Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Colorectal Measures
Version 4.0

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	13695
Title	Colorectal Measures
Author	National Cancer Peer Review -National Cancer Action Team
Publication Date	April 2013
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Foundation Trust CEs , SHA Cancer Leads
Circulation List	Cancer Network Medical Directors, Cancer Network Directors, Cancer Network Lead Nurses, Cancer Action Team, DH Policy Officials, NHS Improvement managers, Royal Colleges, Members of the National Cancer Peer Review Steering Group, National Cancer Peer Review User Group, Voluntary Sector
Description	Following a three month consultation period, this is the final version of the Colorectal measures for inclusion within the Manual for Cancer Services. The measures can also be found on the CQUINS website at www.cquins.nhs.uk
Cross Ref	Manual for Cancer Services
Superseded Docs	
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

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National Cancer Peer Review and The Manual for Cancer Services

1 Introduction

The National Cancer 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 Commissioning Board 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

COLORECTAL MEASURES

Introduction

The revised Improving Outcomes Guidance (IOG) on colorectal cancer has made some key recommendations which are intended to improve the service over and above that described in the original colorectal IOG and peer reviewed in the first round against the quality measures in the Manual for Cancer Services Standards (2000).

These recommendations are as follows: there is a requirement for systematic arrangements to increase the speed and efficiency of initial referral and diagnosis of patients and to make endoscopy the primary diagnostic investigation.There are changes to the minimum required core membership of colorectal MDTs and a requirement for such teams to deal with a minimum of 60 new cases of colorectal cancer per year and for individual core surgical team members to undertake a minimum per year of 20 resections of colorectal cancer performed. Detailed arrangements have been stipulated to ensure that patients with surgical emergencies due to colorectal cancer are dealt with by MDT members.

A degree of consolidation of specialist expertise is required, resulting in the treatment of anal cancer and the local resection of early rectal cancer being performed by a limited number of colorectal MDTs. Specialised MDTs are defined for the surgical resection of liver metastases in selected patients. These 'liver resection MDTs' may be the same MDTs that currently manage pancreatic cancer, or new liver resection MDTs may be established specifically for this task. For either of these two models the resulting MDT should have a minimum of 2 million for referral for resection of liver metastases. Because of this, no cancer network in England should be able to support more than one liver resection MDT on the basis of its own population, and some will have to refer to a team in a neighbouring network.

These recommendations have determined the revisions to the quality measures for colorectal cancer. Because of the likelihood of some degree of service reconfiguration, the NSSG in consultation with the CCGs is given the responsibility for review purposes of deciding the network configuration of the teams for anal cancer, local resection of early rectal cancer and resection of liver metastases.

As far as measures for diagnosis and assessment are concerned, because no major reconfigurations necessarily follow from the revised IOG, the responsibility lies with the NSSG and the locality groups for those localities which host a trust which deals with colorectal cancer.

The different types of MDT outlined above should fulfil certain specific 'Team Criteria'.

The measures also now incorporate sections for both NSSGs and colorectal MDTs on laparoscopic colorectal cancer surgery, taking into account the recommendations of the Review of NICE technology appraisal guidance 105. (Review of NICE technology appraisal 17): NICE, September 2006.

Team Criteria

(i) MDT for colorectal cancer (not treating anal cancer or offering local resection of early rectal cancer)

- It should be declared as part of the services of a named locality in the network.
- Its core surgical MDT members should, as a group, perform a total of 60 colorectal cancer resections with curative intent, per year. (This has a separate measure in the MDT section).

(ii) Colorectal MDT treating anal cancer

In addition to the criteria in (i) above:

- It should be the only MDT in the network treating anal cancer.

(iii) Colorectal MDT offering local resection for early rectal cancer.

(iv) MDT for resection of liver metastases.

- Either:

a) It may be made up of the same personnel who also serve as and are put forward for review as a pancreatic cancer MDT and who discuss the business of liver resection as part of the same MDT meetings,

and

b) it should be the only MDT in the network for resection of liver metastases.

- Or

a) It may be a separate MDT, put forward for review independently as a liver resection MDT.

and

b) It should be declared as part of the services of a named locality in the network.

and

c) It should be the only such MDT in the network.

Whichever of the above two options apply, it should have a minimum catchment population of 2 million for referral for resection of liver metastases.

Building the Colorectal Cancer Network to Comply with the Revised IOG

The measures assign the responsibility for the following steps to the NSSG acting in consultation with the CCGs.

1) Agree the identity and location of all colorectal MDTs in the network.

2) Agree the identity and location of the colorectal MDT which will deal with anal cancer for the network.

3) Agree the referral guidelines between the colorectal MDTs and the selected MDTs for anal cancer

4) Agree the identity and location of the MDT for resection of liver metastases for the network.

5) Agree the referral guidelines between the colorectal MDTs and the liver resection MDT.

6) From the population of the CCGs which are served by the colorectal MDTs and the referral guidelines between the colorectal MDTs and the liver resection MDT, confirm that the referring catchment population of the liver resection MDT is 2 million or more.

Notes:

The identity and location of all the above types of MDT make up the network configuration for colorectal cancer. The network may choose a configuration such that some or all of the specialised MDTs which it makes use of (anal cancer, and liver resection) are in a neighbouring network.

Reviewing Colorectal Cancer Against the Revised Measures

1) The network configuration of colorectal MDTs and functions of the colorectal NSSG is the responsibility for review purposes of the Chair of the NSSG and is reviewed under topic 1C, compliance counting towards the review of the colorectal NSSG.

2) The locality groups providing named personnel with specified time, to run the diagnostic service. This is the responsibility for review purposes of the chairs of the relevant locality groups and is reviewed under topic 1D compliance counting towards the review of the locality group.

3) The colorectal MDTs - applying the relevant sets of the following measures to each MDT in the colorectal cancer network: (Sections 2D-1 and 2D-2)

The MDT measures are the responsibility for review purposes of the Lead Clinician of the MDT in question and compliance counts towards the review of that MDT.

Note on applicability of measures for liver resection teams

Where there is a stand-alone liver resection MDT all the measures of conventional MDTs are not completely duplicated, since the liver resection MDT, unlike for example the colorectal MDT, does not deal with a patient straight from diagnosis of a primary cancer site. The team is, in effect, called in to consult on, and possibly manage one part of the patient's journey. The rest of the journey is managed by the original colorectal MDT. Thus, for example, issues around informing the GP of the diagnosis of malignancy and the provision of a key worker are not covered again.

Where the work of resection of liver metastases is done by the personnel of a pancreatic MDT the liver resection measures for the pancreatic team (2F-4) should, for convenience, be considered part of the review of upper GI, and compliance should count towards the overall review of the pancreatic MDT.

For some aspects of MDT function there are measures which cover the role which the liver resection team should fulfil, as it is dovetailed into the overall management of colorectal cancer. Examples of this are the agreement to collect the relevant part of the overall minimum dataset, and to take part in any relevant parts of the network's list of approved trials for colorectal cancer.

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

Introduction

The measures in this section should be applied separately to each Network Site Specific Group (NSSG). Thus there will be as many sets of compliance results as there are Colorectal NSSGs.

Prior to review, the boundaries of the 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.

NB: For this transition year the measures for NSSGs that were previously applied to the network board (1A) have been incorporated into these measures (1C). These have all been added to the end, so as not to disrupt the established measure numbers.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
GENERAL ACTIVITIES	
NSSG Meeting	
11-1C-101d	The NSSG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed as part of each MDTs' measures.*
Compliance:	A list of meeting dates and attendance records in the last 12 months.
Annual Work Programme and Annual Report	
11-1C-102d	The NSSG should have agreed an annual work programme. The NSSG should have produced an annual report.
Compliance:	The annual work programme agreed by the Chair of the NSSG. The annual report agreed by the Chair of the NSSG.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

CLINICAL GUIDELINES

Introduction

The responsibility for review purposes for the network guidelines measures lies with the team lead clinicians, the colorectal NSSG and the Chair of the Network Board.

