is best answered from the patient's point of view. If you were a patient who would you consider to be your MDT? Primarily it is that group of people of different health care disciplines which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. They constitute that patient's MDT.

The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient. For some cancer types the IOG has laid down detailed requirements over how the diagnostic process should be incorporated into the MDT system and this has also been translated into the measures where applicable.

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

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

The main examples of this are as follows:

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

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

but they will directly relate to that MDT and be specified by it, because at least one key functionary, the surgeon, will be a core member of that MDT.

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility, for review purposes, for measure 08-2C-101 lies with the lead clinical of the host trust (see topic 1A).

MDT LEADERSHIP

08-2C-101

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

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

Note:

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

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

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

Note:

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

MDT STRUCTURE

08-2C-102

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

The core team specific to the lung MDT should include:

- designated respiratory physician(s);
- designated thoracic surgeon(s);
- clinical oncologist;
- medical oncologist (where the responsibility of chemotherapy is not undertaken by the clinical oncologist core member);
- imaging specialist;
- histopathologist;
- designated cytologist;
- lung nurse specialist;
- a core member of the specialist palliative care team;
- MDT co-ordinator/secretary;
- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;
- a member of the core team nominated as the person responsible for ensuring recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.

Notes:

- *Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a*

medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.

- *The medically qualified core member(s) depend on the cancer site of the MDT.*
- *The co-ordinator/secretary role needs different amounts of time depending on team workload. See appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial role may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description.*
- *There may be additional core members agreed for the team besides those listed above.*

Compliance: Name of each core team member with their role, agreed by the lead clinician of the MDT.

Notes:

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

08-2C-103 The MDT should send a team member as a representative to at least two thirds of the network site specific group (NSSG) meetings.

Compliance: The attendance record of the NSSG.

MDT MEETINGS

08-2C-104 If there is a separate MDT meeting to discuss the diagnosis of all referrals prior to the discussion of the definitive treatment of those patients diagnosed with malignancy, the membership of this separate diagnostic MDT meeting should be named. No other measures then apply to this team meeting.

Note:

The multidisciplinary discussion of diagnosis should always take place, whether it is done for all referrals in one single MDT meeting or not. This measure merely deals with the situation where an entirely separate meeting of a subset of the MDT membership is used to filter out the possibly large number of referrals with a benign condition, allowing the MDT to meet specifically to make the treatment planning decision on the patients with malignancy. The measure is intended to prevent both meetings being separately reviewed in parallel against all the measures, which is not necessary.

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

08-2C-105 The team should hold its meetings at least fortnightly, record core members' attendance and have a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (Guidance only - e.g. letters, emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting).

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	Attendance records of the meetings. Written procedure agreed by the lead clinician of the MDT.
08-2C-106	The MDT should agree cover arrangements for each core member. *Notes:* • *This refers to the nominating of staff who should in general be expected to provide cover for core members e.g. a specialist trainee on a consultant's team or core members of the same discipline providing cover for each other. It does not refer to the member having to provide a person to cover for each and every absence. This aspect is dealt with by the attendance measure below.* • *Where a medical specialty is referred to the cover for a core member need not be a consultant, but should be a specialist trainee or non-career grade.*
Compliance:	Written arrangements agreed by the lead clinician of the MDT.
08-2C-107	Core members or their arranged cover (see measures 08-2C-102 and 08-2C-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.* *The reviewers should identify the particular roles where attendence is below the requirements of this measure.*
OPERATIONAL POLICIES	
08-2C-108	Besides the regular meetings to discuss individual patients, the team should meet at least annually to discuss, review, agree and record at least some operational policies.
Compliance:	Written confirmation of at least one meeting agreed by the lead clinician of the MDT to illustrate the recording of at least some operational policies.
08-2C-109	There should be an operational policy for the team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan. *Note:* *As stated in the Cancer Reforms Strategy, the care of all patients should be formally reviewed by a MDT.*
Compliance:	The written operational policy agreed by the lead clinician of the MDT.
08-2C-110	The MDT should have agreed a policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis by the end of the following working day. The MDT should have completed an audit against this policy, of the timeliness of notification to GPs of the diagnosis of cancer.

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

08-2C-111

There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s).

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

Notes:

- *For information: according to the NICE 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.

08-2C-112

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

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

MDT NURSE SPECIALIST MEASURES

Introduction

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

The modern change to MDT working has created and then highly developed the specific role of nurse member, with its related activities, which in full measure, go to make up the role of cancer nurse specialist. The roles of the medical specialties in the MDT have not been so profoundly influenced or so extensively developed by their MDT membership itself, compared to that of the MDT nurse specialist. The role definitions and training requirements of nurse MDT members are not very well "officially" established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were thoracic surgeons and palliative care physicians before there were established lung MDTs and specialist palliative care teams). Therefore a particularly strong need was perceived for using the measures to define more clearly the role of the nurse specialist and to set out minimum training requirements for nursing input into MDTs. This is in order to establish these roles more firmly in the NHS infrastructure, and to avoid the situation where MDTs can comply with measures by having generalist nurses who "sit in" on MDT meetings and sign attendance forms but play no defining role in the team's actual dealings with its patients.

08-2C-113

The MDT should have at least one core nurse specialist who should have successfully completed a programme of study in their specialist area of nursing

practice, which has been accredited for at least 20 credits at first degree level or equivalent.

