

Manual for Cancer Services

Health and Social Care Cancer Measures

Version F



VERSION CONTROL SHEET

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HPB Cancer Measures

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National Cancer Peer Review and The Manual for Cancer Services

1 Introduction

The National Peer Review Programme provides important information about the quality of clinical teams and a national benchmark of cancer services across the country. It 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 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 supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

The Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Robert Francis Jan 2013) said the creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement. Among the recommendations made is recommendation 49, Enhancement of monitoring and the importance of inspection, which states;

Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.

The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.

1.1 National Cancer Measures

The development of cancer measures is a dynamic process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;

- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new developments and initiatives in treatment and patient care;
- reflect the NHS England specialised service specifications.

1.2 Clinical Indicators/ Outcomes

Peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, clinical indicators have been introduced and form part of the review process along with a reduced number of structure and process measures.

2 Interpretation of the National Manual for Cancer Services

2.1 Guidance Compared to Cancer Measures

National 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, 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. Without this underlying type of mind-set 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 the specific purpose of being used to assess a service; to aid self assessment and team development; to be fair compared to visits to other services elsewhere and to past and future visits to the same service. Therefore, the measures have to:

- be objective;
- be measurable;
- be specific, clear and unambiguous;
- be verifiable;
- state who exactly is responsible for what;
- be discriminating;
- be achievable;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure.

2.2 "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.

2.3 "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.

2.4 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.

2.5 "Quality" Aspects of Cancer Service Delivery

The peer review process recognises the qualitative as well as quantitative aspects of review and in addition to the objective recording of compliance against the measures there is a narrative part to the report that provides an overall summary of a team's performance.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at <http://www.cquins.nhs.uk>

Hepato-Pancreato-Biliary Cancer Measures

Introduction

Context

The context and the underlying sources for these Hepato-Pancreato-Biliary (HPB) measures are:

- i) Improving Outcomes in Upper Gastro-intestinal Cancers. (DH 2001).
- ii) A relevant part of the NICE Colorectal Quality Standard. (QS 20).
- iii) The discussions of the National Cancer Peer Review, HPB reference group.
- iv) The recommendations from the Association of Upper Gastro-intestinal Surgeons (AUGIS). (The Provision of Services for Upper Gastrointestinal Surgery, 2011 and Guidance on Minimum Surgeon Volumes, 2010).
- v) The increase in the radical treatment of liver metastases, especially from colorectal cancer, which has required measures for patient pathways covering this area of practice.

Some aspects of these measures (derived from similar sources) are reflected in the NHS Service Specification No. B3e. The measures will supersede the previous section of the Upper Gastro-intestinal (UGI) measures, covering pancreato-biliary MDTs (Topic 2F). There will be a separate section covering overarching network site specific groups (NSSGs) for HPB cancer.

Clinical Scope of the Measures

The measures cover the diagnosis and treatment of primary liver, biliary tract (including gall bladder), duodenal and pancreatic cancers and the radical management of liver metastases. Currently, the majority of such radically managed metastases are from colorectal primaries, due to the anatomy of the venous drainage and its effect on disease spread.

Liver resections for colorectal metastases (or metastases from any other primary) are only one part of the patient pathway for these patients and the major part of the pathway will be managed by, and be the responsibility of, the MDT for the primary site. This, from the HPB MDT's point of view, is fundamentally different from the role of an MDT for the primary site and is a fundamentally different role than the one an HPB team would have for its pancreatic/biliary practice and its primary liver tumour practice. This means that the patient pathways for its management of liver metastases of colorectal origin need to be agreed, not only between all HPB MDTs in their network with the HPB NSSG, but between the HPB and colorectal NSSGs.

The NSSG may wish to formally agree joint pathways with NSSGs for other primary sites but this is not required in the measures. This requirement is currently confined to colorectal NSSGs because of the preponderance of colorectal metastases in this practice.

Ground Rules for Networking for HPB Networks

The term 'network' for these measures should usually be understood as the networking arrangements specifically for HPB cancer and metastasectomy and the overarching clinical networking group for HPB will be called a Network Site Specific Group, (NSSG). Ground rules for networking have been developed, applicable to all cancers, which set out rational principles for the establishment of teams and groups, and the relationship between MDTs and their NSSG (Appendix 1).

The configuration of an HPB network under review will need to be agreed with commissioners and will be reviewed against measures which require compliance with these networking ground rules.