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 guidance is available. The measures count towards the review of the NSSG and the individual team.

Network Agreed Clinical Guidelines

11-1C-103d The NSSG should agree network-wide clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques).

Note:

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

Compliance: The clinical guidelines agreed by the Chair of the NSSG.

Agreed NSSG Referral Guidelines for Patient, Within or Outside the Network

11-1C-104d 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.

OPERATIONAL POLICIES OF THE COLORECTAL DIAGNOSTIC SERVICE

Trust Agreed Single Initial Decision Point for Referral

11-1C-105d The NSSG should agree with the trust lead cancer clinician for each trust hosting a diagnostic service, a policy to the effect that for each trust there should be a single initial decision point (final common path) for prioritising appointments for patients referred for investigation of large bowel symptoms, rather than initial referral direct to individual, named consultant surgeons or gastroenterologists.

Note:

This relates to the single referral contact point in the primary care referral guidelines (measure 11-1C-116d) and the clinical lead and administrative personnel (measure 11-1D-102d).

Compliance: The policy agreed by the Chair of the NSSG and the relevant trust lead clinicians.

Network Agreed Protocol for Prioritising Appointments and Referral Proforma

11-1C-106d The NSSG should agree a network-wide protocol for placing which types of clinical presentation into which level of priority for booking appointments for investigation of large bowel problems.

The protocol should then form the structure of the network-wide primary care referral proforma (measure 11-1C-116d).

Notes:

- *The clinical presentations should be in accord with the National Referral Guidelines for Suspected Cancer http://www.nice.org.uk/page.aspx?o=261649.*
- *The reviewers need not check this point systematically for compliance.*

Compliance: The protocol agreed by the Chair of the NSSG.
The primary care referral proforma.

INVESTIGATION PROTOCOL

Introduction

The NSSG for its compliance with this measure should produce the investigation protocol and the individual MDTs for compliance with the relevant team measure should agree to it.

Network Agreed Investigation Protocol

11-1C-107d The NSSG should agree in consultation with the MDTs, the Network Cancer Imaging Group and the Network Cancer Pathology Group, a network-wide investigation protocol which specifies, for the different clinical presentations caused directly by a large bowel, primary cancer:

i) the investigations (including imaging, histopathology and laboratory tests) which should be performed and, if applicable, in which sequence, for the diagnosis and, if positive, the subsequent assessment of the case;
ii) which parts of the protocol are the responsibility of the diagnostic service;
iii) which parts of the protocol are the responsibility of the MDT;
iv) that endoscopy is the preferred method for making the initial diagnosis of a large bowel primary cancer.

Note:

The NSSG may agree more wide-ranging investigation protocols - e.g. for patients representing with symptoms due to metastatic disease. This is not subject to review.

Compliance: The protocol agreed by the Chair of the NSSG, the Chair of the Network Cancer Imaging Group and the Chair of the Network Cancer Pathology Group.

CLINICAL RESPONSIBILITY

Introduction

The classical system of referring a patient from primary care directly to an individual hospital practitioner such as a colorectal surgeon or gastroenterologist guaranteed that the patient was understood to be the responsibility of that practitioner from the point of receipt of the initial referral. In order to streamline the process, this system is being replaced by referral to the diagnostic service. One consequence of this change is that a clear agreement is now needed regarding who is clinically responsible for the patient through the diagnostic process.

From a clinical governance point of view, the ultimate clinical responsibility for a patient at a given point should not rest with a department or an MDT but with an identifiable practitioner.

Network Policy on Named Medical Practitioner with Clinical Responsibility

11-1C-108d The NSSG should agree in consultation with the MDTs and the Network Cancer Imaging Group a policy specifying the medical practitioner (whether primary care practitioner, consultant surgeon, gastroenterologist or investigational consultant) who is considered to be responsible for the patient at each stage from referral from primary care to the treatment planning decision of the colorectal MDT.

Compliance: The policy agreed by the Chair of the NSSG and the Chair of the Network Cancer Imaging Group.

Network Agreed Onward Referral Policy

11-1C-109d The NSSG should agree, in consultation with the MDTs and the Network Cancer Imaging Group, a policy governing onward referral from the colorectal diagnostic service when a diagnosis is made of either malignant disease or non-malignant disease. The policy should specify:

- the procedure to be followed;
- the personnel responsible for making the onward referral;
- the contact points for the MDTs;
- the points in the process and personnel responsible for informing the patient and the GP of the diagnosis;

- an intention to inform the GP of a diagnosis of malignancy by the following working day after the patient has been informed.

Compliance: The policy, specifying the above points, agreed by the Chair of the NSSG and the Chair of the Network Cancer Imaging Group.

NETWORK GUIDELINES FOR THE MANAGEMENT OF ANAL CANCER, EARLY RECTAL CANCER AND RESECTION OF LIVER METASTASES

Introduction

These are specific guidelines for anal cancer, early rectal cancer and the resection of liver metastases. The clinical guidelines for the general management of colorectal cancer are covered by measure 11-1C-103d.

The NSSG, for compliance, should produce the guidelines and the individual MDTs, for their compliance with the relevant team measure, should agree with them.

Network Agreed Guidelines for Management of Anal Cancer

11-1C-110d The NSSG should agree, in consultation with the MDTs, network-wide guidelines for the management of anal cancer, including:

- pre-treatment assessment methods;
- indications of radiotherapy, chemo-radiotherapy and surgery;
- the stages in the assessment process where the patient is the responsibility of the colorectal MDT and those where they are the responsibility of the anal cancer MDT.

Compliance: The guidelines agreed by the Chair of the NSSG.

Network Agreed Guidelines for Management of Rectal Cancer

11-1C-111d The NSSG should agree in consultation with the MDTs network-wide guidelines for the management of early rectal cancer, including:

- criteria based on clinical, MRI and endosonography parameters, for selecting patients for consideration of curative treatment of early rectal cancer by local resection;
- that all patients with possible T_1 lesions (on the basis of clinical and MRI parameters) should be referred for endosonography;
- that, following endosonography, all patients then suitable should be referred to one of the MDTs agreed as specialising in local resection.

Compliance: The guidelines agreed by the Chair of the NSSG.

Network Agreed Guidelines for the Resection of Liver Metastases

11-1C-112d The NSSG should agree, in consultation with the MDTs (including a representative of the liver resection MDT), network-wide guidelines for the resection of liver metastases from colorectal cancer, including:

- the indications (in terms of specific clinical and investigational parameters) for metastatectomy and for its use in combination with chemotherapy;
- the stages in the assessment process where the patient is the responsibility of the colorectal MDT and those where they are the responsibility of the liver resection MDT.

Compliance: The guidelines agreed by the Chair of the NSSG.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

NETWORK AGREED COLORECTAL STENTING POLICY

Introduction

This measure is intended to make sure that those practising colorectal stenting (if any) for the network are judged as being competent. It is **not** intended that the agreed levels of competency are so low as to ensure that at least one person is practising stenting in the network at the time of the peer review. For compliance the NSSG should produce the policy and the list of the named competent personnel. The individual MDTs for their compliance with the relevant team measure should agree to the list of competent personnel.

Network Agreed Colorectal Stenting Policy

11-1C-113d

The NSSG should agree in consultation with the MDTs a policy that the practice of colorectal stenting should be limited to named personnel agreed as being competent in this practice by the NSSG.

