

UPPER GI STANDARDS

Introduction

The Improving Outcomes Guidance (IOG) Upper GI tract cancer guidance has further developed the concepts previously used for gynae cancer. The latter involved a simple division between centre and unit teams with instructions on distribution of work. Thus, for Upper GI (UGI) tract cancer the guidance describes a network-wide structure of team types with more detailed instructions on how these teams should relate to each other and to primary care. The specific configuration of teams in a given centre or unit may take different forms depending on the catchment population and the overall structure of the service in the network to which the centre or unit belongs. The recommended minimum catchment population is 1 million for oesophago-gastric (OG) cancer and 2 million for pancreatic cancer. These considerations have determined the format of this section of the standards and have necessitated specific standards for UGI tract cancer for the network management group and the network site specific group. These have been incorporated into UGI-specific parts of topic 10, which have been attached to the UGI standards. The standards also move more into the areas of the diagnostic process and liaison with primary care. This has been considered necessary because the organisation of the diagnostic process has such an obvious and far-reaching effect on the overall pathway of those patients who are subsequently found to have the disease.

It is recognised that the changes necessary to achieve full compliance with these standards will take time and resources. A given network may need to take a phased approach to this (over transfer of workload for instance). To help with this and to ensure that some early progress is intended by networks, the first standard in the network section deals with the production of an agreed action plan which meets specific criteria. This written action plan is required within 3 months of the release of the UGI standards on the Internet, and therefore well before the next peer review against the rest of the standards.

Implications of the IOG Upper GI Tract Guidance

Levels of Care

There are three defined levels of care:

- a) The diagnostic process
- b) Local care

All patients diagnosed with UGI cancer should be individually discussed with a member of the specialist team (see references to 'teams' below), prior to any proposed treatment. Subject to this and subject to agreement in the network's own guidelines (see standards on clinical guidelines in topic 2.6), local care may be delivered under the care of a member(s) of the local UGI team.

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

1. Palliative surgical bi-pass procedures
2. Palliative stenting
3. Other endoscopic debulking methods to clear blockage by tumour, except intraluminal radiotherapy
4. Palliative chemotherapy
5. Palliative and supportive care, not involving active, tumour shrinking or debulking therapy.

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

c) Specialist Care

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

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

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

Notes:

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

Shape of the Service

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

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

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

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

- In a given single centre or unit which has a specialist OG team, it should be the only OG team for that centre or unit.
- In a given centre which has a specialist pancreatic team it should be the only pancreatic team for that centre.

The exact boundaries of what constitutes a team and what does not, as outlined in the introduction to topic 2 of the Manual of Cancer Services Standards, is especially important here.

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

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

Configurations

These implications of the guidance lead to the possible service configurations within a given centre or unit which may be offered for assessment having first been agreed by the relevant network management group. (See relevant parts of topic 10). The configurations are set out below. Their agreement is the overall responsibility of the chair of the network management group and their establishment is assessed under topic 10.

- **Centre with specialist teams for pancreatic and OG cancer, and diagnostic team(s).**
 - a) Single specialist/local care team for pancreatic cancer; and
 - b) Single specialist/local care team for OG cancer; and
 - c) One or more diagnostic teams conforming to the referral agreement between the network management group and local PCO's for the secondary referral catchment population of the centre (see standard 10.1/34).

Note:

It is recommended that local care for the centre's secondary catchment population is provided by the specialist teams. In exceptional circumstances where this produces excessive travelling for frail patients, the extension of named diagnostic teams to provide local care in named locations should be agreed by the network management group as in standard 10.1/34.

- **Centre or larger unit with specialist team for OG and diagnostic team(s).**
 - a) Single specialist team giving OG specialist care and local care for both OG and pancreatic.
 - b) One or more diagnostic teams conforming to the referral agreement between the network management group and local PCO's for the secondary referral catchment population of the centre or larger unit (see standard 10.1/34).

Note:

It is recommended that local care for the centre's (or larger unit's) secondary catchment population is provided by the specialist team. In exceptional circumstances where this produces excessive travelling for frail patients, the extension of named diagnostic teams to provide local care in named locations should be agreed by the network management group as in standard 10.1/34.

- **Cancer unit or small centre with no specialist teams.**

- a) A single diagnostic/local care team.

Note:

In exceptional circumstances where this produces excessive travelling for frail patients, the establishment of more than one named diagnostic/local care team in named locations should be agreed by the network management group as in standard 10.1/34.

Building the UGI Cancer Network

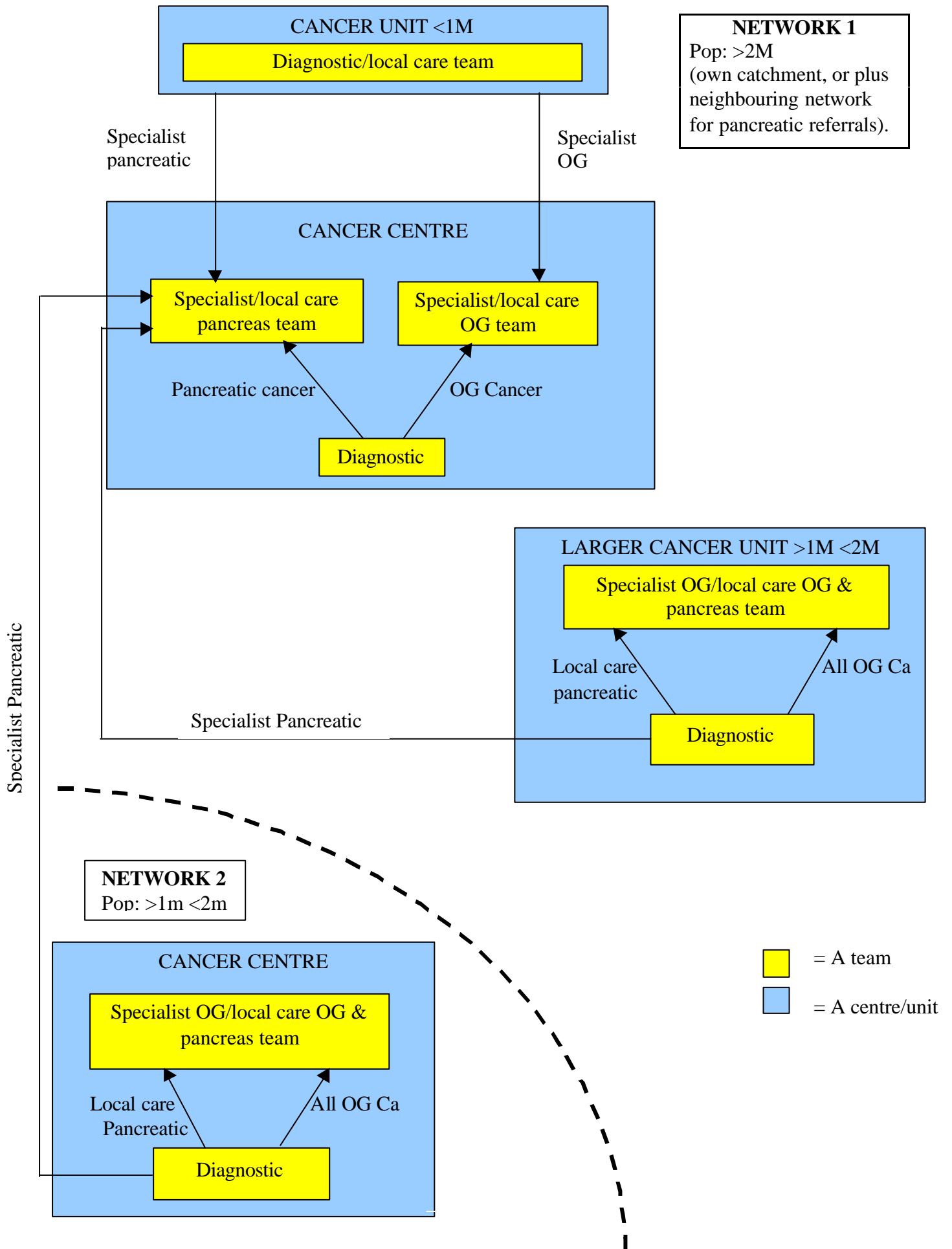
The standards assign the responsibility for establishing the UGI cancer network arrangements to the network management group, acting in agreement with the network site-specific group and the PCO's.

The logical progression of this process as laid out in the standards in topic 10 for the network management group is as follows:

1. Agree the identity and location of diagnostic UGI teams for the network.
2. Agree the referral arrangements between PCO's and diagnostic teams.
3. Find the referring catchment population of each diagnostic team from the numbers associated with its referring PCO's.
4. Agree the configuration of diagnostic/local care/specialist teams for the network.
5. Agree the specific referral guidelines between teams across the network and if necessary between neighbouring networks.
6. Confirm the referring catchment populations of each specialist team by adding the populations of the teams own referring diagnostic teams.

How the Configurations Work

The following figure illustrates examples of the configurations and how a typical group of centres/units would relate, according to the standards, within and across networks.



TOPIC 10.1 CANCER NETWORKS. UGI-SPECIFIC STANDARDS

STD	DESCRIPTION	LEVEL
10.1/32	Action plan	1*
10.1/33	Primary Care Referral Guidelines	1*
10.1/34	Location of Diagnostic Service	1*
10.1/35	Diagnostic and Diagnostic/Local Care Team Catchment Populations	1*
10.1/36	Team Configurations in Units, Centres and Networks	1*
10.1/37	Referral Guidelines Between Teams	1*
10.1/38	Specialist Team Catchment Populations	1*

TOPIC 10.1 CANCER NETWORKS. UGI-SPECIFIC STANDARDS

Assessors should enquire as to the configuration of teams which has been agreed for each centre or unit and which is referred to in the list in standard 10.1.35. Only those teams in the list are eligible to be offered for assessment. The standards for the relevant team type (as listed in topic 2.6) should be applied to each team. See topic 2, of the Manual of Cancer Services Standards, the specialist multidisciplinary team introduction for guidance on which activities may be legitimately shared between teams and which may not.