Local MDTs

Local MDTs for HPB are the local UGI MDTs and referring colorectal MDTs, which will be assessed under their respective sets of measures.

Each MDT should be associated with a single named NSSG however, MDTs which deal with a group of related cancer sites, rather than a single site, may be associated with more than one NSSG, but should have only one NSSG per cancer site. e.g. A local UGI MDT dealing with oesophago-gastric (OG) and HPB could be associated with a separate NSSG for each of its specialty sites.

Specialist MDTs

The specialist HPB MDT should have a catchment population for their specialist practice of at least 2 million. This applies to both the HPB primary and liver metastasis practices, whichever are engaged in by the MDT.

Viability Criteria for MDTs and Individual Surgeons

The IOG requirements for specialist MDTs to have minimum catchment populations have been added to by the AUGIS requirement for them to have minimum, team operating caseloads and for individual, core surgical team members to perform minimum numbers of procedures.

Levels of Care

1. Primary HPB Cancer

For primary cancers, there is the diagnostic process and three defined levels of care, with regard to which type of MDT should carry out such care and the site of its delivery. Emergency surgical procedures where the diagnosis is unforeseen and is made at the time of the operation are not subject to these levels but the cases should be referred for discussion retrospectively by the specialist HPB MDT treatment planning meeting.

Any of the treatments or procedures may, subject to network agreement, be dealt with at a higher level than specified, but not at a lower level. I.e. the network may choose to consolidate services more than as specified, but not less.

The diagnostic process:

There should be a defined diagnostic team (which may be part of a local UGI MDT) which liaises with primary care using the NICE referral guidelines for cancer. Patients may, however be diagnosed incidentally and unexpectedly, outside this referral process.

Level one care:

This needs:

- Case discussion at the treatment planning meeting of the specialist HPB MDT.
- Treatment plan decided by the specialist HPB MDT.
- Treatment delivery under the care of a core member of the specialist HPB MDT.
- Treatment delivery in the specialist HPB MDT's named single site for that treatment.

Level one care consists of:

- Tumour surgical resection (open and laparoscopic).
- Tumour ablative procedures (open, laparoscopic, percutaneous and endoscopic).
- Palliative, biliary, surgical bypass procedures.
- Nuclear medicine treatment.
- Percutaneous interventional procedures including selective internal radiation therapy (SIRT) and portal vein embolisation), except for percutaneous biliary drainage.

Level two care:

This needs:

- Case discussion at the treatment planning meeting of the specialist HPB MDT.
- Treatment plan decided by the specialist HPB MDT.
- The authorised personnel responsible for the treatment and the allowed site or sites of treatment delivery to be restricted to only certain ones agreed in the network patient pathways.

Level two care consists of:

- Elective percutaneous biliary drainage.
- All systemic anticancer therapy.
- Non-palliative radiotherapy.

Level three care:

This needs:

- Discussion of the case with a core member of the specialist HPB MDT with agreement that only level three care is needed. *Note: It would be expected that these cases would be recorded retrospectively at the Specialist MDT meeting, but treatment does not need to be planned at the MDT meeting.*

Treatment may be delivered locally and personnel and delivery site do not need to be specifically restricted by

network agreement.

Level three care consists of:

- Emergency percutaneous biliary drainage.
- Endoscopic, palliative, biliary and/or duodenal stenting. *Note on 'and/or': Biliary and duodenal stenting may be done as individual procedures; both may be done on the same patient in sequential separate procedures, or as a combined, single procedure.*
- Palliative radiotherapy.
- Palliative and supportive care, not involving any tumour shrinking therapy.

2. The Radical Management of Liver Metastases

For the radical management of liver metastases, their diagnosis is the responsibility of the colorectal or other site specific MDT. The specified three levels of care apply as follows:

Level one care:

This needs:

- Case discussion at the treatment planning meeting of the specialist HPB MDT.
- Treatment plan (decision on suitability for radical treatment) by the specialist HPB MDT.
- Treatment delivery under the care of a core member of the specialist HPB MDT.
- Treatment delivery in the specialist HPB MDT's named single site for that treatment.

Level one care consists of :

- Tumour surgical resection (open and laparoscopic).
- Open, laparoscopic, percutaneous and endoscopic tumour ablation.
- Percutaneous interventional procedures including SIRT and portal vein embolisation.