The NSSG should name the current personnel who have been agreed as competent for colorectal stenting.

Compliance: The policy and list of named personnel agreed by the Chair of the NSSG.

The reviewers should enquire as to the personnel practising colorectal stenting in the network.

NETWORK AGREED POLICY ON REFERRAL FOR PATIENTS OUTSIDE THE AGREED PRIMARY CARE REFERRAL PROCESS

Introduction

The next measure is designed to cover patients diagnosed outside the agreed primary care referral process to the colorectal diagnostic service, whose process is dealt with by other relevant measures. The NSSG for compliance should produce the policy and the individual MDT, for its compliance with the relevant team measure, should agree to it.

Network Agreed Policy on Referrals for Patients Outside the Agreed Primary Care Referral Process

11-1C-114d

The NSSG should, in consultation with the MDTs, agree a policy to ensure that when patients are diagnosed unexpectedly or incidentally with colorectal cancer, or known patients are diagnosed with recurrent or metastatic disease - in any of these cases by clinicians who are not members of a colorectal MDT - then they are referred to a named core member of a relevant colorectal MDT.
The referral should be made by the end of the first complete working day following the discovery of the diagnosis.
The policy should include:

- the methods of communication;
- the contact points for relevant core members of colorectal MDTs in the network;
- whose responsibility it is to contact the MDT member;
- whose responsibility it is and what the method is by which the patient is informed of the diagnosis and the referral.

The policy should be distributed to at least all consultant upper and lower GI surgeons, gynaecologists, gastroenterologists, consultant physicians with an interest in medicine for the elderly and lead clinicians of cancer imaging services in the network.

Compliance: The policy, covering the above points, agreed by the Chair of the NSSG.

The reviewers should enquire as to the distribution process. They should not make exhaustive checks on this. Minor shortcomings in the completeness of distribution should not preclude compliance.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

NETWORK AGREED GUIDELINES FOR THE MANAGEMENT OF SURGICAL EMERGENCIES

Introduction

The NSSG, for compliance, should produce the guidelines and the individual MDT, for their compliance with the relevant team measure, should agree to them.

Network Agreed Guidelines for the Management of Surgical Emergencies

11-1C-115d

The NSSG, in consultation with the MDTs and the trust cancer lead clinicians in the network, should agree for each hospital which admits surgical emergencies, network-wide guidelines for the management of surgical emergencies related to colorectal cancer. They should specify at least the following:

- that patients presenting as emergencies with intraluminal large bowel obstruction should be stabilised pre-operatively if necessary so that surgery can wait until it can be performed under the care of the core surgical colorectal MDT member, unless delay would be life-threatening;
- that if the hospital does not host the practice of a core surgical colorectal MDT member, there should be an agreement between the relevant trust cancer lead clinicians to transfer such patients pre-operatively to a named hospital, which hosts the surgical practice of a core surgical colorectal MDT member, for management under the care of that surgeon;
- that the guidelines apply within and outside normal working hours.

Note:

The NSSG may agree additional guidelines for colorectal cancer emergencies (e.g. for non-surgical emergencies). These are not subject to review.

The guidelines should be distributed to consultant upper and lower GI surgeons, all surgeons on the surgical emergency take rota of their hospitals, gynaecologists and all physicians on the medical emergency take rota of their hospitals.

Compliance: The guidelines, covering the above points, agreed by the Chair of the NSSG and the trust lead cancer clinicians.

The relevant named hospitals without an in-house practising core surgical MDT member, with the named hospital to which each one will refer emergency patients, agreed by the relevant trust lead clinicians.

The reviewers should enquire as to the distribution process. They should not make exhaustive checks on this. Minor shortcomings in the completeness of distribution should not preclude compliance.

Primary Care Referral Guidelines

11-1C-116d The NSSG should produce network-wide guidelines for primary care practitioners on the referral for diagnosis of patients with potential colorectal cancer.

The guidelines should include:

(i) a requirement to refer to a network agreed colorectal diagnostic service, not a named individual consultant, and to use a network-agreed referral proforma;

(ii) the proforma, which should specify:

- which type of presentation (in terms of specific symptoms and patient characteristics) should be referred with which level of priority (with regard to how quickly they should be dealt with);
- the single referral contact point for each trust hosting a colorectal diagnostic service in the network.

The primary care guidelines should be distributed to all primary care practices in the network.

Note:

Limited versions of the proforma may be used in local areas of the network provided the information in (i) above is agreed network-wide. The contact points in (ii) may be limited to those relevant to the local area in question.

Compliance: The primary care guidelines, including the proforma, agreed by the Chair of the NSSG.

The reviewers should enquire as to the distribution process. They should not make exhaustive enquires on this. Minor short comings in the completeness of distribution should not preclude compliance.

Assessment Protocol for Early Rectal Cancer

11-1C-117d The NSSG, in consultation with the MDTs, should agree network-wide guidelines for the assessment of patients with early rectal cancer. It should specify at least the following:

- an investigation protocol specifying the imaging techniques and selection criteria for identifying patients with T_1 rectal cancer which are suitable for local resection. The protocol should specify the role of MRI scanning;
- that rectal endosonography should be used in that part of the protocol which deals with selection for suitability for trans-anal endoscopic microsurgery (TEMS), if patients are referred for this procedure.

Notes:

- *The term 'local resection' is defined here, for the purposes of peer review, as a resection procedure intended to achieve complete local removal of malignant disease from the primary site, but which does not involve the resection of the full circumference of the bowel and removal of a complete segment.*
- *Specific surgical techniques as agreed in the network, may be named in the protocol such as 'endo anal resection', 'endoscopic mucosal resection' etc. The details of procedures are not subject to review except for the requirement for rectal endosonography prior to the procedure referred to as TEMS.*

Compliance: The protocol agreed by the Chair of the NSSG.

Agreed Collection of Minimum Dataset

11-1C-118d The NSSG should agree an area-wide minimum dataset (MDS) which covers at least the latest approved cancer dataset at www.isb.nhs.uk.
The NSSG may wish to agree additional data items such as:

- 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 Service;

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	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. The NSSG should agree a network-wide policy specifying: • which team should collect which portion of the MDS; • when each data items should be captured on the patient pathway; • how the data will be stored and managed within local data systems.
Compliance:	The MDS agreed by the Chair of the NSSG. The policy agreed by the Chair of the NSSG. *Note:* *The NSSG for their compliance with this measure should, in consultation with the MDTs, agree the MDS and the individual MDTs, for compliance with their relevant measure, should agree to collect it.*
NETWORK AUDIT	
Introductory Notes For review purposes an area audit project is an audit project related to the cancer site or sites of the NSSGG and the activities of its MDTs. The same project should be carried out by all MDTs for that cancer site in the area, each team's results being separately identified. The individual MDTs, for compliance with their relevant MDT measure, should agree to participate in the audit.	
Network Audit	
11-1C-119d	The NSSG should agree a network audit project. The NSSG should annually review the progress of the audit project or discuss the results of the completed area audit project. *Note:* *Where national audits have been developed these should be part of the area audit programme.* *Additional projects may be agreed.*
Compliance:	The project agreed by the Chair of the NSSG. Written confirmation of an annual review sufficient to how compliance with the measures. *Note:* *An agreed summary is sufficient provided it shows compliance with the measure.*
Discussion of Clinical Trials	
11-1C-120d	The NSSG should discuss at least annually, the report on clinical trials from each of its MDTs (see relevant MDT measures). The following should be present at the discussion: • the Chair of the NSSG or a nominated representative; • the NSSG research lead • the lead clinician of the MDT or nominated representative from that MDT; • the clinical lead of the research network or a nominated representative from the research network. A programme for improvement for clinical trial entry for the MDT should be agreed at the discussion.