NETWORK MANAGEMENT GROUP

The responsibility for assessment purposes for standards 10.1/32 – 10.1/38 lies with the Chair of the Network Management Group (NMG).

<i>STANDARD & LEVEL</i>	<i>STANDARD</i>	<i>DEMONSTRATION OF COMPLIANCE</i>
UGI NETWORK ACTION PLANS		
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> Standard 10.1/32 Level 1* UGS </div>	<p>The NMG should produce an action plan (AP) meeting the following criteria:</p> <ol style="list-style-type: none"> 1. The AP should explicitly mention all the separate steps outlined in "building the UGI network" in the introduction to the UGI standards, stating the estimated date when each step will be achieved. 2. For all proposed UGI teams in the network (diagnostic or diagnostic/local care or specialist) the AP should state an estimated date by which each named team will start to function and (for teams transferring specialist cases to other teams) when such transfer of workload will start. 3. The AP should be agreed and signed off by: <ul style="list-style-type: none"> The chair of the NMG. The CE of the Trust(s) whose hospitals will, according to the AP, be affected by any proposed changes. At least one CE of the PCO's in the network, as a representative(s) of the commissioners. 4. The AP should be signed off and sent to the Strategic Health Authority(ies) relevant to the Action Plan and copied to the Cancer Action Team within 3 months of the release of the UGI 	<p>The written Action Plan within 3 months of the release of the standards on the Internet.</p> <p><i>Note:</i> <i>The Action Plan is not expected to be more than a few pages in length.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<p>standards on the internet.</p> <p><i>Notes:</i></p> <p><i>The contents of the AP and their robustness are not subject to assessment save as per the standard. (I.e. the standard only requires that all points mentioned, are covered by the AP and it is produced on time.)</i></p> <p><i>The AP does not exempt the network from being assessed against the rest of the UGI standards at a Peer Review visit, planned as part of the National Peer Review 2nd round. Compliance against the standards will be the final yardstick of progress.</i></p> <p><i>It is recognised that components of the AP may eventually have to be changed to achieve compliance with the standards.</i></p> <p><i>Agreement in principle with PCO's and Health Authorities is needed, but this is an AP, and agreement does not imply binding contractual arrangements between parties. The AP should not be withheld because of lack of agreement over future SaFF arrangements.</i></p>	

**PRIMARY CARE REFERRAL GUIDELINES AND LOCATION OF DIAGNOSTIC SERVICE
(STANDARDS 10.1.33 AND 10.1.34)**

<p>Standard 10.1/33 Level 1* UGS</p>	<p>The NMG should agree, with PCO leads for the catchment population of their network, a policy that their primary care practitioners will refer all patients defined by the “urgent, suspicious of cancer guidelines” for UGI cancer to the contact point of a single named diagnostic or diagnostic/local care team on the list agreed in standard 10.1.34.</p>	<p>The written policy signed by the chair of the NMG and the PCO leads.</p>
<p>Standard 10.1/34 Level 1* UGS</p>	<p>The NMG should agree with PCO leads and the NSSG for UGI cancer:</p> <ul style="list-style-type: none"> • The location of named diagnostic and diagnostic/local care teams in the network. • The named PCO’s or named individual practices which will refer patients (defined as in standard 10.1.33) to which named diagnostic or 	<p>The list of named teams of which named type, hosted by which named hospital together with the list of each team’s named referring PCO’s or individual practices. The lists should be signed by the chair of the NMG, chair of the NSSG for UGI cancer and network PCO leads.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	diagnostic/local care team, one practice referring to only one team.	
DIAGNOSTIC AND DIAGNOSTIC/LOCAL CARE TEAM CATCHMENT POPULATIONS		
Standard 10.1/35 Level 1* UGS	The NMG should calculate from the list in standard 10.1.34, the referring catchment population of each named diagnostic or diagnostic/local care team. No individual primary care practice's population should count more than once.	The catchment populations of each named team, signed by the chair of the NMG.
TEAM CONFIGURATIONS IN UNITS, CENTRES AND NETWORKS		
Standard 10.1/36 Level 1* UGS	<p>The NMG should agree, in consultation with the NSSG and Lead Clinicians of each unit/centre in the network, the configuration of the teams in each unit/centre in the network, complying with the following:</p> <ul style="list-style-type: none"> • The configurations should conform to one or other of those described in the introduction to UGI standards (pages 3 & 4). • All diagnostic and diagnostic/local care teams should be included in the configuration of one or other centre or unit. 	The agreed configurations for each unit and centre in the network signed by the chair of the NMG, chair of the NSSG and the relevant Lead Clinician for each centre or unit. The configuration should name each team of named type hosted by named hospitals.
REFERRAL GUIDELINES BETWEEN TEAMS		
<p>The format of this standard and related standards in topic 2.6 is specific to UGI cancer. In view of (a) the various possible configurations of service and (b) the need to have agreed the particular group of configurations for the network, the responsibility for assessment purposes for referral guidelines lies with the Lead Clinician of the MDT, the chair of the NSSG and the chair of the NMG. For compliance the NMG in consultation with the NSSG should produce agreed guidelines and the individual MDT, for their compliance should agreed to abide by them. The standards count towards the assessment of the NMG and the individual team.</p>		
Standard 10.137 Level 1* UGS	<p>The NMG should agree in consultation with the NSSG, referral guidelines for each named team in the network, complying with the contents specified in the "Referral Guidelines between Teams" standards for each team type in topic 2.6.</p> <p><i>Note:</i> <i>Diagnostic teams and teams dealing with local care may make referrals to specialist</i></p>	The written referral guidelines for each named team in the network, agreed by the Lead Clinician of the MDT, the chair of the NSSG and chair of the NMG.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
	<p><i>teams in another network, and specialist teams may receive referrals from another network, all on the grounds of minimum catchment populations. These agreed arrangements should be stated, naming teams and their host hospitals as in the referral guidelines in topic 2.6. For these inter-network arrangements the responsibility for assessment purposes lies with the NMG and MDT Lead Clinician from the referring network.</i></p>		
SPECIALIST TEAM CATCHMENT POPULATIONS			
<table border="1" style="width: 100%;"> <tr> <td data-bbox="129 770 418 864"> Standard 10.1/38 Level 1* UGS </td> </tr> </table>	Standard 10.1/38 Level 1* UGS	<p>The NMG should agree, in consultation with the NSSG and Lead Clinician of each specialist team in the network, the catchment populations for referral for specialist care to named specialist teams. This should be a minimum of 1 million for OG teams and 2 million for pancreatic teams. The population should be estimated, in each case, from the catchment populations of their respective referring diagnostic and diagnostic/local care teams (see standard 10.1/35).</p> <p><i>Note:</i> <i>All specialist teams should be offered for assessment against this standard.</i></p>	<p>A list of each named specialist team in the network with the relevant catchment population signed by the chair of the NMG, chair of NSSG and relevant MDT Lead Clinician.</p> <p><i>Notes:</i> <i>When specialist teams receive referrals from other networks the catchment populations of the referring diagnostic and diagnostic/local care teams from the other networks should be counted towards the total catchment populations of the receiving specialist team in the receiving network.</i> <i>The population of diagnostic and diagnostic/local care teams should count once and in only one network for each of the two cancer groups, OG and pancreatic. If, for example, a team refers, say OG patients to a centre OG specialist team in their own network but pancreatic patients to a centre pancreatic specialist team in another network, its catchment population counts once for OG cancer to their own networks OG team and once for pancreatic cancer to the other, receiving network pancreatic team.</i> <i>For compliance with this</i></p>
Standard 10.1/38 Level 1* UGS			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
		<p><i>standard, a NMG should have in their network EITHER a specialist team or teams each with at least the minimum referral catchment population OR no specialist teams. This can be achieved by the network having agreed to refer patients for specialist care for one or both of the cancer groups (OG and pancreatic) to the relevant team in another receiving network, if the original (referring) network is unable to provide the specialist teams serving the minimum population. This should be agreed as part of the network's "Referral Guidelines between Teams" (standard 10.1.37).</i></p>

TOPIC 10.1 – DUTIES OF NETWORK SITE SPECIFIC GROUPS. UGI-SPECIFIC NOTES

Additional notes specific to Upper GI NSSGs. Where there are no additional notes the standards under “duties of network site specific groups” in topic 10.1 apply unchanged.

Standard 10.1/21
Level 1
(Clinical and referral
and minimum dataset)

(Cross reference to standards: 2.6/33, 2.6/36, 2.6/38, 2.6/74, 2.6/76 and 2.6/77)

- Clinical guidelines for UGI cancer should make specific reference to:
 - a) Those parameters in terms of disease severity and patient fitness which determine whether a patient should be offered specialised rather than local care as defined in the introduction to UGI – Specific Standards.
 - b) Which local care procedures which may be offered by a given local team.
 - c) Which sites may be used to deliver specialist care by specialist team members outside the specialist team’s host hospital.
- Referral guidelines between primary care and UGI teams and UGI referral guidelines between teams are the responsibility for assessment purposes of the NMG and are assessed as part of the UGI-specific standards for the NMG.
- Minimum dataset. An additional part of standard 10.1/21 for the Upper GI NSSG is that they should agree a network-wide policy specifying which team type should collect which portions of the MDS. For compliance the NSSG should produce the agreed policy and for their compliance individual teams should agree to abide by it. The “demonstration of compliance” for this, is the policy, agreed by the chair of the NSSG and the Lead Clinician of the MDT.

Standard 10.1/22
Level 1
(Annual review and
update of clinical and
referral guidelines)

This does not apply since UGI networks are being newly formed.

Standard 10.1/23
Level 1
(network audit)

(Cross reference to standards: 2.6/39, 2.6/79)

Because of the hierarchy of team types for UGI cancer a given audit project although it should be network-wide, may not involve all teams in the network.

Standard 10.1/25
Level 1
(participation in
approved clinical trials)

(Cross reference to standards: 2.6/40, 2.6/80)

Because of the hierarchy of team types for UGI cancer not all teams may be able to enter patients into a given trial on the list.