Level two care:

This needs:

- Case discussion at the treatment planning meeting of the specialist HPB MDT.
- Treatment plan (decision on suitability for radical treatment) by the specialist HPB MDT.
- The authorised personnel responsible for the treatment and the allowed site or sites of treatment delivery to be restricted to only certain ones agreed in the network patient pathways.

Level two care consists of systemic treatment and radiotherapy as part of the radical management of liver metastases.

Level three care: This is not strictly applicable as this is radical management, but the issue is dealt with by the policy for all scans showing liver predominant metastatic colorectal cancer to be sent for opinion to the specialist HPB MDT.

Network Site Specific Group Measures

<p>Introduction</p> <p>Prior to review, the boundaries of the HPB network to be reviewed should be agreed with the relevant Strategic Clinical Networks (SCNs) and a named SCN should agree to take responsibility for the purpose of the peer review, for managing the immediate process of dealing with the outcomes of the review.</p> <p>Responsibility for the purpose of peer review for the first two measures in this section lies with the medical director of the relevant NHS Area Team. Responsibility for the purpose of peer review for the subsequent measures in this section lies with the chair of the NSSG. The HPB MDTs referred to in these measures are classed as specialist MDTs, but will be referred to simply as HPB MDTs.</p>		
<p>Key Theme</p> <p>Structure and Function</p>		
<p>Objective</p> <p><i>Patients have access to appropriate care supported by best practice guidance.</i></p>		
13-1C-101n	Network Configuration	
<p>The HPB MDTs should be named, with their host hospitals and trusts and referring diagnostic/ local care UGI MDTs.</p> <p>Those HPB MDTs which have a liver metastasis treatment practice should be named with their host hospitals and trusts.</p> <p>The associated colorectal MDTs should be specified in the case of those HPB MDTs with a liver metastatectomy practice.</p> <p>The HPB MDTs should each have a catchment population for their specialist practice of at least 2 million. This applies to both the HPB primary and liver metastasis practices, whichever are engaged in by the MDT.</p> <p>The HPB MDTs should each have an annual team case throughput, depending on the practice the MDT is engaged in, of at least 80 pancreatic surgical procedures for neoplastic disease or suspected neoplastic disease and 150 liver surgical procedures (75 of which should be major - 3 or more segments) for neoplastic disease or suspected neoplastic disease (1).</p> <p>The relationship of the MDTs to their catchments and their hospitals should comply with the peer review ground rules for networking as follows.</p> <ul style="list-style-type: none"> • The HPB MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area. • The HPB MDT should be the only such specialist/supranetwork MDT for its cancer site, functioning on or covering a given hospital site. • The HPB MDT should act as the 'local' type MDT for its cancer site, for its own secondary catchment population, if it deals with potentially 	<p>(1) Cases operated on by MDT members using the facilities of the private or independent sector do not count towards this statistic, since it is a measure of the viability of the NHS unit associated with the MDT. Apart from this issue, the way this parameter is calculated for individuals, is explained in 13-2N-101.</p> <p>(2) The NSSG need only be associated with one HPB MDT but may be associated with more than one. Unless there are multiple MDTs associated with the NSSG, there is no coordinated networking. Without this ground rule, each MDT could effectively set itself up as an independent 'network', with members acting as their own NSSG.</p>	<p>Constitution.</p>

<p>the whole patient pathway for its cancer site. If, for all or part of its practice, it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, (i.e. the liver metastases practice) the ground rule does not apply to that part of its practice.</p> <p>A single HPB NSSG should be named for the HPB network under review, with its associated HPB MDTs and colorectal NSSG(s). (2)</p> <p>The relationship between the NSSG with its associated HPB MDTs should comply with the peer review ground rules for networking.</p> <ul style="list-style-type: none"> • The NSSG should be the only such NSSG for the MDTs which are associated with it. • The NSSG should be associated with more than one MDT, including local MDTs. <p>All the above arrangements, which constitute the configuration of the HPB cancer clinical network, should be agreed by the medical director of the relevant area teams.</p>		
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Objective

There are clinical networking structures in place to support equity of patient care.