Compliance: Confirmation of discussions, sufficient to show compliance with the measure, including those present.

The programmes for improvement, agreed by the lead clinicians of the MDTs and the clinical lead of the cancer research network.

Notes:

The discussion with various individual MDTs may take place at different meetings of the NSSG. All of the MDTs of the NSSG need to have attended such a meeting for the measure to be compliant .

Network Agreed Three Year Service Delivery Plan

11-1C-121d The NSSG should agree proposed service developments for its cancer site for three contracting years, as advice to the board for the network proposed service delivery plan.

Compliance: The plan agreed by the Chair of the NSSG.

LAPAROSCOPIC COLORECTAL CANCER SURGERY MEASURES

Network Policy and List of Laparoscopic Colorectal Cancer Surgical Practitioners

11-1C-122d There should be a policy for the network, whereby laparoscopic colorectal cancer surgery should only be performed by surgeons in the network who are on the network list as specified below.

There should be a list of surgeons authorised to perform laparoscopic colorectal cancer surgery. Entry on the list should require that the surgeon has been trained on the national laparoscopic colorectal surgery programme or is exempt (see below).

Note: The exemption criteria are as follows:

Either

There is an appointment letter for the consultant authorised by the CE of the trust confirming they have recognised laparoscopic colorectal cancer surgery skills. This confirmation of possession of the necessary skills, on appointment, if it was not included in the appointment letter, in letters issued prior to the publication of this measure, may be obtained retrospectively with the authorisation of the CE of the trust.

Or

The consultant has performed 20 or more laparoscopic colorectal surgical resections, prior to 31st December 2009, the number agreed by the lead clinician of the MDT.

The network list should have been seen and discussed by the NSSG.

Compliance:

- The policy, agreed by the Chair of the NSSG.
- The list of named surgeons.
- A relevant extract of the minutes of a meeting of the NSSG showing that the network list has been seen and discussed.
- For each surgeon on the list, **either** the letter signing off the surgeon from the national laparoscopic colorectal surgery programme, **or** the skill confirmation letter authorised by the CE of the trust or the number of laparoscopic resections agreed by the lead clinician of the MDT.
- The reviewers should enquire as to the working practice of the network with regards to the restriction of the procedure to listed practitioners.

Network Criteria and Referral Guidelines on Laparoscopic Colorectal Cancer Surgery

11-1C-123d The NSSG should, in consultation with the MDTs, agree and produce the minimum network criteria for a patient to be offered laparoscopic colorectal cancer surgery. The criteria should include the following:

- BMI less than 30.
- No previous major abdominal surgery.
- Avoiding obvious T4 cancers on pre-op staging.
- Those tumours not requiring TME (Total Mesorectal Excision).
- No clinical or radiological signs of obstruction.

Notes:

The network may wish to include other criteria besides those specified above. This is not subject to review provided they do not exclude patients fulfilling the minimum criteria above.

The criteria apply whether the patient is going to be treated by a laparoscopic surgeon within the MDT or is going to be referred to one in another MDT.

The NSSG, in consultation with the lead clinicians of the colorectal MDTs should agree and produce a guideline to the effect that MDTs without core surgical members trained on the national laparoscopic colorectal cancer surgery programme or exempt, should refer patients, in line with the network criteria to a named surgeon in a named MDT who is on the network list of surgeons for this procedure.

Compliance: The criteria, agreed by the Chair of the NSSG.

The referral guideline agreed by the Chair of the NSSG.

Note:

The NSSG, for compliance with this measure should in consultation with the MDTs, produce the criteria and referral guideline and the MDT, for compliance with their relevant measure should agree to abide by them.

CHEMOTHERAPY TREATMENT ALGORITHMS

Introduction

- For the purposes of peer review, a chemotherapy regimen is defined by the therapeutic chemotherapy drugs used, often expressed as an acronym e.g. 'FEC'. A change of one or more of these drugs themselves would normally be necessary for it to be classed as a change of regimen. In some cases major changes in the dose or route of administration of one or more of the drugs effectively changes the regimen but these cases are generally known and recognised nationally. A given network is free to choose any further changes which they classify as changing the regimen, as long as it is in accord with the above definition and national exceptions; i.e. they are free to make the definition of a regimen narrower, but not wider.
- For the purposes of peer review, a chemotherapy treatment protocol is defined as constituting all the parameters specified in the bullet points in chemotherapy measure 11-3S-122. A change in any of these parameters would change the treatment protocol but any change other than the therapeutic drugs themselves (apart from the national and local exceptions specified above) would change only the protocol, not the regimen as well.
- For the purposes of peer review a chemotherapy treatment algorithm may be described as a guideline which specifies the acceptable ranges of regimen options for named steps on the patient pathway. Treatment algorithms are cancer site-specific. They are not specific to individual patients, i.e. they are not individual treatment plans. Thus, a treatment algorithm for breast cancer would include a statement of the range of regimens agreed as acceptable for adjuvant chemotherapy and for first, second and third line palliative chemotherapy etc. Illustrative examples of treatment algorithms in different formats may be found in appendix 1 in the chemotherapy measures. There may be other formats which would be acceptable to the reviewers. Thus, a change of regimen or order of regimens may no longer comply with a previous treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply.

Chemotherapy Treatment Algorithms

11-1C-124d The NSSG, in consultation with the Network Chemotherapy Group (NCG) should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.

Notes:

- *The intention is **not** to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.*
- *The NSSG should produce the algorithms for its compliance with this measure and the chemotherapy multi-professional team should produce a compatible list of algorithms for the NSSG's cancer site for their own service (measure 11-3S-122).*
- *The chemotherapy multi-professional team should agree lists with all the NSSGs relevant to their practice, for compliance with their measure.*

- *The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the NSSG agreed list.*
- *This exercise should include oral chemotherapy.*
- *This measure is assessed as part of the responsibility of each NSSG, but from the NCG's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time.*

Compliance: The algorithms in place prior to the self assessment/peer review visit agreed by the Chair of the NSSG, and the Chair of the NCG.

For NSSGs meeting for three or more years since the publication of the measures, the algorithms are needed from the first year, then the agreed updates every two years up to the self assessment/peer review visit.

The TYACN Pathway for Initial Management

11-1C-125d The NSSG should agree, with the chair of the relevant TYACNCG, the TYACN patient pathway for initial management, including any features specific to the NSSG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

The NSSG should distribute the pathway to the lead clinicians of the MDTs of their cancer site in their host cancer network.

Compliance: The pathway, agreed by the Chair of the NSSG and the chair of the relevant TYACNCG.

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

The TYACNCG should, for compliance with their relevant measure, produce the pathway and the NSSG, for compliance with this measure, should agree to abide by it, add local contact points and distribute it.

The TYA Pathway for Follow Up on Completion of First Line Treatment

11-1C-126d The NSSG should agree, with the chair of the relevant TYACNCG the TYACN patient pathway for follow up on completion of first line treatment including any features specific to the NSSG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

The NSSG should distribute the pathway to the lead clinicians of the MDTs of their cancer site in their host cancer network.

Compliance: The pathway, agreed by the Chair of the NSSG and the chair of the relevant TYACNCG.

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

The TYACNCG should, for compliance with their relevant measure, produce the pathway and the NSSG, for compliance with this measure, should agree to abide by it, add local contact points and distribute it.

Network Agreed List of Named Hospitals

11-1C-127d The Colorectal MDTs should be named, with their host hospitals and trusts.

The hospitals and trusts that host a colorectal diagnostic service should be named.

Note:

Not every hospital in the network need host a diagnostic service.

The colorectal MDTs dealing with rectal cancer should be specified.