TOPIC 2.6 – UPPER GI MULTIDISCIPLINARY TEAM (MDT) STANDARDS

NB: *Standards labelled UGS are Upper Gastrointestinal specific*
Standards labelled UGS OG are Upper Gastrointestinal oesophago-gastric specific
Standards labelled UGS P are Upper Gastrointestinal pancreatic specific

DIAGNOSTIC & DIAG/ LOCAL TEAM STD	SPECIALIST TEAM STD	DESCRIPTION	LEVEL
2.6/1	2.6/41	Named Lead Clinician for the MDT	1*
2.6/2	2.6/42	Lead Clinician written responsibilities	1*
2.6/3 UGS	2.6/43 UGS P	Names of core team members of MDT	1*
	2.6/44 UGS OG	Names of core team members of MDT	1*
2.6/4	2.6/45	Relating delivery of care to team membership	1*
2.6/5	2.6/46	Lead Histopathologist for the MDT	1*
2.6/6	2.6/47	Consistency between histopathologists audit	1
2.6/7	2.6/48	Lead Imaging Consultant for the MDT	1*
2.6/8 UGS	2.6/49 UGS	MDT meetings – to be held weekly	1*
2.6/9	2.6/50	Core members attend half of MDT meetings	1*
2.6/10	2.6/51	Core members attend two thirds of MDT meetings	1
2.6/11	2.6/52	Cover arrangements for core members	1*
2.6/12	2.6/53	Annual operational policy meeting	1*
2.6/13	2.6/54	Operational policy – MDT review of new cancer patients	1*
2.6/14		Written operational policy – all patients discussed with a member of the relevant specialist team	1*
2.6/15		Written operational policy – General Practitioner informed of diagnosis by end of following working day	1
	2.6/55	Operational policy – patients discussed prior to referral between specialist teams	1*
2.6/16		Audit of timeliness of notification to general practitioners	2
2.6/17		Inform primary care on the appropriateness of referrals	1

DIAGNOSTIC & DIAG/ LOCAL TEAM STD	SPECIALIST TEAM STD	DESCRIPTION	LEVEL
	2.6/56 UGS	a) Meeting between representatives of the diagnostic and diagnostic/local care team and the specialist team b) Specialist team network audit project	1
	2.6/57	Follow-up arrangements	1
2.6/18 UGS	2.6/58 UGS	Radiologist reporting on cross sectional imaging	1
2.6/19 UGS	2.6/59 UGS	Interventional radiologist in core team	1*
	2.6/60 UGS	Core team member trained in endoscopic ultrasonography	1
	2.6/61 UGS	Endoscopic team member to regularly perform stenting	1*
	2.6/62 UGS	24hr on-call consultant specialist surgical cover for post operative care	1
	2.6/63 UGS	ITU and HDU facilities	1
	2.6/64 UGS	Meetings, operations and acute post-operative care in same hospital	1
2.6/20 UGS	2.6/65 UGS	<i>Specific standards on nursing qualifications are currently being reviewed</i>	
2.6/21 UGS	2.6/66 UGS	<i>Specific standards on nursing qualifications are currently being reviewed</i>	
2.6/22 UGS diagnostic/ local care		Endoscopic team member to regularly perform stenting	1*
2.6/23 UGS		Follow-up arrangements	1
2.6/24 UGS diagnostic		Names of extended team members or no team	1*
	2.6/67 UGS Specialist	Names of extended team members	1*
2.6/25 UGS diagnostic/ local care		Names of extended team members	1*
2.6/26	2.6/68	Arrangements for access to MDT	1*

DIAGNOSTIC & DIAG/ LOCAL TEAM STD	SPECIALIST TEAM STD	DESCRIPTION	LEVEL
2.6/27	2.6/69	Survey of patients experience undertaken	1*
2.6/28	2.6/70	Survey results presented and discussed at MDT	1
2.6/29	2.6/71	Action taken as a result of the survey	1
2.6/30 UGS	2.6/72 UGS	Written information material available	1*
2.6/31 UGS diagnostic		Diagnostic/referral decision	1*
2.6/32 UGS diag/local care team		Diagnostic/referral decision	1*
	2.6/73	Treatment planning decisions	1*
2.6/33 UGS	2.6/74 UGS	Clinical guidelines	1*
2.6/34 UGS diagnostic		Referral guidelines between teams	1*
	2.6/75 UGS Specialist	Referral guidelines between teams	1*
2.6/35 diag/local care team		Referral guidelines between teams	1*
2.6/36	2.6/76	Network wide dataset	1
2.6/37 UGS	2.6/77 UGS	Policy for collecting the MDS	1
2.6/38	2.6/78	Recording of dataset for individual patients	2
2.6/39	2.6/79	Network audit	2
2.6/40	2.6/80	Participation in approved clinical trials	2
APPENDIX		Responsibilities of MDT co-ordinator/ secretary	

Topic 2.6 – Upper GI Multidisciplinary Teams (MDT)

This topic covers standards for the UGI diagnostic team, the diagnostic/local care team and also for the specialist team.

Standards for UGI diagnostic team and the diagnostic/local care team are from 2.6/1 to 2.6/40.
Standards for Specialist UGI teams are from 2.6/41 to 2.6/80.

Objectives	<ul style="list-style-type: none"> To ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions. To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision-making and to support clinical governance/audit. To ensure that mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.
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Introduction

Assessors should enquire as to the agreed configuration of teams for each centre or unit and which is referred to in the list in standard 10.1.36. Only those teams in the list are eligible to be offered for assessment. The standards for the relevant team type (see below) should be applied to each team. See topic 2 the specialist multidisciplinary team introduction for guidance on which activities may be legitimately shared between teams and which may not.

UPPER GI DIAGNOSTIC TEAM AND DIAGNOSTIC/LOCAL CARE TEAM

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

The responsibility for assessment purposes for standards 2.6/1 and 2/6/2 lies with the Lead Clinician of the cancer centre or cancer unit whichever applies.