13-1C-102n	Network Site Specific Group Membership	
<p>There should be a single NSSG, having the following membership: (1)</p> <ul style="list-style-type: none"> • a core member from each of the associated HPB MDTs; • a core member from each of the associated local UGI MDTs; • a surgical core member from each of the associated local colorectal MDTs; • a hepatic surgeon; • a pancreatic surgeon; • representation covering both ERCP and EUS practitioners; • representation covering both diagnostic and interventional radiology; • representation covering both clinical and medical oncology; • a hepatologist or gastroenterologist with a hepatology interest; • a histopathologist; • an HPB cancer nurse specialist; • two user representatives;(2) • one of the NHS employed members of the NSSG should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the NSSG nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the NSSG; • named secretarial/administrative support; 	<p><i>(1) There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members. Any one individual may fulfil more than one of the roles on the list, compatible with their discipline and status.</i></p> <p><i>(2) If there are no user representatives, there should be an agreed mechanism for obtaining user advice.</i></p> <p><i>(3) There may be additional points in the agreed terms of reference.</i></p>	<p>Constitution.</p> <p>Annual Report including meeting attendance spread sheet.</p> <p>The spread sheet should include names, roles and MDT represented.</p>

<ul style="list-style-type: none"> • there should be a named chair who should be a core member of one of the associated MDTs. <p>There should be terms of reference agreed for the NSSG which include: (3)</p> <ul style="list-style-type: none"> • the provision of clinical opinion on issues relating to HPB cancer for the network; • the development of patient pathways and clinical guidelines; • the co-ordination and consistency across the network for cancer policy, practice guidelines, audit, research and service development; • consulting with the relevant 'cross cutting' network groups on issues involving chemotherapy, cancer imaging, radiotherapy, histopathology and laboratory investigation and specialist palliative care. 		
13-1C-103n Network Site Specific Group Meetings		
<p>The NSSG should meet regularly and record attendance.</p>	<p><i>The attendance of MDT representatives is reviewed as part of the MDT measures.</i></p>	<p>Constitution. Annual Report including meeting attendance spread sheet.</p>
13-1C-104n Work Programme and Annual Report		
<p>The NSSG should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the medical director of the relevant area team.</p> <p>The NSSG should have produced an annual report for the SCN and relevant area team.</p>		<p>Work programme including details of any planned service development. Specify responsibility and timescales. Annual report including details of any service development.</p>
<p>Key Theme</p> <p>Co-ordination of Care / Patient Pathways</p>		
<p>Objective</p> <p><i>All patients receive agreed treatment that is consistent and equitable.</i></p>		
13-1C-105n Clinical Guidelines		
<p>The NSSG should produce clinical guidelines (i.e. how a given patient should be clinically managed, usually at the level of which modalities of imaging and pathology investigation and which modalities of treatment are indicated, rather than detailed regimens or techniques).</p> <p>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are</p>	<p><i>Chemotherapy treatment algorithms are dealt with in a separate measure in this section. Radiotherapy treatment techniques are dealt with in the Radiotherapy measures.</i></p>	<p>Clinical guidelines.</p>

adopted.			
13-1C-106n	Chemotherapy Treatment Algorithms		
The NSSG, in consultation with the relevant chemotherapy cross cutting groups should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.	<i>Please see further details in appendix 3.</i>	Annual report. Work programme. Examples of treatment algorithms should be seen at Internal Validation (IV) and Peer Review Visit (PR).	
Objective <i>All patients receive co-ordinated care.</i>			
13-1C-107n	Patient Pathways		
<p>The NSSG should produce patient pathways (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the services, hospitals and MDTs. (1,2)</p> <p>The pathways should include the following:</p> <ul style="list-style-type: none"> to what extent and in what circumstances the referring diagnostic and diagnostic/local care teams may further investigate a patient after the diagnosis of malignancy and before referral to the specialist team; the specification that all images suspicious of primary HPB cancers should be referred by diagnostic/local care teams for diagnostic review by the specialist team, and it should specify radiological criteria for suspicion; the agreed levels of care; (3) the named relevant MDTs, personnel and hospital sites authorised for specific treatments, as specified in the care levels classification; in the case of diagnostic only teams, the names of any local teams to which they refer for local care; those parts of the colorectal cancer pathway which are the primary responsibility of the named colorectal MDTs and those which are the primary responsibility of the named HPB MDT; that patients with chest, abdomen and pelvic imaging suggestive of liver predominant metastatic disease from colorectal cancer should have their images referred to the HPB team for opinion on suitability for radical treatment of the metastases; the referral pathway for liver transplant with referral criteria from the specialist HPB MDT to the named, relevant liver transplant centre; that any patient with metastatic carcinoma of 	<p><i>(1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the NSSG.</i></p> <p><i>(2) Rehabilitation pathways should include reference to the NCAT rehabilitation care pathways.</i></p> <p><i>(3) The way the HPB practice should be distributed between MDTs and individual personnel across the HPB network is addressed in the introduction to these HPB measures. A model is used of the diagnostic process and then three defined levels of care, depending on the degree of specialist expertise and consolidation of the service required.</i></p>	Constitution.	

unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.		
Key Theme Patient Experience		
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
13-1C-108n	Patient Experience	
In the course of their regular meetings, the NSSG should annually review patient feedback of their associated MDTs and any actions implemented, and should agree an improvement programme with them.		Annual report.
Key Theme Clinical Outcomes / Indicators		
Objective <i>All patients receive treatments intended to provide the best possible outcomes, consistent across the MDTs.</i>		
13-1C-109n	Clinical Outcomes Indicators and Audits	
<p>In the course of their regular meetings, the NSSG should annually review the progress (or discuss the completed results, as relevant), of their associated MDTs' outcome indicators and audits, which should have been carried out, or the data examined across all its associated MDTs.</p> <ul style="list-style-type: none"> Any cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS). Clinical indicators identified in section 2 of the measures. Any additional audits for hospital practice, which the NSSG has agreed across its relevant, associated MDTs. 	<p><i>Information from the cancer outcomes and service dataset (COSD) should be used where relevant.</i></p> <p><i>The compliance for this measure relates to the discussion of the MDT data with the NSSG.</i></p>	Annual Report. Work Programme.
Objective <i>All patients have equitable access to treatments that could potentially improve outcome.</i>		
13-1C-110n	Discussion of Clinical Trials	
The NSSG should discuss the MDT's report on clinical trials, annually with each of its associated MDTs and agree an improvement programme with them.		Annual report. Work Programme.

Hepato-Pancreato-Biliary MDT Measures

Introduction

The MDT is the group of people from 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. 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.

Local MDTs for HPB are the local UGI MDTs and referring colorectal MDTs, which will be assessed under their respective sets of measures.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.

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

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

13-2N-101

Core Membership

There should be a single named lead clinician with agreed list of responsibilities for the HPB MDT who should then be a core team member.(1)

The MDT should provide the names of core team members and their cover for named roles in the team. (2)

The core team specific to the HPB cancer MDT should include: (3)

- 2 HPB surgeons each meeting the individual minimum case numbers relevant to their practice; (4)
- 2 radiologists at least one of which should be an interventional radiologist so that interventional and diagnostic radiology are covered;
- 2 HPB nurse specialists;
- 2 endoscopy practitioners, between them, covering endoscopic ultrasound and ERCP;
- a physician gastroenterologist;
- an oncologist taking responsibility for systemic therapy;
- a histopathologist;
- a core member of the specialist palliative care team;
- MDT co-ordinator/secretary; (5)
- at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6)
- an NHS-employed member of the core or

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

(2) Where a medical specialty is referred to the cover for a core member need not be a consultant, but if not, they should be a specialist trainee (at minimum training level of ST7) or non-consultant career grade. All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.

(3) There may be additional named core members at the team's discretion but they then become subject to all relevant constraints on core members which the measures require.

(4) Pancreatic surgeons should perform at least 12 pancreatic surgical procedures per year for neoplastic disease or suspected neoplastic disease. Pancreatic procedures for the purposes of this statistic

Operational Policy including confirmation of any specific requirements of the roles.

Annual Report including meeting attendance spread sheet.

The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.