The colorectal MDTs dealing with anal cancer should be specified.

Notes:

- *An MDT to which patients with anal cancer are referred may be in a neighbouring network*;
- *It is expected and intended that the measures relating to colorectal MDTs which specialise in the treatment of anal cancer will normally result in a network either having only one such MDT or even referring all its patients to a specialised MDT for anal cancer in a neighbouring network. In a very few of the largest networks, more than one such MDT might be feasible although even in this case, they should seriously consider having only one MDT for anal cancer;*
- *The reviewers should comment specifically in their report, where there are multiple MDT's for anal cancer in a network of around average or less than average size.*

The HPB MDT and host hospital /trust to which patients are referred for resection of liver metasteses should be named .

The relationship of the MDTs to their catchments and their hospitals should comply with the peer review ground rules for networking.

- The MDT should be the only such MDT for its cancer site, for its referral catchment area;
- The MDT should be the only such MDT for its cancer site, functioning on or covering a given hospital site.

A single Colorectal NSSG should be named for the Colorectal network under review, with its associated Colorectal MDTs

The relationship between the NSSG with its associated Colorectal MDTs should comply with the peer review ground rules for networking.

- 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.

All the above arrangements, which constitute the configuration of the colorectal cancer clinical network, should be agreed by the medical director of the relevant area teams.

Compliance: The names, locations and types of team agreed by the Chair of the NSSG.

Agreed Named Members and Terms of Reference of NSSG

11-1C-128d

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

- the MDT lead clinician from each MDT in the network;
- at least one nurse core member of a MDT in the network;
- there should be a named chair who should be a core member of one of the associated MDTs;
- two user representatives;
- one of the NHS employed members of the NSSG should be nominated as having specific responsibility for users' issues and information for patients and carers;
- a member of the NSSG nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the NSSG;
- named secretarial/administrative support.

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

- the provision of clinical opinion on issues relating to colorectal 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, 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 to, 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.*

Compliance: The named members and terms of reference agreed by the Chair of the NSSG.

REFERRAL GUIDELINES BETWEEN TEAMS

Network Agreed Referral Guidelines for Anal Cancer

11-1C-129d The NSSG should agree a referral guideline to the effect that colorectal MDTs should refer patients with anal cancer suitable for curative treatment to the MDT agreed for the network.

Compliance: The referral guideline agreed by the Chair of the NSSG and the trust lead clinicians.

Network Agreed Referral Guidelines for Early Rectal Cancer

11-1C-130d The NSSG should agree a policy naming those surgeons authorised to perform curative local resection of suitable stage T1 rectal cancer, for the network.

Notes:

- *'Suitable T1 rectal cancer' is defined here as those selected for local resection by the network assessment protocol for early cancer (see Topic 1C).*
- *The term 'local resection' is defined here for the purposes of Peer Review, as a resection procedure intended to achieve complete local removal of malignant disease from the primary site, but which does not involve the resection of the full circumference of the bowel and removal of a complete segment.*
- *It is expected that of the various colorectal MDT's and colorectal surgeons in a network, not all of them will offer this service, which is intended to be consolidated into the hands of a limited number of specialist practitioners.*

Compliance: The referral guideline agreed by the Chair of the NSSG and the trust lead clinicians.

Network Agreed Referral Guidelines for Liver Metastases

11-1C-131d The NSSG should agree a referral guideline to the effect that colorectal MDTs should refer patients with liver metastases, selected according to the network clinical guidelines (measure 11-1C-112d) to the liver resection MDT specified in measure 11-1C- 127d.

Note:

This MDT may be in another network.

Compliance: The referral guideline agreed by the Chair of the NSSG and the trust lead clinicians.

TOPIC 11-1D-1 FUNCTIONS OF THE LOCALITY GROUP

Introduction

The measures here in topic 1D should be applied to each locality group in the network. The responsibility for review purposes lies with the chair of the locality group and each set of separate results count as the review of each separate locality group. Previously designated centres and unit groups should be put forward for review as locality groups. It should be noted that the accountability of individual statutory organisations for the collective commissioning and provision of cancer services, as well as their effective collective working, will be reviewed through the concept of the locality group.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE
The responsibility for the purposes of peer review, for measures 11-1D-101d to 11-1D-102d, lies with the chair of the locality group.
Single Named Lead Clinician with Responsibility for Colorectal Diagnostic Service
11-1D-101d There should be a single named lead clinician with responsibility for the colorectal diagnostic service who has a list of responsibilities for the role, agreed with the lead clinician of the local trust. *Note:* *The lead clinician should be a consultant.* *Compliance:* The named lead clinician for the diagnostic service agreed by the lead clinician of the host trust. The list of responsibilities agreed by the lead clinician of the diagnostic service and the lead clinician of the host trust.
Named Administrative Personnel for Colorectal Referrals
11-1D-102d There should be administrative personnel with time specified in their list of duties for assessing and prioritising colorectal referrals from primary care to the referral contact point of the diagnostic service and for arranging appointments for investigational procedures. *Note:* *The actual number of personnel per service and actual amount of time specified are not subject to review.* *Compliance:* The named personnel and their list of duties agreed by the relevant hospital manager.

TOPIC 11-2D-1 - COLORECTAL 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 who is it who is held compliant or non 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 teleconferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. They constitute that patient's MDT.

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

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

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

The main examples of this are as follows:

- a combined operational policy meeting but the policies are agreed on behalf of each MDT by its Lead Clinician;
- network-wide clinical, referral, imaging and pathology guidelines, but each MDT agrees to abide by them;
- the same network-wide project for network audit, but each MDT agreeing to participate;
- a common minimum dataset, but each MDT agrees to collect its portion of it;
- a network list of approved trials, but each MDT agrees to enter patients;
- an individual health professional being made 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, anaesthetic and skilled theatre and aftercare staff. This is ensured by requiring services to be organised for that MDT so that all cases of a given procedure are performed in the same hospital. The people will largely be a different set of people from those who meet to make the diagnostic and treatment decisions (the MDT as defined as in the measures) but they will directly relate to that MDT and be specified by it, because at least one key functionary, the surgeon, will be a core member of that MDT.

In requiring all the complex procedures to be performed in the same hospital of the MDT, this ties in the referral catchment population of the MDT to that hospital.

This provides a direct link between the referring catchment population for MDT **discussion**, and the **treatment caseload** of the treatment team and its hospital facilities.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

The responsibility for review purposes for measures 11-2D-101 lies with the lead clinician of the host trust.

MDT STRUCTURE

Lead Clinician and Core Team Membership

11-2D-101

There should be a single named lead clinician for the colorectal 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 of superior clinical ability.

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

The core team specific to the colorectal cancer MDT should include:

- two colorectal surgeons;
- a clinical oncologist who takes responsibility for radiotherapy for rectal carcinoma;
- an oncologist who takes responsibility for chemotherapy;

Note:

This may be the clinical oncologist who is also responsible for radiotherapy for rectal carcinoma, or it may be another oncologist, clinical or medical.

- imaging specialist;
- histopathologist;
- colonoscopist of any of the following disciplines: surgeon, physician or specialist nurse;
- colorectal nurse specialist;
- MDT co-ordinator/secretary;
- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;
- a member of the core team nominated as the person responsible for ensuring recruitment into clinical trials and other well designed studies is integrated into the function of the MDT.

Notes:

- *Each clinical core member should have sessions specified in the job plan for the care of patients with colorectal cancer and attendance at MDT meetings.*
- *Where a medical specialty is referred to, the core team member should 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 co-ordinator/secretary role needs different amounts of time depending on team workload. See appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial roles may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description.*
- *There may be additional core members agreed for the team besides those listed above.*

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

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

Note:

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

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

Notes:

The reviewers should record in their assessment each case where the post(s) needed to provide the minimum core membership, for a given listed role in the measure, is unfilled or non-existent, or existing posts cannot provide the service.