Note: Standards labelled UGS are Upper Gastrointestinal specific

<i>STANDARD & LEVEL</i>	<i>STANDARD</i>	<i>DEMONSTRATION OF COMPLIANCE</i>
MDT STRUCTURE		
Standard 2.6/1 Level 1*	There should be a single named Lead Clinician for the MDT who should then be a core team member.	Named clinician for the MDT agreed by the Lead Clinician of the centre or unit, whichever applies.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/2 Level 1*</div>	<p>The Lead Clinician of the MDT should have agreed the responsibilities of the position with the Lead Clinician of the centre or unit.</p> <p><i>Note:</i></p> <p><i>The role of Lead Clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i></p>	<p>The written responsibilities agreed by the Lead Clinician of the MDT and Lead Clinician of the centre or unit.</p> <p><i>Notes:</i></p> <p><i>The nature of these responsibilities is not subject to assessment save as per the standard.</i></p> <p><i>See appendix 1 at the end of topic 2 (page 109) for an illustration of the responsibilities of the role.</i></p>
<p>The responsibility for assessment purposes for the subsequent standards lies with the Lead Clinician of the MDT.</p>		
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/3 Level 1* UGS</div>	<p>The MDT should provide the names of core team members for named roles in the team.</p> <p>The core team specific to the UGI cancer diagnostic or diagnostic/local care team should include:</p> <ul style="list-style-type: none"> • One or more clinicians (physicians or surgeons) specialising in gastroenterology. • Endoscopist of any discipline, who could be one of the other team members. • Histopathologist (see pathology standards 3.2/info 1 to 3.2/info 3). • Radiologist (see imaging standards 3.1/info 1 to 3.1/info 2). • Nurse specialist. • MDT co-ordinator/secretary. <p><i>Notes:</i></p> <p><i>The MDT may choose to name additional core members. These are not subject to assessment, save as per the standard.</i></p> <p><i>Where a medical specialty is referred to the core team member should be a consultant. The cover for this member need not be a consultant (see standard</i></p>	<p>Name of each core team member agreed by the Lead Clinician of the MDT.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<p>2.6/11).</p> <p><i>The co-ordinator/secretary role needs different amounts of time depending on team workload. See the appendix at the end of this topic for illustration of the responsibilities of this role. The co-ordinator and secretarial roles may be filled by two different named individuals or the same one. It may not occupy the whole of an individual's job description. The responsibilities/job description are not subject to assessment, save as per the standard.</i></p>	
<p>This standard only applies to teams offering local care in addition to diagnostic services.</p>		
<p>Standard 2.6/4 Level 1*</p>	<p>Each consultant in the host hospital(s) of the MDT, who is responsible for the elective delivery of any of the major treatment modalities to UGI cancer patients (surgery, chemotherapy, radiotherapy) should be a core member of at least one MDT* for that cancer.</p> <p><i>Notes:</i></p> <p><i>*This need not be the MDT being assessed.</i></p> <p><i>This standard allows for (a) the treatment by non-MDT members of emergency presentations where the diagnosis is unforeseen and (b) the situation where a consultant core member because of special interest or experience offers advice or treatment to the patient of another MDT for the same cancer type.</i></p>	<p>Assessors should enquire of the working practice of each consultant delivering these treatments for patients with UGI cancer in the host hospital(s).</p>
<p>Standard 2.6/5 Level 1*</p>	<p>There should be a single lead histopathologist for the MDT who should be a core member of the team.</p> <p><i>Notes:</i></p> <p><i>Histopathologist may be the lead histopathologist for more than one tumour site and need not report all cases for that site.</i></p> <p><i>Other histopathologists may also attend MDT meetings if desired.</i></p>	<p>Named histopathologist agreed by the Lead Clinician of the MDT.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>Standard 2.6/6 Level 1</p>	<p>If more than one histopathologist issues reports on the cancer site for the MDT, all those histopathologists reporting for that MDT should have subjected themselves to an audit of consistency between themselves of reporting results on that cancer site.</p>	<p>The written results of the audit.</p> <p><i>Note:</i> <i>The degree of consistency between them is not subject to assessment.</i></p>
<p>Standard 2.6/7 Level 1*</p>	<p>There should be a single lead Imaging Consultant for the MDT who should be a core member of the team.</p> <p><i>Notes:</i> <i>An imaging consultant may be the lead-imaging consultant for more than one tumour site and need not report all imaging for that site.</i> <i>Other imaging consultants may attend the MDT meetings as well.</i></p>	<p>Named Imaging Consultant agreed by the Lead Clinician of the MDT.</p>
MDT MEETINGS		
<p>Standard 2.6/8 Level 1* UGS</p>	<p>The MDT should hold its meetings <u>weekly</u>, and record core members attendance.</p>	<p>The programme of dated meetings. Attendance records of the meeting.</p>
<p>Standard 2.6/9 Level 1*</p>	<p>Core members or their arranged “cover” (see standard 2.6/11) should attend at least half of the number of meetings.</p>	<p>Attendance record of the MDT.</p> <p><i>Note:</i> <i>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. Assessors should use their judgement on this matter and should highlight in their report where this commitment is lacking.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>Standard 2.6/10 Level 1</p>	<p>Core members or their arranged cover (see standard 2.6/11) should attend at least two thirds of the number of meetings.</p>	<p>Attendance record of the MDT</p> <p><i>Note:</i></p> <p><i>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. Assessors should use their judgement on this matter and should highlight in their report where this commitment is lacking</i></p>
<p>Standard 2.6/11 Level 1*</p>	<p>The MDT should agree cover arrangements for each core member.</p> <p><i>Note:</i></p> <p><i>Where a medical specialty is referred to the cover for a core member need not be a consultant but if not, should be a Specialist Registrar or Staff Grade.</i></p>	<p>Written arrangements agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i></p> <p><i>The actual arrangements and judgements on their appropriateness are not subject to assessment save as in the note opposite.</i></p>
<p>OPERATIONAL POLICIES</p>		
<p>Standard 2.6/12 Level 1*</p>	<p>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.</p>	<p>Minutes of at least one meeting agreed by the Lead Clinician of the MDT to illustrate the recording of at least some operational policies.</p>
<p>Standard 2.6/13 Level 1*</p>	<p>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.</p> <p><i>Note:</i></p> <p><i>As stated in the NHS Cancer Plan the care of all patients should be formally reviewed by a multidisciplinary team. This will be done either through direct assessment or through formal discussion with the team by the responsible clinician. This will</i></p>	<p>Written operational policy agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i></p> <p><i>The contents of the policy are not subject to assessment save as per the standard.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<i>help ensure that all patients have the benefit of the range of expert advice needed for high quality care.</i>	
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/14 Level 1*</div>	<p>The MDT should have agreed a policy whereby all patients diagnosed with UGI cancer are discussed with a member of the relevant specialist team prior to referral to the specialist team or prior to proposed local care. The date at which the discussion took place should be recorded in the case notes.</p>	<p>The policy, agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i> <i>The contents of the policy are not subject to assessment save as per the standard.</i></p>
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/15 Level 1</div>	<p>The MDT should have agreed a policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner is informed of the diagnosis by the end of the following working day.</p>	<p>The written policy agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i> <i>The contents of the policy are not subject to assessment save as per the standard.</i></p>
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/16 Level 2</div>	<p>The MDT should have completed an audit against the policy in the preceding standard, of the timeliness of notification to general practitioners of the diagnosis of cancer.</p>	<p>The written results of the audit.</p> <p><i>Note:</i> <i>The results of the audit ie the degree of timeliness itself is not subject to assessment save as per the standard. The methodology is not subject to assessment.</i></p>
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/17 Level 1</div>	<p>The MDT should have agreed the following as one of its operational policies. To provide information to referring GPs and other PCOs on the appropriateness and timeliness of urgent and suspected cancer GP referrals in line with HSC 2000/013.</p> <p><i>Note:</i> <i>HSC 2000/013 specified that hospital clinicians will need to audit the appropriateness of the referral against the agreed referral criteria and to feedback information to PCOs and referring GPs. NHS Trusts will also need to monitor the number of patients referred as urgent, the</i></p>	<p>The written policy agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i> <i>The contents of the policy are not subject to assessment save as per the standard.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<i>proportion of urgent referrals who are subsequently found to have cancer, and the numbers of routine referrals who are found to have cancer.</i>	
Standard 2.6/18 Level 1 UGS	At least one of the core team radiologists should be a radiologist who regularly reports cross sectional imaging.	Assessors to enquire of imaging departmental arrangements.
Standards 2.6/19, 2.6/22, 2.6/23 apply to the diagnostic/local care team only.		
Standard 2.6/19 (diagnostic/ local care) Level 1* UGS	At least one of the core team radiologists should be an interventional radiologist.	Assessors to enquire of imaging departmental arrangements.
Standard 2.6/20	<i>Specific standards on nursing qualifications are currently being reviewed.</i>	
Standard 2.6/21	<i>Specific standards on nursing qualifications are currently being reviewed.</i>	
Standard 2.6/22 (diagnostic/ local care) Level 1* UGS	<p>The endoscopist member(s) of the core MDT should be among those regularly performing endoscopic stenting procedures for the host hospital.</p> <p><i>Note:</i></p> <p><i>This standard is intended to ensure that the team endoscopists have special expertise in stenting. The practitioner carrying out endoscopic stenting (the 'endoscopist' of this standard) may be of any discipline.</i></p> <p><i>The standard does not preclude the use of other methods of stenting, but these are not subject to the current standards.</i></p>	Assessors to enquire of the working arrangements of the relevant department of the host hospital.
Standard 2.6/23 Level 1 UGS	Follow-up arrangements between the specialist team and the referring diagnostic/local care team(s) may vary locally according to circumstances, but written follow-up guidelines should be agreed between the specialist team and the referring team(s).	<p>Follow-up guidelines agreed by the Lead Clinician of the specialist MDT and the Chair of the NSSG.</p> <p><i>Note:</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	The arrangements should include those for patients who are referred to the Specialist Team but are found to be unsuitable for specialist care.	<i>The contents of the guidelines are not subject to assessment save as per the standard.</i>
EXTENDED TEAM		
The following standard applies to the diagnostic team only.		
Standard 2.6/24 (diagnostic) Level 1* UGS	The MDT should provide the names of members of the extended team for named roles in the team. <i>Note:</i> <i>The MDT may choose to have no extended team. This should be stated in writing.</i>	Name of each extended team member or written agreement to have no extended team, agreed by the Lead Clinician of the MDT. <i>Note:</i> <i>The exact constitution of the extended team and judgements over its appropriateness are not subject to assessment save as per the standard.</i>
The following standard applies to the diagnostic/local care team only.		
Standard 2.6/25 (diagnostic/local care) Level 1* UGS	If they are not already offered as core team members, the named team for the extended MDT should include: <ul style="list-style-type: none"> • Palliative care team representative. • Dietitian. <i>Note:</i> <i>The MDT may wish to name additional extended team members. These are not subject to assessment save as per the standard.</i>	Name of each extended team member agreed by Lead Clinician of the MDT. <i>Note:</i> <i>The exact constitution of the extended team and judgements over its appropriateness are not subject to assessment save as per the standard.</i>
FUNCTIONS OF THE TEAM PROVIDING PATIENT CENTRED CARE		
Standard 2.6/26 Level 1*	Arrangements should be agreed (in addition to the initial clinic consultation in which the diagnostic/referral decision is communicated to the patient), such that, if necessary, patients and/or carers may gain access to members of the MDT to discuss problems or concerns.	Written arrangements agreed by the Lead Clinician of the MDT.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>Standard 2.6/27 Level 1*</p>	<p>The MDT should have undertaken or be undertaking a survey of its patients' experience of the services offered by the team.</p> <p><i>Notes:</i></p> <p><i>The survey should be carried out by personnel not perceived by the patients as being team members.</i></p> <p><i>The methodology is not subject to assessment save as per the standard.</i></p>	<p>The survey results (complete or in progress).</p> <p><i>Note:</i></p> <p><i>The contents of the results are not subject to assessment save as per the standard.</i></p>
<p>Standard 2.6/28 Level 1</p>	<p>If the survey in 2.6/27 has been completed the team should have presented and discussed its results at an MDT meeting and should have agreed at least one action point arising from the survey.</p>	<p>Extract of minutes of the MDT meeting.</p>
<p>Standard 2.6/29 Level 1</p>	<p>If the survey in 2.6/27 has been completed and presented and its results discussed at an MDT meeting, the team should have implemented at least one action point arising from the survey.</p>	<p>Assessors to enquire of actions taken.</p>
<p>Standard 2.6/30 Level 1* UGS</p>	<p>The MDT should provide written material for patients diagnosed as having cancer, which includes:</p> <ul style="list-style-type: none"> • Information specific to the local care team and specialist care teams to whom the MDT refers patients, about provision of the services offering treatment for that cancer site. <p><i>Note:</i></p> <p><i>Information should be formatted such that patients for local care and patients for specialist care are able to receive only that relevant to their particular level of care.</i></p> <ul style="list-style-type: none"> • <i>Information about patients' self-help groups if available.</i> • <i>Information about the services offering psychological, social and spiritual/cultural support if available.</i> 	<p>The written material (visual and audio if used – see note below)</p> <p><i>Notes:</i></p> <p><i>Its contents and format are not subject to assessment save as per the standard. It is recommended however that it is available in languages and formats understandable by patients including local ethnic minorities.</i></p> <p><i>This may necessitate the provision of visual and audio material.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<ul style="list-style-type: none"> Information specific to UGI cancer about the disease and its treatment options. 	
DIAGNOSTIC/REFERRAL DECISION		
The following standard applies to the diagnostic team only.		
<div style="border: 1px solid black; padding: 5px;"> Standard 2.6/31 (diagnostic) Level 1* UGS </div>	<p>The core MDT at their regular meetings should agree and record patients' diagnosis and subsequent referral. The record should include:</p> <ul style="list-style-type: none"> The identity of patients discussed. The diagnosis, at the time of making the referral decision. <ol style="list-style-type: none"> i) Benign ii) Malignant (with histological confirmation) iii) Malignant (without histological confirmation) Type of cancer (pancreatic or OG). Referral decision (which should be updated if necessary after the discussion of the case with a specialist team member): <ol style="list-style-type: none"> i) To which named team (if more than one is possible from the relevant configuration) ii) Level of care – specialist or local 	<p>Examples of the record of a meeting.</p> <p><i>Note:</i> Only exactly what is required in the list opposite is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence. For assessment purposes patient specific information should be anonymised.</p>
The following standard applies to the diagnostic/local care team only.		
<div style="border: 1px solid black; padding: 5px;"> Standard 2.6/32 (diagnostic/ local care) Level 1* UGS </div>	<p>The core MDT at their regular meetings should agree and record patients' diagnosis and subsequent referral. The record should include:</p> <ul style="list-style-type: none"> The identity of patients discussed. The diagnosis, at the time of making the referral decision. <ol style="list-style-type: none"> i) Benign ii) Malignant (with histological confirmation) iii) Malignant (without histological confirmation) 	<p>Examples of the record of a meeting.</p> <p><i>Note:</i> Only exactly what is required in the list opposite is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence. For assessment purposes patient specific information should be anonymised.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<ul style="list-style-type: none"> • Type of cancer (pancreatic or OG). • Referral decision (which should be updated if necessary after the discussion of the case with a specialist team member): <ul style="list-style-type: none"> i) Retained for local care by diagnostic/local care team ii) To which specialist team (named if more than one is possible from the relevant configuration). 	