Note:

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

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

08-2C-114 The MDT should have agreed a list of responsibilities with each of the core nurse specialists of the team, which includes the following:

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings;
- providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice;
- involvement in clinical audit;
- leading on patient and carer communication issues and co-ordination of the patient'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.

Note:

Additional responsibilities to those in this measure and the next measure may be agreed.

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

08-2C-115 The MDT should have agreed a list of responsibilities with at least one of the core nurse specialists of the team, which, in addition to the items listed in measure 08-2C-114, includes:

- 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 relevant core nurse member(s).

08-2C-116 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 TEAM

08-2C-117 The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members.

The named extended team for the lung MDT should include:

- a core member of the specialist palliative care team;
- psychologist/psychiatrist;
- chaplain/pastoral care worker;
- bereavement care worker.

Notes:

- *The MDT may choose to name additional extended team members.*
- *Although there is not a requirement to have a named social worker as part of the extended team, there should be arrangements in place to access a social worker when required.*

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

FUNCTIONS OF THE TEAM

Providing Patient Centred Care

08-2C-118 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.

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.

08-2C-119 The MDT should have undertaken or be undertaking an exercise during the previous two years prior to review to obtain feedback on patients experience of the services offered.

The exercise should at least ascertain whether patients were offered:

- a key worker;
- the information for patients (written or otherwise) (see measure 08-2C-121);
- 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.

Compliance: The results (complete or in progress) of the exercise.

08-2C-120 Exercises in 08-2C-119 which have been completed during the previous two years 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 actions taken.

08-2C-121 The MDT should provide patients and carers with 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 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).

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

Note:

It is recommended that it is available in languages and formats understandable by patients including local ethnic minorities and people with disabilities. This may necessitate the provision of visual and audio material.

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

TREATMENT PLANNING DECISION

08-2C-122 The core MDT, at their regular meetings, should agree and record individual patient's treatment plans. A record should be made of the treatment plan. The record should include:

- the identity of patients discussed;
- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment-surgery, radiotherapy, chemotherapy, or supportive care or combinations of the same, that are to be referred for consideration).

Note:

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

Compliance: Anonymised examples of the record of 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 peer review purposes patient specific information should be anonymised.

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

CLINICAL GUIDELINES

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

08-2C-123 The MDT should agree specified network-wide clinical guidelines* with the NSSG for that cancer site. Where there are agreed national clinical guidelines the network and the MDT should accept these.

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

Notes:

- *More details of regimens and techniques may be agreed if desired.*
- *See 08-1C-103c.*

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

REFERRAL GUIDELINES

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

08-2C-124 The MDT should agree referral guidelines* with the NSSG for that cancer site.

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

Notes:

- *For compliance the NSSG should produce an agreed guideline and the individual MDT for their compliance, should agree to abide by it.*
- *See 08-1C-104c.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Compliance: The referral guidelines agreed by the lead clinician of the MDT and the chair of the NSSG and chair of the network board.

IMAGING GUIDELINES

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

08-2C-125 The MDT should agree imaging guidelines for the diagnosis and assessment of that cancer site. The guidelines should address:

- imaging modalities;
- their specific indications.

Note:

See 08-1C-105c.

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 the chair of the NSSG. For compliance the NSSG, in consultation with the MDTs, should produce the agreed network-wide pathology guidelines. The individual MDTs, for their compliance with this measure, should agree to them.

08-2C-126 The MDT should agree pathology guidelines for the diagnosis and assessment of that cancer site. The guidelines should address:

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

Note:

See 08-1C-106c.

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

DATA COLLECTION

08-2C-127 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 the National Cancer Dataset and the NHS Data Dictionary.

Notes:

- *The network MDS may include additional data items.*
- *See 08-1C-107c.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

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

Note:

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

08-2C-128 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 (see 08-1C-108c).

Compliance: Anonymised examples of the record data for individual patients.

Note:

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

NETWORK AUDIT

Introductory Notes

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

The minimum progress needed for the NSSG's compliance with this measures (since audit is a long and multistage process) is that the NSSG in consultation with the MDTs agrees at least one network audit project with the network board, with any necessary sources of funding agreed with commissioners from elsewhere.

08-2C-129 The MDT should agree to participate in the network audit project with the necessary funding, agreed with the NSSG.

Notes:

- *See appendix 1 for audit.*
- *See 08-1C-109c.*

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

08-2C-130 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.*
- *See 08-1C-110c.*

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

Note:

Compliance with this measure automatically confers compliance with the previous measure.

CANCER RESEARCH NETWORK

08-2C-131 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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
patients or state the reason why it will not be able to; • the remedial action arising from the MDT's recruitment results, agreed with the NSSG. *Compliance:* The response including remedial action agreed by the lead clinician of the MDT and chair of the NSSG.
08-2C-132 The remedial action arising from the MDT's recruitment results, agreed with the NSSG should of been carried out. *Compliance:* The reviewers should enquire as to the implementation of the recommended actions.
MDT WORKLOAD
There is no definite evidence base for a minimum viable workload in the *'Improving Outcomes Guidance'* for lung cancer, so it is not incorporated into measures for this MDT.

Appendix 1 – Network Audit

This appendix is to follow

Appendix 2 - Outline of Roles

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.

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