This does not refer to mere holiday or sickness absence, or less than 67% attendance, and it refers only to the core member roles listed in the measure, not to additional roles that the MDT has decided locally to include as core members, e.g. from the list in the 'extended MDT' measure. The reviewers should identify the particular missing roles and identify the particular MDT in the report.

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

Level 2 Practitioners for Psychological Support

11-2D-102 At least one clinical core member of the team should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *The relevant discipline include medical, surgical, nursing and allied health professionals*.
- *If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.*
- *The definition of the levels may be found in appendix 1 of the Psychological Support measures.*

Compliance: The named member. Written confirmation of completion of training agreed by the lead clinician of the MDT.

Support for Level 2 Practitioners

11-2D-103 The level 2 practitioner(s) should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month.

Compliance: Reviewers should enquire to ascertain that this is taking place.

MDT SPECIALISING IN ANAL CANCER

Introduction

The next measure should be applied to any colorectal MDT treating patients with anal cancer, with curative intent.

Named Consultant Core Member(s) for Anal Cancer

11-2D-104 The MDT should have at least one and no more than two each of the following:

- consultant surgical core members, under whose care all operations for anal cancer take place for the patients of the MDT.
- consultant clinical oncology core members under whose care all curative chemotherapy and/or radiotherapy (including chemo-radiotherapy) for anal cancer takes place, for the patients of the MDT.

Compliance: The name(s) of the relevant core member(s) agreed by the lead clinician of the MDT.

The reviewers should enquire of the working practice of the team.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Named MDT for Anal Cancer

11-2D-105 The MDT should be the team or one of the teams named in the network agreement for anal cancer and the network referral guideline for anal cancer.

Compliance: The network agreement and referral guideline.

Notes:

It is expected and even intended that the measures relating to colorectal MDTs which specialise in the treatment of anal cancer will normally result in a network either having only one such MDT or even referring all its patients to a specialised MDT for anal cancer in a neighbouring network. In a very few of the largest networks, more than one such MDT might be feasible although even in this case, they should seriously consider having only one MDT for anal cancer.

The reviewers should comment specifically in their report where there are multiple MDTs for anal cancer in a network of around average or less than average size.

If the MDT is not agreed as a specialised MDT for anal cancer by the network this should be commented on specifically in the report, but the MDT should still be reviewed against the rest of the relevant measures.

Team Attendance at NSSG Meetings

11-2D-106 The lead clinician of the MDT or representative should attend at least two thirds of the NSSG meetings.

Compliance: The attendance record of the NSSG.

MDT Meeting

11-2D-107 The team should hold its meetings weekly, record core members' attendance and have a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (Guidance only - e.g. letters, emails or phone calls between certain specified members, restrospective discussion at the next scheduled meeting.)

Compliance: Attendance records of the meetings.

Written procedure agreed by the lead clinician of the MDT.

MDT Agreed Cover Arrangements for Core Members

11-2D-108 The MDT should agree named cover arrangements for each core member.

Notes:

- *This refers to the nominating of staff who should in general be expected to provide cover for core members, e.g. a specialist trainee on a consultant's team or core members of the same discipline providing cover for each other. It does not refer to the membership having to provide a person to cover for each and every absence. This aspect is dealt with by the attendance measure above.*
- *Where a medical specialty is referred to, the cover for a core member need not be a consultant but should be a specialist trainee or non-career grade.*

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

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

11-2D-109 Core members or their arranged cover (see measures 11-2D-101 and 11-2D-108) should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT.

Notes:

The intention is that core members of the team should be personally committed to it, reflected in their personal attendance at a substantial proportion of meetings, not relying instead on their cover arrangements. Reviewers should use their judgement on this matter and should highlight in their report where this commitment is lacking.

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

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2D-110 Besides the regular meetings to discuss individual patients, the team should meet at least annually to discuss, review, agree and record at least some operational policies.

Compliance: Written confirmation of at least one meeting agreed by the lead clinician of the MDT to illustrate the recording of at least some operational policies.

Policy for All New Patients to be Reviewed by MDT

11-2D-111 There should be an operational policy for the team whereby it is intended that all new cancer patients will be reviewed by a multidisciplinary team for discussion of initial treatment plan.

The policy should specify at what other stages in the patient pathway patients are referred back for discussion.

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

Policy for Communication of Diagnosis to GP

11-2D-112 The MDT should have an agreed policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis by the end of the following working day.

The MDT should have completed an audit against this policy of the timeliness of notification to GPs of the diagnosis of cancer.

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

The written results of the audit.

Operational Policy for Named Key Worker

11-2D-113 There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT members for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s).

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

Notes:

- *For information: according to the NICE supportive and palliative care guidance, a key worker is a person who, with the patient's consent and agreement, takes a key role in co-ordinating the patient's care and promoting continuity, e.g. ensuring the patient knows who to access for information and advice. This is not intended to have the same connotation as the key worker in social work.*
- *It may be necessary to agree a single key worker across both a cancer site specific MDT and the specialist palliative care MDT for certain patients.*

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The written policy agreed by the lead clinician of the MDT. Reviewers should spot check some of the relevant patients case notes.

Core Histopathology Member Taking Part in Histopathology EQA

11-2D-114	The core histopathology member(s) of the MDT should be taking part in an EQA scheme, either a specialist scheme for the cancer site(s) of the team or a general EQA scheme which has a section covering the cancer site(s) of the team.
Compliance:	Documentary evidence to show that they are taking part in a relevant EQA. *Note:* *Their actual performance against the requirements of the EQA is not subject to peer review.*

MDT Agreement to Network Guidelines on Management of Surgical Emergencies

11-2D-115	The MDT should agree the network guidelines on the management of surgical emergencies related to colorectal cancer (measure 11-1C-116d).
Compliance:	The network guidelines agreed by the lead clinician of the MDT and the Chair of the NSSG.

MDT Agreement to Network Onward Referral Policy

11-2D-116	The MDT should agree the network onward referral policy (measure 11-1C-109d).
Compliance:	The network policy agreed by the lead clinician of the MDT and the Chair of the NSSG.

MDT Agreement to Network List of Personnel Judged Competent for Colorectal Stenting

11-2D-117	The MDT should agree to the network list of named personnel judged competent for colorectal stenting (measure 11-1C-113d).
Compliance:	The network list agreed by the lead clinician of the MDT and the Chair of the NSSG.

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 the 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 colorectal surgeons and palliative care physicians before there were established colorectal 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 member and to set out minimum training requirements for nursing input into MDTs. This is in order to establish these roles more firmly in the NHS infrastructure, and to avoid the situation where MDTs can comply with measures by having generalist nurses who 'sit in' on MDT meetings and sign attendance forms but play no defining role in the team's actual dealings with its patients.

Core Nurse Members Completed Specialist Study

11-2D-118	Each core nurse specialist should have successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent.
Compliance:	Confirmation of successful completion of the course/module.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Agreed Responsibilities for Core Nurse Members

11-2D-119

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

- contributing to the multidisciplinary discussion and patient assessment/care planning decision of the team at their regular meetings;
- providing expert nursing advice and support to other health professionals in the nurse's specialist area of practice;
- involvement in clinical audit;
- leading on patient and carer communication issues and co-ordination of the patient pathway for patients referred to the team - acting as the key worker or responsible for nominating the key worker for the patient's dealings with the team;
- ensuring that results of patients' holistic needs assessment are taken into account in the decision making;
- contributing to the management of the service (see note below);
- utilising research in the nurse's specialist area of practice.