<p>extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;</p> <ul style="list-style-type: none"> • a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT. 	<p><i>include extra hepatic bile duct resections (perihampullary, lower bile duct) and duodenal resections.</i></p> <p><i>Liver surgeons should perform at least 15 liver surgical procedures per year for neoplastic disease or suspected neoplastic disease at least 10 of which should be major (3 or more segments). Liver resections include intrahepatic bile duct resections.</i></p> <p><i>Any core surgical MDT members additional to the specified 2 should also each fulfil the minimum personal case numbers.</i></p> <p><i>A single individual who practices in both pancreatic and liver surgery should fulfil both sets of case volume requirements.</i></p> <p><i>If two surgeons share the surgery of a given case, this would count as a case for each.</i></p> <p><i>Core members should be scrubbed and in theatres and named on the operating notes for them to count it as one of their cases when they are supervising trainees.</i></p> <p><i>Numbers are taken as the average over the two complete years prior to assessment.</i></p> <p><i>Cases performed in the private or independent sector do count towards an individual's total.</i></p> <p><i>(5) The co-ordinator/secretary role needs different amounts of time depending on team workload.</i></p> <p><i>(6) For level 2 psychological support, the relevant disciplines include medical, surgical, nursing and allied health professionals.</i></p> <p><i>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</i></p>	
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		<i>this measure.</i> <i>The definition of the levels may be found in appendix 4.</i>	
13-2N-102	MDT Quorum		
<p>The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday.</p> <p>The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1)</p> <p>The quorum for the HPB cancer MDT is made up of the following core members, or their cover: (2)</p> <ul style="list-style-type: none"> • one designated HPB surgeon; • one oncologist taking responsibility for systemic therapy; • one hepatologist or gastroenterologist with an interest in hepatology; • both diagnostic and interventional radiology should be represented, and may be by a single individual with the relevant skills; • one histopathologist; • one HPB nurse specialist; • one MDT co-ordinator. 	<p>(1) <i>The % should be calculated over the 12 months prior to the assessment.</i></p> <p>(2) <i>The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.</i></p> <p><i>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.</i></p>	<p>Annual Report including meeting attendance spread sheet.</p> <p>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</p>	
13-2N-103	MDT Review		
<p>There should be an operational policy for the team whereby all new patients should be reviewed by a multidisciplinary team for discussion of the initial treatment plan. (1)</p> <p>The policy should specify that the results of patients' holistic needs should be taken into account in the decision making.</p> <p>There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (2)</p>	<p>(1) <i>For specialist teams, this applies to that part of their practice where they are acting as the local team for their own secondary catchment area. For their specialist practice, the issue is dealt with by the levels of care and the network patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion.</i></p> <p>(2) <i>e.g. letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.</i></p>	Operational policy.	
Objective			
<i>Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.</i>			
13-2N-104	Core Members Attendance		
All core members of the MDT should attend at least two thirds of the number of meetings.			Annual Report including meeting attendance spread

		sheet. The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.
13-2N-105	Extended Membership	
The MDT should provide the names of members of the extended team for named roles in the team. If they are not already offered as core team members, the named team for the extended MDT should include:		Operational policy.
<ul style="list-style-type: none"> • cytopathologist; • anaesthetist/intensivist; • clinical oncologist; • dietician. 		
13-2N-106	Specialist Surgical Cover	
The MDT should provide a rota of consultant core surgical members whereby at least one is available for telephone advice and potential face to face patient assessment and intervention, 24/7, 365 days a year, for the MDT's post-operative patients.	<p><i>The rota should be drawn from the core members of the MDT under review. i.e. A rota should not cover the practice of more than one HPB MDT.</i></p> <p><i>On the rota a liver surgeon may cover for a pancreatic surgeon and vice versa, provided they are both core members of the HPB MDT.</i></p>	Operational Policy. The rota should be available for review at IV/PR.
13-2N-107	Specialist Interventional Radiology Cover	
The MDT should provide a rota of consultant interventional radiologists whereby at least one is available for telephone advice and potential intervention, 24/7, 365 days a year, for the MDT's patients.	<p><i>The consultants need not all be core HPB MDT members, but may include general interventionists and the cover may be provided by an interventionist cover rota acting for a variety of types of practice.</i></p>	Operational Policy. The rota should be available for review at IV/PR.
	Measure	Notes
13-2N-108	Single Site Surgery and Post-Operative Care	
The operations and acute post-operative care activities of the MDT should all be carried out in the same hospital. This hospital should have intensive care (ITU) and high dependency (HDU) on site.	<p><i>The named single site for the hepatic practice may be a different site from the named single site for the pancreatic practice, provided the whole of a given practice takes place on one named site. If there are two sites, each one should have ITU and HDU.</i></p>	Operational Policy.

