# TOPIC 9 - THE SPECIALIST PALLIATIVE CARE TEAM (MDT)

## Introduction

The National Institute for Clinical Excellence has developed Guidance on Supportive and Palliative Care for patients with cancer. The standards under this topic are derived from the NICE recommendations in chapter 3 *Co-ordination of Care* and 7 *Specialist Palliative Care Services*.

A significant number of people with advanced cancer suffer from a range of complex problems – physical, psychological, social and spiritual – which cannot always be dealt with by generalist services in hospitals or the community. Much less frequently, people with early (curable) cancer may experience a similar range of problems and may benefit from specialist input. Their families and informal carers may also need expert support during their lives and in bereavement.

A range of core specialist palliative care services is required to meet these needs. Core services may be provided by the NHS and/or by the voluntary sector.

### Definition of Palliative Care

NICE employs the following definition of palliative care which is based on the 1990 WHO definition. Palliative care is:

"…… the active holistic care of patients with advanced, progressive illness. Managements of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments".

Palliative care is based on a number of principles, and aims to:

- Affirm life and regard dying as a natural process.
- Provide relief from pain and other symptoms.
- Integrate psychological and spiritual aspects of care.
- Offer a support system to help patients to live as actively as possible until death.
- Offer a support system to help the family cope during the patient's illness and in their own bereavement.

Palliative care is the responsibility of all health and social care professionals and is delivered by two distinct categories of staff:

- The patient and carers' usual professional carers.
- Professionals who specialise in palliative care, some of whom are accredited specialists.

### Relation to Cancer Networks

The NICE guidance on supportive and palliative care recommends that (paragraph 1.12), Strategic Health Authorities should ensure structures and processes are in place to plan and review local supportive and palliative care services. In this manual, for ease of reference, such structures are referred to as the "palliative care network".

They will be considered as, and peer reviewed as, an integral part of a named host cancer network.

In practice the details of such structures and the names they are given may vary from one cancer network to another. This is not subject to assessment provided the structures are put forward for review against these standards in "cancer networks, palliative care specific standards".

At the current time, caring for patients with cancer comprises a very large part of the workload of supportive and palliative care providers, although it is recognised that this may change with time. For this reason, the NICE guidance has been developed on the basis that supportive care and palliative care will be organised within the cancer network model and reviewed as stated above, within a given cancer network's cancer peer review process.

**Malignant and Non-Malignant Disease**

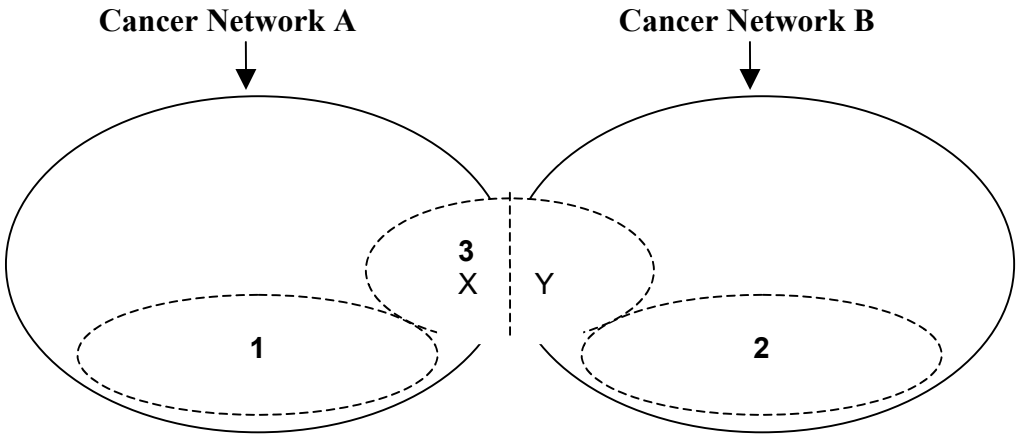
Although part of the palliative care service's activity is directed to patients who suffer from non-malignant disease, the standards apply to the service irrespective of whether the patients they are dealing with at a given time suffer from cancer or non-malignant disease. If some palliative care services or facilities specialise entirely in non-malignant disease, they should discus with the zonal peer review team whether they should be put forward for assessment.

**Relationship To Other Cancer Services Within The Cancer Network**

Palliative care is offered across NHS hospitals, voluntary sector and community settings. All of these settings will be subject to the standards and peer review. They do not necessarily coincide with a given network's way of organising the rest of its cancer services. This will be addressed as follows:

Regarding the palliative care network as defined above, much of its constituent palliative care services and teams will have similar catchments to the "local" or "secondary" catchments for the rest of cancer services, of the hospitals in their vicinity. It will then be self-evident that the cancer network to which these hospitals and cancer services belong is the cancer network which the collection of specialist palliative care teams in question, are an integral part of. They should be considered as the palliative care network of this particular cancer network and should be reviewed as part of this cancer network's review.

However, some teams (often voluntary sector and community-based ones) happen to serve a catchment population which is divided between more than one Cancer network for the rest of cancer services. These teams should be reviewed as part of only one cancer network. See the following for an illustration of this and of its implications.




1, 2, 3: Catchments of specialist palliative care teams.

Team 1: Reviewed as part of cancer network A's, palliative care network.

Team 2: Reviewed as part of cancer network B's, palliative care network.

Team 3: A decision has to be made and agreed with networks A and B, on which single cancer network's palliative care network it will join and be peer reviewed under. The team's clinical and referral guidelines should, as far as possible, be uniform and consistent with those of the single, chosen host cancer network. Some aspects of practice in part X, may have to be different from part Y, if local commissioners are different and similar agreements cannot be reached. This should be avoided if possible and is a matter for negotiation and then agreement by the chosen host network.