Notes:

- *"Management" in this context does not mean clerical tasks involving the documentation on individual patients i.e. this responsibility does not overlap with the responsibility of the MDT co-ordinator.*
- *A list of responsibilities containing all the elements in this measure and the previous measure would encompass all of the four domains of specialist practice required for the role of cancer nurse specialist.*
- *Additional responsibilities may be agreed.*

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

Attendance at National Advanced Communication Skills Training Programme

11-2D-120

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 who 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 who 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.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Extended Membership of MDT

11-2D-121

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

The named extended team for the MDT should include:

- gastroenterologist;
- **either** a core surgical member of a stand-alone liver resection MDT **or** a core surgical member of a pancreatic MDT which is also being put forward for review as a liver resection MDT; the surgeon in question being one of the surgeons who carries out metastatectomies.
  Note:
  This surgical member of the extended MDT plays an advisory role to the core colorectal MDT on liver metastatectomy.
- thoratic surgeon who has a practice in lung metastatectomy;
- interventional radiologist who is named in the network guidelines as being competent in lower intestinal stenting;
- dietician/nutritionist;
- clinical geneticist/genetics counsellor;
- liaison psychiatrist/clinical psychologist;
- a core member of the specialist palliative care team;
- a specialist screening practitioner (SSP);
- A MDT being put forward for review as a colorectal MDT and additionally specialising in the treatment of anal cancer, should provide the names of the following members of the extended team:
  - gynaecologist with a surgical practice in the treatment of vulval cancer;
  - plastic surgeon.

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.

Regarding the liver resection surgeon - the core membership list of their liver resection MDT.

Regarding the radiologist - the network list of people judged competent in lower intestinal stenting.

PROVIDING PATIENT CENTERED CARE

Patient Permanent Consultation Record

11-2D-122

The MDT should be giving patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor when the following are discussed:

- diagnosis;
- treatment options and plan;
- relevant follow up (discharge) arrangements.

Note:

The MDT may, in addition, offer a permanent record of consultations undertaken at other stages of the patient's journey.

The record of consultation should identify areas discussed during consultation and include a diagram where appropriate which supports the consultation discussion.

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

A record should be kept in the notes.

Compliance: The reviewers should enquire of the working practice of the team and see anonymised examples of records given to patients.

Note:

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

Patient Experience Exercise

11-2D-123

The MDT should have undertaken an exercise during the previous two years prior to review or completed self-assessment to obtain feedback on patients' experience of the services offered.

The exercise should at least ascertain whether patients were offered:

- a key worker;
- assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment);
- the MDTs information for patients and carers (written or otherwise)
- the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed.

Notes:

- *The exercise may consist of a survey, questionnaire, focus group or other method.*
- *There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered.*

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

Compliance: The results of the exercise.
A report for the action taken.

Provision of Written Patient Information

11-2D-124

The MDT should provide written material for patients and carers which includes:

- information specific to that MDT about local provision of the services offering the treatment;
- information about patient involvement groups and patient self-help groups;
- information about the services offering psychological, social and spiritual/cultural support, if available;
- information specific to the MDT's cancer site or group of cancers about the disease and its treatment options (including names and functions/roles of the team treating them);
- information about services available to support the effects of living with cancer and dealing with its emotional effects.

It is recommended that the information and its delivery to patients and carers follow the principles of the NHS Information Prescription project. (www.informationprescription.info).

Notes:

- *The information prescription should be tailored to the patients/carers needs based on an information needs assessment. Information may be generated and dispensed outside of the clinic environments within an information centre where a clear operational policy between the clinic and information centre is in place which*

identifies how clinic records are updated and that facilities and resources within the information centre are appropriate to providing such a service.

- *The information prescription should be composed of information from the national pathways supplemented with national and local accredited information.*

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

Notes:

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

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

Agree and Record Individual Patient Treatment Plans

11-2D-125 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 the patients discussed;
- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment-surgery, radiotherapy, chemotherapy, biological therapy or supportive care, or combinations of the same, they are to be referred to for consideration);
- in the case of patients with anal cancer, where the MDT under review does not treat anal cancer, whether the patient is referred to the network's nominated anal cancer MDT.

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 a MDT decision proforma as well as in individual patient's notes.

CLINICAL GUIDELINES

The next measure deals with the clinical management of colorectal cancer in general. The responsibility for review purposes for this 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 MDT for their compliance should agree to them.

There follows three measures dealing with the clinical management of three specific situations in this area of practice:

- anal cancer
- local research and early rectal cancer
- resection of liver metastases

Again, for compliance, the NSSG, in consultation with the MDTs, should produce the agreed network-wide clinical guidelines. The individual MDT for their compliance with these measures should agree to them.

Finally there are measures which deal with referral of patients between different MDTs. In the area of practice covered by the revised colorectal IOG, the measures only cover inter-team referrals for the same three clinical situations mentioned above, i.e. colorectal cancers in general, anal cancer and resection of liver metastases.

Because the establishment of specialist MDTs for these areas of practice may involve a degree of service reconfiguration, the responsibility for review purposes for producing these last three guidelines lies with the

NSSG. For their compliance the NSSG should produce the network-wide guidelines on referral between MDTs and the individual MDT, for their compliance with these measures, should agree to them.

MDT Agreement to Network Clinical Guidelines for Colorectal Cancer

11-2D-126 The MDT should agree specified, network-wide clinical guidelines* with the NSSG for colorectal cancer in general. Where there are agreed national clinical guidelines, the network and the MDT should accept these.

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

Notes:

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

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

MDT Agreement to Network Guidelines for the Clinical Management of Anal Cancer

11-2D-127 The MDT should agree the network guidelines for the clinical management of anal cancer.

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

MDT Agreement to Network Guidelines for the Clinical Management of Early Rectal Cancer

11-2D-128 The MDT should agree the network guidelines for the clinical management of early rectal cancer by local resection.

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

MDT Agreement to Network Guidelines on the Resection of Liver Metastases

11-2D-129 The MDT should agree the network guidelines on the resection of liver metastases.

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

MDT Agreement to Network Referral Guidelines between Teams for Anal Cancer

11-2D-130 The MDT should agree the network referral guidelines between teams for anal cancer.

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

MDT Agreement to Network Referral Guidelines between Teams for Early Rectal Cancer

11-2D-131 The MDT should agree the network referral guidelines between teams for the treatment of early rectal cancer by local resection.

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

MDT Agreement to Network Referral Guidelines between Teams for the Resection of Liver Metastases

11-2D-132 The MDT should agree the network referral guidelines between teams for the resection of liver metastases.

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

Investigation Protocol

The diagnosis and assessment of colorectal cancer is shared between the MDT and the colorectal diagnostic service. A network-wide investigation protocol should govern this process and should define the respective roles in this of the MDT and the diagnostic service. The responsibility for review purposes for producing this lies with the NSSG in consultation with the MDTs, the network cancer imaging group and the network cancer pathology group. For compliance the NSSG should produce the protocol, and the individual MDT for their compliance with this measure should agree to it.

MDT Agreement to Network Investigation Protocol for Colorectal Cancer

11-2D-133 The MDT should agree the network investigation protocol for colorectal cancer.

Compliance: The network investigation protocol agreed by the lead clinician of the MDT and the Chair of the NSSG.

Agreed Collection of Minimum Dataset

11-2D-134 The MDT should be recording its agreed part of the MDS, according to the network data collection specification, in an electronically retrievable form.

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

Note:

For the purpose of self assessment, the team should confirm that they started to record the MDS.

NETWORK AUDIT

Introductory Notes

For review purposes a network audit project is an audit project related to the cancer site or sites of the NSSG and the activities of its MDTs. The same project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified. The individual MDTs, for compliance with their relevant MDT measure, should agree to participate in the audit. See appendix 1 for audit.