CLINICAL GUIDELINES

<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Standard 2.6/33 Level 1* UGS </div>	<p>a) The MDT should agree network-wide clinical guidelines for patients diagnosed with UGI cancer, with the NSSG. The guidelines should state the parameters of disease stage and patient fitness which determine when each of the treatments/ procedures classified as local care or specialist care, in the Introduction are indicated.</p> <p>b) The diagnostic/local care team should agree with each of its specialist teams and the NSSG:</p> <ul style="list-style-type: none"> • which of the treatments/procedures classified as local care in the Introduction may be delivered by the local care team, subject to each case being discussed with a member of the specialist team prior to the proposed treatment. <p><i>Notes:</i> <i>See topic 10 standard 10.1/21.</i> <i>A diagnostic-only team would usually refer all patients directly to a specialist team</i> <i>Regionally agreed guidelines are not precluded but are not part of the standards since networks may operate in parts of more than one region.</i> <i>For compliance the NSSG should produce an agreed guideline and individual MDTs, for their compliance should agree to abide by it.</i></p>	<p>The clinical guidelines agreed by the Lead Clinician of the diagnostic/local care team and the chair of the NSSG.</p> <p><i>Note:</i> <i>The contents, completeness or judgements on the appropriateness of the guidelines are not subject to assessment save as per the standard.</i></p>
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STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
REFERRAL GUIDELINES BETWEEN TEAMS			
<p>The format of these standards and related standards in topic 10.1 is specific to UGI cancer. In view of (a) the various possible configurations of the service and (b) the need to have agreed the particular group of configurations for the network, the responsibility for assessment purposes for referral guidelines lies with the Lead Clinician of the MDT, the chair of the NSSG, and the chair of the NMG. For compliance the NMG in consultation with the NSSG should produce agreed guidelines and the individual MDT, for their compliance should agree to abide by them. The standards count towards the assessment of the NMG and the individual teams.</p>			
<p>The following standard applies to the diagnostic team only.</p>			
<table border="1"> <tr> <td data-bbox="132 696 411 837"> Standard 2.6/34 (diagnostic) Level 1* UGS </td> </tr> </table>	Standard 2.6/34 (diagnostic) Level 1* UGS	<p>The MDT should agree referral guidelines which includes the following:</p> <ul style="list-style-type: none"> • To what extent and in what circumstances the diagnostic team may further investigate a patient after the diagnosis of malignancy and before referral to other teams. • That patients who need specialist care are referred to teams offering specialist care with the names of the teams and their host hospitals. • That patients who need local care are referred to a team offering local care with the name of the team and their host hospitals. <p><i>Notes:</i></p> <p><i>Specialist care and local care are defined as in the Introduction to the UGI Standards.</i></p> <p><i>It is strongly recommended that when patients are referred for care to another team, all members of the referring MDT refer patients with a given cancer type to the same named team.</i></p> <p><i>Referral agreements between PCOs and the diagnostic team are dealt with in topic 10.1.</i></p>	<p>The referral guidelines agreed by the Lead Clinician of the MDT, chair of the NSSG and chair of the NMG.</p> <p><i>Notes:</i></p> <p><i>The contents of the guidelines are not subject to assessment save as per the standard.</i></p> <p><i>Diagnostic and diagnostic/local care teams may make referrals to specialist teams in another network on the grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (receiving) network, with their host hospitals.</i></p>
Standard 2.6/34 (diagnostic) Level 1* UGS			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
The following standard applies to the diagnostic/local care team only.		
<p>Standard 2.6/35 (diagnostic/ local care) Level 1*</p>	<p>The MDT should agree referral guidelines which includes the following:</p> <ul style="list-style-type: none"> To what extent and in what circumstances the diagnostic team may further investigate a patient after the diagnosis of malignancy and before referral to other teams. That patients who need specialist care are referred to teams offering specialist care with the names of the teams and their host hospitals. <p><i>Notes:</i> <i>Specialist care and local care are defined as in the Introduction to the UGI Standards.</i> <i>It is strongly recommended that when patients are referred for care to another team, all members of the referring MDT refer patients with a given cancer type to the same named team.</i></p> <p><i>Referral agreements between PCOs and the diagnostic team are dealt with in topic 10.1.</i></p>	<p>The referral guidelines agreed by the Lead Clinician of the MDT, chair of the NSSG and chair of the NMG.</p> <p><i>Notes:</i> <i>The contents of the guidelines are not subject to assessment save as per the standard.</i> <i>Diagnostic and diagnostic/ local care teams may make referrals to specialist teams in another network on the grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (receiving) network, with their host hospitals.</i></p>
DATA COLLECTION		
<p>Standard 2.6/36 Level 1</p>	<p>The MDT should agree the same minimum dataset (MDS) for UGI cancer with other UGI MDTs of all types across the network.</p> <p><i>Notes:</i> <i>See topic 10 standard 10.1/21.</i> <i>For compliance the NSSG should produce an agreed MDS and the individual MDT for their compliance should agree to abide by it.</i> <i>The NHS Cancer Plan sets out the timescale for the development of national minimum datasets. When these are available a network and the MDT should</i></p>	<p>The dataset agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p> <p><i>Note:</i> <i>The contents of the dataset are not subject to assessment save as per the standard.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
	<p><i>use the national dataset. Regionally agreed MDS are not precluded but are not part of the standard since networks may operate in parts of more than one region.</i></p> <p><i>These are clinical MDS. They are not the same as the National histopathological MDS referred to in topic 3, but may include part or all of the relevant histopathological MDS.</i></p>		
<table border="1"> <tr> <td data-bbox="132 651 411 736"> Standard 2.6/37 Level 1 UGS </td> </tr> </table>	Standard 2.6/37 Level 1 UGS	<p>The MDT should agree a single policy for the network with the NSSG specifying which team types collect which portions of the MDS.</p> <p><i>Note:</i></p> <p><i>For compliance the NSSG should produce a policy and the individual MDT for their compliance should agree to abide by it.</i></p>	<p>The written policy agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p> <p><i>Note:</i></p> <p><i>The contents of the policy are not subject to assessment save as per the standard.</i></p>
Standard 2.6/37 Level 1 UGS			
<table border="1"> <tr> <td data-bbox="132 1050 411 1135"> Standard 2.6/38 Level 2 </td> </tr> </table>	Standard 2.6/38 Level 2	<p>The MDT should have started to record their portion of the MDS (as agreed in standard 2.6.37) for each patient on proformas and/or in an electronically retrievable form.</p> <p><i>Notes:</i></p> <p><i>See topic 10 standard 10.1/21.</i></p>	<p>Examples of the recorded data for individual patients.</p>
Standard 2.6/38 Level 2			
<p>NETWORK AUDIT</p> <p><u>Introductory Notes:</u></p> <p>For assessment purposes a “network audit project” is an audit project related to the cancer site or sites, of the NSSG which is to be carried out by all MDTs for that cancer site in the network, each team’s results being identified. Because of the hierarchy of team types for UGI cancer, a given audit project, although it should be network-wide, may not involve all teams in the network.</p> <p>The minimum progress needed for compliance (since audit is a long and multi-stage process) is that at least two audit projects are agreed with the NSSG and the NMG with sources of funding where necessary, agreed with Commissioners and other sources. The MDT should agree to participate in the audit project annually for its compliance and the NSSG should produce the project with consultation, and with agreed funding, for the network, for its compliance.</p>			
<table border="1"> <tr> <td data-bbox="132 1830 411 1915"> Standard 2.6/39 Level 2 </td> </tr> </table>	Standard 2.6/39 Level 2	<p>The MDT should agree its participation in the UGI network or audit programme with the NSSG.</p> <p><i>Note:</i></p> <p><i>See topic 10 standard 10.1/23.</i></p>	<p>The network audit programme with the MDT’s participation agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p>
Standard 2.6/39 Level 2			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<i>HSC 2000/013 specified that hospital clinicians will need to audit the appropriateness of the referral against the agreed referral criteria and to feedback information to PCOs and referring GPs. NHS Trust will also need to monitor the number of patients referred as urgent, the proportion of urgent referrals who are subsequently found to have cancer, and the numbers of routine referrals who are found to have cancer.</i>	

PARTICIPATION IN APPROVED CLINICAL TRIALS

Introductory Note:

Because of the hierarchy of team types for UGI cancer, not every team may be able to enter patients into a given trial on the list.