Key Theme		
Co-ordination of Care / Patient Pathways		
Objective <i>All patients receive agreed treatment that is consistent and equitable.</i>		
13-2N-109	Clinical Guidelines	
The MDT should agree the clinical guidelines specified in measure 13-1C-105n, adding relevant local contact points.	<i>Where available, these should reflect national guidelines and policy.</i>	Operational policy. Clinical Guidelines should be available for IV and PR visit.
Objective <i>All patients receive co-ordinated care.</i>		
13-2N-110	Patient Pathways	
The MDT should agree the network-wide patient pathways specified in measure 13-1C-107n, adding relevant local contact points.	<i>This should include follow up and referral pathways.</i>	Operational policy.
13-2N-111	Treatment Planning	
The MDT should agree and record individual patient's treatment plans. The record should include: <ul style="list-style-type: none"> the identity of patients discussed; the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that the patient is to be referred for consideration); confirmation that the holistic needs have been taken into account. 	Operational policy. Example of treatment plan to be available for IV and PR visit.	
13-2N-112	Attendance at the Network Site Specific Group	
The lead clinician of the MDT or representative should attend at least two thirds of the NSSG meetings.		Annual Report including meeting attendance spread sheet.
Key Theme		
Patient Experience		
Objective <i>All patients receive patient centred care with respect and dignity which takes account of their holistic needs.</i>		
13-2N-113	Key Worker	
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		Operational Policy. Examples of patient notes should be available for IV and PR Visit.

member(s). The policy should have been implemented.			
13-2N-114	Patient Information		
<p>The MDT should provide written material for patients and carers which includes:</p> <ul style="list-style-type: none"> information specific to that MDT about local provision of the services offering the treatment for that cancer site; information about patient involvement groups and patient self-help groups; information about the services offering psychological, social and spiritual/cultural support, if available; information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them); information about services available to support the effects of living with cancer and dealing with its emotional effects. 	<p><i>Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.</i></p> <p><i>It is recommended that the information 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.</i></p> <p><i>For the purpose of self-assessment the team should confirm the written information which is routinely offered to patients.</i></p>	<p>Operational policy.</p> <p>Examples should be available for IV and PR Visit.</p>	
13-2N-115	Permanent Record of Consultation		
<p>The MDT should be offering 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:</p> <ul style="list-style-type: none"> diagnosis; treatment options and plan; relevant follow up (discharge) arrangements. 		<p>Operational Policy.</p>	
13-2N-116	Patient Feedback		
<p>The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered.</p> <p>The exercise should at least ascertain whether patients were offered:</p> <ul style="list-style-type: none"> a key worker; assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment); the MDTs information for patients and carers (written or otherwise); the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed. <p>The exercise should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.</p>	<p><i>The exercise may consist of a survey, questionnaire, focus group or other method.</i></p> <p><i>There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.</i></p> <p><i>As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.</i></p>	<p>Annual Report.</p>	

Key Theme**Clinical Outcomes / Indicators****Objective**

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

13-2N-117**Clinical Indicators Review / Audit**

The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the NSSG, at one of the regular NSSG meetings:

- any HPB cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);
- clinical indicators identified in section 2 of the measures.

Information from the cancer outcomes and service dataset (COSD) should be used where relevant.

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Work programme.

Objective

All patients have equitable access to treatments that could potentially improve outcomes.

13-2N-118**Discussion of Clinical Trials**

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

- details of the MDT's trials portfolio including the extent of local provision of the national portfolio;
- the MDT's recruitment to the portfolio, including the extent of delivery against the locally agreed timescales and targets;
- the MDT's programme for improvement for the above, as proposed to the NSSG.

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

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

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Section 2 Clinical Indicators/Lines of Enquiry

Introduction

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. The selected metrics use data which is currently recorded nationally. These sources include Cancer Registry databases, Hospital Episode Statistics (HES) and the AUGIS HPB cancer surgery audit.

These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self-assessment report and any plans for improvement should be included in their work programme.

Clinical Indicators

- ***Number of cases with confirmed histology:***
- ***Number patients having surgical resection:***
- ***One, two and five year survival (rate):***

Appendix 1 Ground Rules for Networking

Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarised as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between NSSGs for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Before a first peer review assessment of any services which, from the networking point of view, come under the governance of a strategic clinical network (SCN), there should be an agreement between the relevant SCNs which describes which provider and commissioner networks come under the governance of each particular SCN. The agreement should delineate the boundaries and list the constituent services and commissioners of those networks. On principle, a single SCN should be agreed as being responsible for the network. This specifies the governance framework within which the networks are placed. Ideally this would apply to all services in a geographical area. However, the arrangements in terms of the governance and ownership of staff and facilities may not be coterminous across different disease sites spread over a similar geographical area. The network function will therefore be reviewed at a disease site specific level. The term 'network' in these measures refers to the disease site clinical network unless otherwise specified. The geographical extent of this and the physical facilities and hospital sites involved should be agreed between the relevant SCNs prior to review, and a named SCN should be considered having ownership and requiring/commissioning the review. This principle becomes especially important for cases of clinical networks for the rarer cancers where catchment areas may overlap those of more than one SCN.