Network Audit

11-2D-135 The MDT should agree to participate in the network audit project agreed by the NSSG.

The MDT should annually review the progress of the project or present the results of the completed network audit project to the NSSG for discussion at one of their meetings.

Notes:

For MDTs which have previously been peer reviewed the project should have been completed since that previous peer review.

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

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

Discussion of Clinical Trials

11-2D-136 The MDT should produce a report at least annually on clinical trials, for discussion with the NSSG. The report should include;

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

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

Note:

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

programme between the participants of the meeting.

In addition, applicable only to MDTs dealing with the following cancer sites:

- Leukaemia
- Lymphoma
- Germ cell malignancy
- Bone and/or soft tissue sarcoma
- Brain and CNS malignancy
- Malignant melanoma

The MDT should produce a report on clinical trials, covering the above points, for TYA patients, for discussion at the teenage and young adults' cancer network co-coordinating group (TYACNCG).

The MDT should agree a final programme for improvement for TYA clinical trials with the TYACNCG.

Note:

The TYACNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.

Compliance: The report, agreed by the lead clinician of the MDT. The reviewers should check that the contents fulfil the points above.

The programme for improvement, agreed by the lead clinician of the MDT and the clinical lead for the cancer research network.

Where relevant, the clinical trials report for TYA patients, agreed by the lead clinician of the MDT, and the programme for improvement agreed by the lead clinician of the MDT, Chair of the TYACNCG and the clinical lead for the cancer research network.

MDT WORKLOAD

MDT to Discuss 60 or More New Cases per Year

11-2D-137 The MDT should discuss and make a treatment planning decision on 60 or more new cases per year.

Note:

The number should be calculated as follows:

- *They should be cases of colorectal/anal cancer presenting to the MDT for the first time in the patient's case history.*
- *The number should be averaged over the two complete calendar years prior to the peer review visit.*
- *The number of cases of colonic, rectal and anal cancer should be summated as one total, combined figure.*
- *A new case counts whatever their initial treatment modality is, and whether they present with metastatic disease, or the primary or both.*

Compliance: The total number of cases as above agreed by the lead clinician of the MDT.

20 or More Operative Procedures per Core Surgical Member

11-2D-138 Each named core surgical member of the MDT should perform 20 or more operative procedures (as defined below) for colorectal cancer, per year.

Note:

The number of operative procedures should be calculated as follows:

- *It should be recorded separately for each individual core surgeon.*
- *It should be averaged over the two complete calendar years prior to the peer review visit.*
- *The procedures should be those performed with the intention of loco-regional*

clearance of disease.

- *Procedures involving colonic cancer, rectal cancer.*
- *Procedures on anal cancer do **not** count.*
- *Only those procedures should count where the core surgical team member has scrubbed up, as evidenced by their name appearing on the operation notes, as a participating surgeon in the procedure.*
- *Emergency procedures count providing the other criteria are fulfilled.*
- *Procedures performed in the private sector count, providing the other criteria are fulfilled and the case is discussed at the regular meeting of the MDT under review.*

Compliance: The named core surgical MDT members with their respective numbers of procedures.

The following measure is applicable to MDTs for anal cancer.

Clinical Oncologist Core Members

11-2D-139 A MDT being put forward for review as a colorectal MDT additionally specialising in the treatment of anal cancer should fulfil the following:

In the radiotherapy department which hosts the radiotherapy practice of the MDT there should be no more than two clinical oncologists who practice radiotherapy (as a single modality or as part of chemotherapy) for anal cancer, and they should be core members of the MDT.

Notes:

- *Where more than one department is associated as above, with the MDT, then each such department should comply separately with this measure for the MDT to comply.*
- *There **need not** be two clinical oncologists - one would be compliant.*

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

Reviewers should enquire as to the working practice of the MDT.

LAPAROSCOPIC COLORECTAL CANCER SURGERY MEASURES

Policy on the Choice of Laparoscopic Colorectal Cancer Surgery

11-2D-140 There should be a policy for the MDT whereby all patients who fulfil the agreed network criteria should be offered the option of laparoscopic surgery as an alternative to open surgery for the surgical treatment of their cancer.

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

The reviewers should enquire as to the working practice of the MDT regarding this policy.

Note:

The NSSG, for compliance with their relevant measure should in consultation with the MDTs, produce the criteria and the MDT, for compliance with this measure should agree to abide by them.

Training in Laparoscopic Colorectal Cancer Surgery

11-2D-141 At least one of the core colorectal cancer surgeons should have been trained on the National Laparoscopic Colorectal Surgery Programme or be exempt according to the exemption criteria (see section 11-1C-122d).

Compliance: A sign off letter from the national training programme confirming that one of the core surgical members has achieved competence in laparoscopic colorectal cancer surgery, **or** verification that one of the core surgical members is exempt, agreed by the Lead Clinician of the MDT.

The network list of laparoscopic colorectal surgeons.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Referral Guidelines for Laparoscopic Colorectal Cancer Surgery (Applicable to Colorectal MDTs Without Trained or Exempt Members)

11-2D-142 The MDT should agree to abide by the network policy and referral guidelines on laparoscopic colorectal cancer surgery.(see section 11-1C-123d).

Compliance: The policy and the referral guidelines, naming the MDT to which, for planning purposes, the team will refer patients, agreed by the lead clinician of the MDT.

The reviewers should enquire as to the working practice of the MDT regarding this policy and referral guideline.

Note:

The NSSG, for compliance with their relevant measure should in consultation with the MDTs, produce the criteria and referral guideline and the MDT, for compliance with this measure should agree to abide by them.

Joint Treatment Planning for TYAs

11-2D-143 For each patient in the TYA age group, the MDT should agree the following decisions with the TYA MDT and record them as part of that patient's joint treatment planning decision:

- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment-surgery, radiotherapy, chemotherapy, biological therapy or supportive care, or combinations of the same, they are to be referred to for consideration);
- the named consultant in charge of each modality of definitive treatment and the named person in charge of organising arrangements for the age-appropriate support and care environment including those when the treatment is delivered outside the PTC facility.

For those in the age range 19 to the end of their 24th birthday, the MDT should record the choice of treatment location, made by the patient, in particular, whether it is the TYA facility or which of the named designated hospitals for TYAs.

Notes:

Patients in the age range 16 to the end of their 18th birthday should be treated in the PTC.

The date of joint agreement to the planning and of the patient's choice of treatment place may be later than the date of the initial treatment planning discussion by the MDT.

Compliance: The reviewers should ask to see examples of the treatment planning decision record of patients from the TYA age group. Evidence of joint agreement should be by individual TYA patient decision records of the site-specific MDT being authorised by a core member of the TYA MDT.

Note:

If the MDT has had no such patients referred since the last assessment/review this part of the measure is considered to have been complied with. The overall compliance depends then, only on the non-TYA aspects of this measure.

APPENDIX 1

Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summaried 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

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.

ADDENDUM - Amendments to measures April 2013

Measure number	Comment
1A-201d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-202d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-203d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-205d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-206d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-207d	Revised and included in NSSG measure 1C-127d to 1C-131d
1A-208d	Revised and included in NSSG measure 1C-127d to 1C-131d
1C-102d	Revised
1C-103d	Revised
1C-104d	Revised
1C-116d	Revised
1C-118d	Revised
1C-119d	Revised
1C-129d	Revised
1C-131d	Revised
2D-105	Revised
2D-130	Revised
2D-131	Revised
2D-132	Revised
2D-134	Revised
2D-221	To be replaced with new HPB measures
Appendix 1	New
Appendix 2	Revised