<p>Standard 2.6/40 Level 2</p>	<p>The MDT should agree with the NSSG a single list of clinical trials and/or studies for the network for UGI cancer into which the MDT's patients may be considered for entry.</p> <p><i>Notes:</i></p> <p><i>See topic 10 standard 10.1.25.</i></p> <p><i>It is expected that approved trials will comprise multi-centre trials organised by recognised national and international research groups where possible.</i></p> <p><i>For their compliance the MDT should agree to abide by the list and for their compliance the NSSG produces the list for the network in consultation.</i></p>	<p>The network approved list of clinical trials and/or studies, agreed by the Lead Clinician of the MDT and the Chair of the NSSG.</p> <p><i>Note:</i></p> <p><i>The content of the list of clinical trials and/or studies is not subject to assessment save as per the standard.</i></p>
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MDT WORKLOAD

The issue of viable MDT workloads has been addressed in the IOG Upper GI guidelines by the requirement for minimum referral catchment populations for specialist teams and is dealt with in topic 10.1, in the UGI-specific standards for the NMG.

UPPER GI SPECIALIST TEAMS

This set of standards should be applied to both types of team (OG and pancreatic) noting that for standards 2.6/43 and 2.6/44 there are specific alternatives for each of the two team types.

The responsibility for assessment purposes for standards 2.6/41 and 2.6/42 lies with the Lead Clinician of the cancer centre or cancer unit whichever applies.

Note: Standards labelled UGS are Upper Gastrointestinal specific

Standards labelled UGS (OG) are Upper Gastrointestinal oesophago-gastric specific

Standards labelled UGS (P) are Upper Gastrointestinal pancreatic specific.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
MDT STRUCTURE		
Standard 2.6/41 Level 1*	There should be a single named Lead Clinician for the MDT who should then be a core team member.	Named Lead Clinician for the MDT agreed by the Lead Clinician of the centre or unit, whichever applies.
Standard 2.6/42 Level 1*	<p>The Lead Clinician of the MDT should have agreed the responsibilities of the position with the Lead Clinician of the centre or unit.</p> <p><i>Note:</i></p> <p><i>The role of Lead Clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</i></p>	<p>The written responsibilities agreed by the Lead Clinician of the MDT and Lead Clinician of the centre or unit.</p> <p><i>Notes:</i></p> <p><i>The nature of these responsibilities is not subject to assessment save as per the standard.</i></p> <p><i>See appendix 1 at the end of topic 2 (page 109) for an illustration of the responsibilities of the role.</i></p>
The responsibility for assessment purposes for the subsequent standards lies with the Lead Clinician of the MDT.		
The following standard applies only to the specialist pancreatic team.		
Standard 2.6/43 Level 1* UGS (P)	<p>The MDT should provide the names of core team members for named roles in the team.</p> <p>The core team specific to the specialist pancreatic MDT should include:</p>	Name of each core team member agreed by the Lead Clinician of the MDT.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<ul style="list-style-type: none"> • Two or more Hepato-pancreatico-biliary surgeons. <p><i>Notes:</i></p> <p><i>It is recommended that these do not function as OG surgeons.</i></p> <p><i>In order to achieve standard 2.6/62– a 24 hour surgical on-call rota – at least 3 specialist consultant surgeons per team would be needed. Standard 2.6/62 has not been given the highest (level 1*) priority for the forthcoming peer review in order to reflect the time needed to achieve this. It is intended to make it a level 1* priority for the following peer review round, however. It is recommended that the specialist teams now put in place the best surgical cover arrangements that they are able to and also begin to work towards completely fulfilling standard 2.6/62</i></p> <ul style="list-style-type: none"> • Physician gastroenterologist. • Radiotherapist (clinical oncologist). • Chemotherapist (clinical oncologist or medical oncologist). • Histopathologist (see pathology standards 3.2/info 1 to 3.2/info 3). • Radiologist (see imaging standards 3.1/info 1 to 3.1/info 2). • Nurse specialist. • Endoscopist of any discipline – who could be one of the other team members. • MDT co-ordinator/secretary. <p><i>Notes:</i></p> <p><i>The MDT may choose to name additional core members. These are not subject to assessment save as per the standard.</i></p> <p><i>Where a medical specialty is referred to the core team member should be a consultant. The cover for this member need not be a consultant (see standard 2.6/52).</i></p>	