NSSGs

- The NSSG should be the only such NSSG for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the NSSG should be associated with more than one MDT.
- The NSSG should be associated with more than one MDT. For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the NSSG need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.

*Notes: The NSSG **need** only be associated with one specialist/supranetwork type MDT but **may** be associated with more than one.*

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These groups need to have working relationships with the hospitals/services system and also the NSSGs / MDTs system, if they are to fulfil their role of acting as leaders of the networking process. Because these groups are service specific, not cancer site specific, it seems most important to lay down ground rules to ensure clarity and co-ordination across a given cross cutting service within a network, and leave ground rules regarding the relationship with NSSGs/MDTs, at a more informal and flexible level. The term 'network' here refers to the networking arrangements and coverage of the service in question.

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

- The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with.
- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.

Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances.
- This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.
- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.
Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.
- The MDT should be associated with a single named network site specific group (NSSG) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one NSSG, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate NSSG for each of its specialty sites.

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the 'local' type MDTs.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.
- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.
- The specialist MDT should act as the 'local' type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.

Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site. The specialist MDT should be associated with a single named network site specific group (NSSG), (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

Appendix 2 Roles and Responsibilities

Roles and Responsibilities

Introduction

Role of the NSSG

The NSSG 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 associated organisations.

The NSSG should:

- agree a set of clinical guidelines and patient pathways to support the delivery of high quality equitable services across the network;
- 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;
- review and discuss identified risks/untoward incidents to ensure learning is spread;
- agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Responsibilities of the MDT lead clinician

The MDT lead clinician should:

- 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;
- 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;
- 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 the MDT meetings and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- provide the link to the NSSG either by attendance at meetings or by nominating another MDT member to attend;
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported.

Appendix 3 Chemotherapy Treatment Algorithms

Introduction

Introduction; (Definitions). Regimens, Protocols and Algorithms

For the purposes of peer review, a chemotherapy **regimen** is defined by the therapeutic chemotherapy drugs used, often expressed as an acronym e.g. 'FEC'. A change of one or more of these drugs themselves would normally be necessary for it to be classed as a change of regimen. In some cases major changes in the dose or route of administration of one or more of the drugs effectively changes the regimen but these cases are generally known and recognised nationally. A given network is free to choose any further changes which they classify as changing the regimen, as long as it is in accord with the above definition and national exceptions; i.e. they are free to make their definition of a regimen narrower, but not wider. This is relevant to measures in the chemotherapy section (Topic 3S).

For the purposes of peer review, a chemotherapy **treatment protocol** is defined as constituting all the parameters specified in the bullet points in chemotherapy measure 11-3S-122. A change in any of these parameters would change the treatment protocol but any change other than the therapeutic drugs themselves (apart from the national and local exceptions specified above) would change only the protocol, not the regimen as well.

For the purposes of peer review a chemotherapy **treatment algorithm** may be described as a guideline which specifies the acceptable range of regimens for each relevant step on the patient pathway. Treatment algorithms are cancer site-specific. They are not specific to individual patients, i.e. they are not individual treatment plans. Thus, a treatment algorithm for breast cancer would include a statement of the range of regimens agreed as acceptable for adjuvant chemotherapy and for first, second and third line palliative chemotherapy etc. Illustrative examples of treatment algorithms in different formats may be found in appendix 1 of the chemotherapy measures. There may be other formats which would be acceptable to the reviewers.

In practice, a change of regimen or order of regimens may no longer comply with a previously agreed treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply. The measure for NSSGs is concerned only with chemotherapy **algorithms**.

Notes:

The intention is not to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.

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

The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the NSSG agreed list.

This exercise should include oral chemotherapy.

This measure is assessed as part of the responsibility of each NSSG, but from the chemotherapy cross cutting group's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time. Updates require changes only when judged clinically necessary by the NSSG.

Appendix 4 Psychological Support Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels. The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note: Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.

The additional training is as follows:

I. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

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II. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the one of the national voluntary regulatory bodies for counselling;
- an NHS psychotherapist accredited by one of the national voluntary regulatory bodies for psychotherapy.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note:

All of the above should have completed an induction at level 3. that meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.