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
	<p><i>The co-ordinator/secretary role needs different amounts of time depending on team workload. See the appendix at the end of this topic for illustration of the responsibilities of this role. The co-ordinator and secretarial roles may be filled by two different named individuals or the same one. It may not occupy the whole of an individual's job description. The responsibilities/job description are not subject to assessment.</i></p>		
<p>The following standard applies only to the specialist OG team.</p>			
<table border="1"> <tr> <td data-bbox="134 786 408 875"> Standard 2.6/44 Level 1* UGS (OG) </td> </tr> </table>	Standard 2.6/44 Level 1* UGS (OG)	<p>The MDT should provide the names of core team members for defined roles in the team.</p> <p>The core team specific to the specialist OG MDT should include:</p> <ul style="list-style-type: none"> • Two or more surgeons. <p><i>Notes:</i></p> <p><i>OG or thoracic surgeons may count as core team surgeons.</i></p> <p><i>It is recommended that these are not also hepato-pancreatico-biliary surgeons.</i></p> <p><i>In order to achieve standard 2.6/62 – a 24 hour surgical on-call rota – at least 3 specialist consultant surgeons per team would be needed. Standard 2.6/62 has not been given the highest (level 1*) priority for the forthcoming peer review in order to reflect the time needed to achieve this. It is intended to make it a level 1* priority for the following peer review round, however. It is recommended that the specialist teams now put in place the best surgical cover arrangements that they are able to and also begin to work towards completely fulfilling standard 2.6/62.</i></p> <ul style="list-style-type: none"> • Physician gastroenterologist. • Radiotherapist (clinical oncologist). • Chemotherapist (clinical oncologist or medical oncologist). • Histopathologist (see pathology standards 3.2/info 1 to 3.2/info 3). 	<p>Name of each core team member agreed by the Lead Clinician of the MDT.</p>
Standard 2.6/44 Level 1* UGS (OG)			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
	<ul style="list-style-type: none"> • Radiologist (see imaging standards 3.1/info 1 to 3.1/info 2). • Nurse specialist. • MDT co-ordinator/secretary <p><i>Notes:</i></p> <p><i>The MDT may choose to name additional core members. These are not subject to assessment save as per the standard.</i></p> <p><i>Where a medical specialty is referred to the core team member should be a consultant. The cover for this member need not be a consultant (see standard 2.6/52).</i></p> <p><i>The co-ordinator/secretary role needs different amounts of time depending on team workload. See the appendix at the end of this topic for illustration of the responsibilities of this role. The co-ordinator and secretarial roles may be filled by two different named individuals or the same one. It may not occupy the whole of an individual's job description. The responsibilities/job description are not subject to assessment.</i></p>		
<table border="1" style="width: 100%; height: 100%;"> <tr> <td style="padding: 5px;"> Standard 2.6/45 Level 1* </td> </tr> </table>	Standard 2.6/45 Level 1*	<p>Each consultant in the host hospital(s) of the MDT, who is responsible for the elective delivery of any of the major treatment modalities to UGI cancer patients (surgery, chemotherapy, radiotherapy) should be a core member of at least one MDT* for that cancer.</p> <p><i>Notes:</i></p> <p><i>*This need not be the MDT being assessed.</i></p> <p><i>This standard allows for (a) the treatment by non-MDT members of emergency presentations where the diagnosis is unforeseen and (b) the situation where a consultant core member because of special interest or experience offers advice or treatment to the patient of another MDT for the same cancer type.</i></p>	<p>Assessors should enquire of the working practice of each consultant delivering these treatments for patients with UGI cancer in the host hospital(s).</p>
Standard 2.6/45 Level 1*			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>Standard 2.6/46 Level 1*</p>	<p>There should be a single lead histopathologist for the MDT who should be a core member of the team.</p> <p><i>Notes:</i></p> <p><i>Histopathologist may be the lead histopathologist for more than one tumour site and need not report all cases for that site.</i></p> <p><i>Other histopathologists may also attend MDT meetings if desired.</i></p>	<p>Named histopathologist agreed by the Lead Clinician of the MDT.</p>
<p>Standard 2.6/47 Level 1</p>	<p>If more than one histopathologist issues reports on the cancer site for the MDT, all those histopathologists reporting for that MDT should have subjected themselves to an audit of consistency between themselves of reporting results on that cancer site.</p>	<p>The written results of the audit.</p> <p><i>Note:</i></p> <p><i>The degree of consistency between them is not subject to assessment.</i></p>
<p>Standard 2.6/48 Level 1*</p>	<p>There should be a single lead Imaging Consultant for the MDT who should be a core member of the team.</p> <p><i>Note:</i></p> <p><i>An imaging consultant may be the lead imaging consultant for more than one tumour site and need not report all imaging for that site.</i></p> <p><i>Other imaging consultants may attend the MDT meetings as well.</i></p>	<p>Named Imaging Consultant agreed by the Lead Clinician of the MDT.</p>
MDT MEETINGS		
<p>Standard 2.6/49 Level 1* UGS</p>	<p>The MDT should hold its meetings <u>weekly</u>, and record core team members attendance.</p>	<p>The programme of dated meetings.</p> <p>Attendance records of the meeting.</p>
<p>Standard 2.6/50 Level 1*</p>	<p>Core members or their arranged “cover” (see standard 2.6/52) should attend at least half of the number of meetings</p>	<p>Attendance record of the MDT.</p> <p><i>Note:</i></p> <p><i>The intention is that core</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
		<i>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. Assessors should use their judgement on this matter and should highlight in their report where this commitment is lacking.</i>
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/51 Level 1</div>	<p>Core members or their arranged cover (see standard 2.6/52) should attend at least two thirds of the number of meetings.</p>	<p>Attendance record of the MDT</p> <p><i>Note:</i> <i>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. Assessors should use their judgement on this matter and should highlight in their report where this commitment is lacking</i></p>
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/52 Level 1*</div>	<p>The MDT should agree cover arrangements for each core member.</p> <p><i>Note:</i> <i>Where a medical specialty is referred to the cover for a core member need not be a consultant but if not, should be a Specialist Registrar or Staff Grade.</i></p>	<p>Written arrangements agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i> <i>The actual arrangements and judgements on their appropriateness are not subject to assessment save as in the note opposite.</i></p>
OPERATIONAL POLICIES		
<div style="border: 1px solid black; padding: 2px;">Standard 2.6/53 Level 1*</div>	<p>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.</p>	<p>Minutes of at least one meeting agreed by the Lead Clinician of the MDT to illustrate the recording of at least some operational policies.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>Standard 2.6/54 Level 1*</p>	<p>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.</p> <p><i>Notes:</i></p> <p><i>As stated in the NHS Cancer Plan the care of all patients should be formally reviewed by a multidisciplinary team. This will be done either through direct assessment or through formal discussion with the team by the responsible clinician. This will help ensure that all patients have the benefit of the range of expert advice needed for high quality care.</i></p> <p><i>See Standard 2.6/14 for the discussion of all cancer patients seen by the diagnostic teams.</i></p>	<p>Written operational policy agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i></p> <p><i>The contents of the policy are not subject to assessment save as per the standard.</i></p>
<p>The next standard applies to specialist teams referring some cancer types to another specialist team elsewhere in the network or neighbouring network.</p>		
<p>Standard 2.6/55 Level 1* UGS</p>	<p>The MDT should have agreed a policy whereby all cancers diagnosed with the relevant cancer type are discussed with a member of the relevant specialist team prior to referral to that specialist team or prior to proposed local care. The date at which the discussion took place should be recorded in the case notes.</p>	<p>The policy agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i></p> <p><i>The contents of the policy are not subject to assessment save as per the standard.</i></p>
<p>For the following standard, the specialist team should comply with either section a) or section b).</p>		
<p>Standard 2.6/56 Level 1 UGS</p>	<p>a) During the year prior to the peer review visit, the specialist MDT should have held a meeting at which at least one core member representative of the specialist team met with at least one core member representative of each of its referring diagnostic, diagnostic/local care teams, and any specialist referring teams, to review all the cases during the previous year diagnosed as having cancer (with or without histological confirmation). At the meeting they should have ascertained whether all cases diagnosed with UGI cancer, relevant to that specialist team,</p>	<p>The minutes and attendance list of the meeting.</p> <p>The written results of the audit as applied to the specialist team in question.</p> <p><i>Note:</i></p> <p><i>The details of the results i.e. the level of consistency with the clinical and referral guidelines is not subject to assessment</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
	<p>were discussed with them, prior to referral or to proposed local care, and whether referrals were consistent with the network clinical and referral guidelines defined in standards 2.6/74 and 2.6/75.</p> <p>b) During the year prior to the peer review visit, the specialist team, with any other specialist teams in the network, should have carried out as one of the agreed network audit projects the following:</p> <p>An audit of cases (over at least the previous year) diagnosed as having cancer by its referring diagnostic and diagnostic/local care teams (with or without histological confirmation). Cases referred for specialist care and local care should be audited for consistency with the clinical and referral guidelines defined in standards 2.6/74 & 2.6/75. The audit should also ascertain whether all cases diagnosed with UGI cancer relevant to that specialist team were discussed with it prior to referral or to proposed local care.</p> <p><i>Notes:</i></p> <p><i>The meeting should include a representative of any specialist team referring a certain cancer type to the team in question, whether from within the network or from a neighbouring network.</i></p> <p><i>For sections a) and b) of this standard, compliance or non-compliance count towards the specialist MDT.</i></p> <p><i>In section b), completion of the relevant audit project would provide compliance for this standard as well as compliance for part of the network audit (see standard 2.6/79).</i></p>		
<table border="1" style="width: 100%;"> <tr> <td style="padding: 5px;">Standard 2.6/57 Level 1</td> </tr> </table>	Standard 2.6/57 Level 1	<p>Follow-up arrangements between the specialist team and the referring diagnostic/local care team(s) may vary locally according to circumstances, but written follow-up guidelines should be agreed between the specialist team and the referring team(s).</p> <p>The arrangements should include those for patients who are referred to the Specialist Team but are found to be unsuitable for specialist care.</p>	<p>Follow-up guidelines agreed by the Lead Clinician of the specialist MDT and the Chair of the NSSG.</p> <p><i>Note:</i></p> <p><i>The contents of the guidelines are not subject to assessment save as per the standard.</i></p>
Standard 2.6/57 Level 1			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
Standard 2.6/58 Level 1 UGS	At least one of the core team radiologists should be a radiologist who regularly reports cross sectional imaging.	Assessors to enquire of imaging departmental arrangements.
Standard 2.6/59 Level 1* UGS	At least one of the core team radiologists should be an interventional radiologist.	Assessors to enquire of imaging departmental arrangements.
Standard 2.6/60 Level 1 UGS	There should be a core team member trained in endoscopic ultrasonography.	Named team member and assessors to enquire of team member's training history.
Standard 2.6/61 Level 1* UGS	<p>The endoscopist core team member(s) should be among those regularly performing endoscopic stenting procedures for the host hospital.</p> <p><i>Note:</i></p> <p><i>This standard is intended to ensure that the team endoscopists have special expertise in stenting. The practitioner carrying out endoscopic stenting (the 'endoscopist' of this standard) may be of any discipline.</i></p> <p><i>The standard does not preclude the use of other methods of stenting, but these are not subject to the current standards.</i></p>	Assessors to enquire of hospital's working practice.
Standard 2.6/62 Level 1 UGS	<p>There should be 24 hour on-call consultant specialist surgical cover for post operative care.</p> <p><i>Note:</i></p> <p><i>To achieve this standard at least 3 specialist consultant surgeons per team would be needed. This standard has not been given the highest (level 1*) priority for the forthcoming peer review in order to reflect the time needed to achieve this. It is intended to make it a level 1* priority for the following peer review round, however. It is recommended that the specialist teams now put in place the best surgical cover arrangements that they are able to and also begin to work towards completely fulfilling this standard.</i></p>	24 hour on-call rota staffed by core team surgical members.

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
Standard 2.6/63 Level 1 UGS	There should be intensive care (ITU) and high dependency unit (HDU) facilities available in the hospital hosting the specialist MDT.	Assessors to view the facilities.
Standard 2.6/64 Level 1 UGS	The treatment planning meetings, operations and acute post-operative care activities of the MDT should all be carried out in the same hospital.	Assessors to view the facilities and enquire of team working arrangements.
Standard 2.6/65	<i>Specific standards on nursing qualifications are currently being reviewed.</i>	
Standard 2.6/66	<i>Specific standards on nursing qualifications are currently being reviewed.</i>	
EXTENDED TEAM		
Standard 2.6/67 Level 1* UGS	<p>The MDT should provide the names of members of the extended team for named roles in the team.</p> <p>If they are not already offered as core team members, the named team for the extended MDT should include:</p> <ul style="list-style-type: none"> • Cytopathologist. • Palliative care team representative. • Anaesthetist/intensivist. <p><i>Notes:</i></p> <p><i>The anaesthetist/intensivist should at least represent this specialty at MDT operational policy meetings and co-ordinate this aspect of the MDT's activities. Attendance at the treatment planning meetings of the MDT is not subject to assessment.</i></p> <p><i>The MDT may choose to name additional extended team members. These are not subject to assessment save as per the standard.</i></p>	<p>Name of each extended team member agreed by the Lead Clinician of the MDT.</p> <p><i>Note:</i></p> <p><i>The exact constitution of the extended team and judgements over its appropriateness are not subject to assessment save as per the standard.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
FUNCTIONS OF THE TEAM PROVIDING PATIENT CENTRED CARE		
Standard 2.6/68 Level 1*	Arrangements should be agreed (in addition to the initial clinic consultation in which the treatment planning decision is communicated to the patient), such that if necessary patients and/or carers may gain access to members of the MDT to discuss problems or concerns.	Written arrangements agreed by the Lead Clinician of MDT.
Standard 2.6/69 Level 1*	<p>The MDT should have undertaken or be undertaking a survey of its patients' experience of the services offered by the team.</p> <p><i>Notes:</i></p> <p><i>The survey should be carried out by personnel not perceived by the patients as being team members.</i></p> <p><i>The methodology is not subject to assessment save as per the standard.</i></p>	<p>The survey results (complete or in progress).</p> <p><i>Note:</i></p> <p><i>The contents of the results are not subject to assessment save as per the standard.</i></p>
Standard 2.6/70 Level 1	If the survey in 2.6/69 has been completed the team should have presented and discussed its results at an MDT meeting and should have agreed at least one action point arising from the survey.	Extract of minutes of the MDT meeting.
Standard 2.6/71 Level 1	If the survey in 2.6/69 has been completed and presented and its results discussed at an MDT meeting, the team should have implemented at least one action point arising from the survey.	Assessors to enquire of actions taken.
Standard 2.6/72 Level 1* UGS	<p>The MDT should provide written material for patients diagnosed as having cancer, which includes:</p> <ul style="list-style-type: none"> Information specific to the local care team and specialist care teams to whom the MDT refers patients, about provision of the services offering treatment for that cancer site. <p><i>Note:</i></p> <p><i>Information should be formatted such that patients for local care and patients for</i></p>	<p>The written material (visual and audio if used – see note below).</p> <p><i>Notes:</i></p> <p><i>Its contents and format are not subject to assessment save as per the standard. It is recommended however that it is available in languages and formats understandable by patients including local ethnic minorities.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<p><i>specialist care are able to receive only that relevant to their particular level of care.</i></p> <ul style="list-style-type: none"> • <i>Information about patients' self-help groups if available.</i> • <i>Information about the services offering psychological, social and spiritual/cultural support if available.</i> • <i>Information specific to UGI cancer about the disease and its treatment options.</i> 	<p><i>This may necessitate the provision of visual and audio material.</i></p>

TREATMENT PLANNING DECISION

Introductory Note:

As stated in the NHS Cancer Plan, the care of all patients should be formally reviewed by an MDT. This will be done either through direct assessment or through formal discussion with the team by the responsible clinician. This will help ensure that all patients have the benefit of the range of expert advice needed for high quality care.

<table border="1" style="width: 100%;"> <tr> <td style="padding: 5px;">Standard 2.6/73 Level 1*</td> </tr> </table>	Standard 2.6/73 Level 1*	<p>The core MDT, at their regular meetings should agree and record individual patient's treatment plans. A record is made of the treatment plan. The record should include:</p> <ul style="list-style-type: none"> • The identity of patients discussed. • The Multidisciplinary treatment planning decision i.e. to which modalities of specialist care, or local care (surgery, radiotherapy, chemotherapy, combinations or supportive care) they are to be referred for consideration. • In the case of patients referred for specialist care to another specialist team in the network, or in a neighbouring network, the named specialist team to which they are referred. <p><i>Note:</i></p> <p><i>A therapeutic operation may in effect form part of the initial essential investigation and staging procedure to render the patient suitable for discussion and for a subsequent treatment planning decision. This operation should be recorded.</i></p>	<p>Examples of the record of a meeting.</p> <p><i>Note:</i></p> <p><i>Only exactly what is required in the list opposite is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence. For assessment purposes patient specific information should be anonymised.</i></p>
Standard 2.6/73 Level 1*			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
CLINICAL GUIDELINES		
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Standard 2.6/74 Level 1* UGS </div>	<p>a) The MDT should agree network-wide clinical guidelines for patients diagnosed with UGI cancer, with the NSSG. The guidelines should state the parameters of disease stage and patient fitness which determine when each of the treatments/procedures classified as local care or specialist care, in the Introduction, and relevant to the specialist team's cancer type are indicated.</p> <p>b) The specialist team should agree with each of its referring teams and the NSSG:</p> <ul style="list-style-type: none"> • Which of the treatments/procedures classified as local care in the Introduction and relevant to the specialist team's cancer type, may be delivered by that local team subject to each case being discussed with a member of the specialist team prior to the proposed treatment. • Which sites may be used by specialist team members to deliver those 'specialist classified' treatments which may be carried out, outside the specialist team's host hospital. <p><i>Notes:</i></p> <p><i>See topic 10 standard 10.1/21.</i></p> <p><i>A diagnostic-only team would usually refer all patients directly to a specialist team.</i></p> <p><i>Regionally agreed guidelines are not precluded but are not part of the standards since networks may operate in parts of more than one region.</i></p> <p><i>For compliance the NSSG should produce an agreed guideline and individual MDTs, for their compliance should agree to abide by it.</i></p>	<p>The clinical guidelines agreed by the Lead Clinician of the specialist team and the chair of the NSSG.</p> <p><i>Note:</i></p> <p><i>The contents, completeness or judgements on the appropriateness of the guidelines are not subject to assessment save as per the standard.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
<p>REFERRAL GUIDELINES BETWEEN TEAMS</p> <p>The format of these standards and related standards in topic 10.1 is specific to UGI cancer. In view of (a) the various possible configurations of the service and (b) the need to have agreed the particular group of configurations for the network, the responsibility for assessment purposes for referral guidelines lies with the Lead Clinician of the MDT, the chair of the NSSG, and the chair of the NMG. For compliance the NMG in consultation with the NSSG should produce agreed guidelines and the individual MDT, for their compliance should agree to abide by them. The standards count towards the assessment of the NMG and the individual teams.</p>		
<p>Standard 2.6/75 Level 1* UGS</p>	<p>The MDT should agree referral guidelines which includes the following.</p> <ul style="list-style-type: none"> • To what extent and in what circumstances the referring diagnostic teams may further investigate a patient after the diagnosis of malignancy and before referral to the specialist team. • That patients who need specialist care are referred to (name of team being assessed) from the (name of referring diagnostic and diagnostic/local care teams). • That patients who need local care are referred to (name of team being assessed) from the (name of diagnostic teams referring for local care). (Applies to specialist teams also providing local care). • That patients who need specialist care in another network, are referred to (name of team in the other network) from the (name of the team being assessed). <p><i>Notes:</i></p> <p><i>Specialist care and local care are defined as in the Introduction to the UGI Standards.</i></p> <p><i>It is strongly recommended that when patients are referred for care to another team, all members of the referring MDT refer patients with a given cancer type to the same named team.</i></p> <p><i>Referral agreements between PCOs and UGI teams are dealt with in topic 10.1.</i></p>	<p>The referral guidelines agreed by the Lead Clinician of the MDT, chair of the NSSG and chair of the NMG.</p> <p><i>Notes:</i></p> <p><i>The contents of the guidelines are not subject to assessment save as per the standard.</i></p> <p><i>Specialist teams may receive referrals from diagnostic and diagnostic/local care teams in other networks on grounds of minimum catchment populations. The referral guidelines should then name the relevant teams in the other (referring) networks with their host hospitals.</i></p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
DATA COLLECTION		
<p>Standard 2.6/76 Level 1</p>	<p>The MDT should agree the same minimum dataset (MDS) for the whole of UGI cancer with other UGI MDTs of all types across the network.</p> <p><i>Notes:</i> See topic 10 standard 10.1/21. For compliance the NSSG should produce an agreed MDS and the individual MDT for their compliance should agree to abide by it. The NHS Cancer Plan sets out the timescale for the development of national minimum datasets. When these are available a network and the MDT should use the national dataset. Regionally agreed MDS are not precluded but are not part of the standard since networks may operate in parts of more than one region. These are clinical MDS. They are not the same as the National histopathological MDS referred to in topic 3, but may include part or all of the relevant histopathological MDS.</p>	<p>The dataset agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p> <p><i>Note:</i> The contents of the dataset are not subject to assessment save as per the standard.</p>
<p>Standard 2.6/77 Level 1 UGS</p>	<p>The MDT should agree a single policy for the network with the NSSG specifying which team types collect which portions of the MDS.</p> <p><i>Note:</i> See topic 10 standard 10.1/21. For compliance the NSSG should produce a policy and the individual MDT for their compliance should agree to abide by it.</p>	<p>The policy agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p> <p><i>Note:</i> The contents of the policy are not subject to assessment save as per the standard.</p>
<p>Standard 2.6/78 Level 2</p>	<p>The MDT should have started to record their portion of the MDS (as agreed in standard 2.6/77 for each patient on proformas and/or in an electronically retrievable form.</p>	<p>Examples of the recorded data for individual patients.</p>

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE	
NETWORK AUDIT			
<u>Introductory Notes:</u>			
<p>For assessment purposes a “network audit project” is an audit project related to the cancer site or sites, of the NSSG which is to be carried out by all MDTs for that cancer site in the network, each team’s results being identified. Because of the hierarchy of team types for UGI cancer, a given audit project, although it should be network-wide, may not involve all teams in the network.</p> <p>The minimum progress needed for compliance (since audit is a long and multi-stage process) is that at least two audit projects are agreed with the NSSG and the NMG with sources of funding where necessary, agreed with Commissioners and other sources. The MDT should agree to participate in the audit project annually for its compliance and the NSSG should produce the project with consultation, and with agreed funding, for the network, for its compliance.</p>			
<table border="1"> <tr> <td data-bbox="132 763 413 853"> Standard 2.6/79 Level 2 </td> </tr> </table>	Standard 2.6/79 Level 2	<p>The MDT should agree its participation in the UGI network or audit programme with the NSSG.</p> <p><i>Note:</i> See topic 10 standard 10.1/23. HSC 2000/013 specified that hospital clinician will need to audit the appropriateness of the referral against the agreed referral criteria and to feedback information to PCOs and referring GPs. NHS Trust will also need to monitor the number of patients referred as urgent, the proportion of urgent referrals who are subsequently found to have cancer, and the numbers of routine referrals who are found to have cancer.</p>	<p>The network audit programme with the MDT’s participation agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p>
Standard 2.6/79 Level 2			
<u>PARTICIPATION IN APPROVED CLINICAL TRIALS</u>			
<u>Introductory Note:</u>			
<p>Because of the hierarchy of team types for UGI cancer, not every team may be able to enter patients into a given trial on the list.</p>			
<table border="1"> <tr> <td data-bbox="132 1646 413 1736"> Standard 2.6/80 Level 2 </td> </tr> </table>	Standard 2.6/80 Level 2	<p>The MDT should agree with the NSSG a single list of clinical trials and/or studies for the network for UGI cancer into which the MDT’s patients may be considered for entry.</p> <p><i>Notes:</i> See topic 10 standard 10.1.25. It is expected that approved trials will</p>	<p>The network approved list of clinical trials and/or studies, agreed by the Lead Clinician of the MDT and the chair of the NSSG.</p> <p><i>Note:</i> The content of the list of clinical trials and/or studies is not subject to assessment save as</p>
Standard 2.6/80 Level 2			

STANDARD & LEVEL	STANDARD	DEMONSTRATION OF COMPLIANCE
	<p><i>comprise multi-centre trials organised by recognised national and international research groups where possible.</i></p> <p><i>For their compliance the MDT should agree to abide by the list and for their compliance the NSSG produces the list for the network in consultation.</i></p>	<p><i>per the standard.</i></p>
<p>MDT WORKLOAD</p>		
<p>The issue of viable MDT workloads has been addressed in the IOG Upper GI guidelines by the requirement for minimum referral catchment populations for specialist teams and is dealt with in topic 10.1, in the UGI-specific standards for the NMG.</p>		

This appendix is for illustration purposes. It is not subject to assessment.

APPENDIX

Responsibilities of the MDT co-ordinator/secretary include:

- **Arranging MDT meetings;**
- **Ensuring all necessary patient information is available for effective team functioning;**
- **Ensuring co-ordination and communication regarding individual patients between the team and its related teams (referring and specialist) in the network and neighbouring networks if relevant, and with its referring PCO's;**
- **Ensuring that all decisions about individual patients management and the attendance of MDT members are recorded;**
- **Ensuring that the discussion date of each UGI cancer case with the relevant specialist team is recorded in the case notes, and the MDT record is updated if necessary after discussion with the specialist team.**