Referral contact points may well differ for certain highly localised services between parts X and Y. This should be dealt with in referral guidelines and is a matter of common sense.

At local level, an individual specialist palliative care team may function in settings which may over-arch NHS hospitals, the community and the voluntary sector. This may make it difficult to organise the specialist palliative care services across the network in a way which is coterminus with the local divisions into which the rest of cancer services are organised. The standards require that the latter are organised pragmatically into portions defined by the network according to the direction of patient flow and concentrations of population and facilities. These are termed "localities" and are more flexibly defined than previous cancer centres or cancer units although established centres and units would also comply as localities.

For the purposes of local management and organisation, specialist palliative care services should similarly be pragmatically divided into portions which the network agrees are appropriate according to patient flow and the concentrations of population and facilities. For the purposes of the standards and peer review, those portions are termed "areas". As explained above, they may not naturally coincide with the localities as defined for the rest of cancer services, particularly when considering the catchments of some voluntary sector hospices. This is not subject to assessment. It is strongly recommended, however, for clarity of management and organisation that the "localities" of cancer services and the "areas" of specialist palliative care are defined so as to be as coterminus as possible or at least to map simply onto each other.

**Geographical Extent and Level of Service Provisions**

The national guidance on certain specific cancer types results in definite levels of service provision expressed in terms of catchment populations or case workload for individual MDTs. It is also determined to some extent for all cancer types by the requirement that new patients should not be referred for definite anti-cancer treatment outside MDTs. The situation is not yet so clearly defined for the provision of palliative care to patients by specialist palliative care teams. Such patients may on occasion bypass the team entirely. The eventual aim is to provide the service at a level determined by population-based needs assessment. This principle is included in the standards but will not be fulfilled by some networks by the time of their peer review. As an interim standard therefore, it is required that all parts of the network and all settings for palliative care are covered by a named specialist palliative care team. The size of a given team's "patch" will not be subject to a limit. In order to assess the degree of coverage by teams, the network is required to name the catchments and palliative care settings which it encompasses and each team is required to do the same.

**Building The Palliative Care Network**

The above considerations give rise to the following process of building (or if it is already in operation, "clarifying and defining") the cancer network's palliative care network. The responsibility for this lies with the network palliative care group, and with the board.

(i) Agree the catchments and care settings encompassed by the palliative care network.

*Note:*

*The catchments and care settings will be expressed in terms of named NHS hospitals/hospices, voluntary sector hospitals/hospice and communities defined by their respective, named PCTs.*

(ii) For specialist palliative care teams covering catchments and care settings which span more than one cancer network for other cancer services, agree which single cancer network's peer review they will be assessed under and therefore, effectively, which single cancer network they belong to.

(iii) Agree the areas (as defined above) into which the palliative care network will be divided.

Agree for each area, the catchments and palliative settings which it encompasses, and which teams cover it.

**Assessing Specialist Palliative Care**

- The cancer network board's responsibilities in relation to specialist palliative care are assessed by applying the standards on palliative care in topic …… section 1, to the board and compliance counts toward the board's overall performance.

- The network palliative care group's responsibilities are assessed by applying the standards in topic …… section …… to the group, and compliance counts as the network palliative care group's performance.

- The responsibilities of the specialist palliative care teams are assessed by applying the standards in topic …… to each individual team in the network. Compliance counts as each individual team's performance.

**The standards in this topic should be applied to each specialist palliative care MDT and the results of their compliance count as the MDTs assessment.**

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| **Objectives** | • **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.**<br><br>• **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.** |

| ***STANDARD & LEVEL*** | ***STANDARD*** | ***DEMONSTRATION OF COMPLIANCE*** |
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| **MDT LEADERSHIP** | | |
| The responsibility for assessment purposes for standards …. to … lies with the area lead clinician for palliative care. | | |
| Standard<br>Level 1* | There should be a single named palliative care lead clinician for the team, who should be a core member of the team.<br><br>*Notes:*<br>*They may be from any clinical profession.*<br><br>*They may be the area palliative care lead clinician.* | The named clinician for the MDT, agreed by the area lead clinician for palliative care.<br><br>*Note:*<br>*If the team lead and the area lead are the same individual, this should be agreed by the network palliative care group chair.* |
| Standard<br>Level 1* | The team lead clinician for palliative care should have agreed the responsibilities of the position with the area lead clinician.<br><br>*Note:*<br>*The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.* | The written responsibilities agreed by the team lead and the area lead (or the network group chair, where the team and area lead are the same individual).<br><br>*Note:*<br>*The exact nature of these responsibilities are not subject to assessment, save as per the standard. See approx at end of topic… for an illustration of the responsibilities of this role.* |
| The responsibility for assessment purposes for standards … to … lies with the specialist palliative care team lead clinician. | | |

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| **TEAM CRITERIA** | | |
| Standard<br>Level 1* | The MDT should be listed as part of the services of a named locality of the network. | The list of services of the locality. |
| MDT STRUCTURE | | |
| Standard<br>Level 1* | *The MDT should provide the names of core team members for named roles in the team.*<br><br>*They should include:*<br><br>• *Palliative medicine specialist.*<br>• *Palliative care nurse specialist.*<br>• *MDT co-ordinator/secretary.*<br><br>*Notes:*<br>*Where a medical speciality is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a speciality is referred to (e.g. colonoscopy in the case of colorectal MDTs) this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.*<br><br>*The medically qualified core member(s) depend on the cancer site of the MDT.*<br><br>*The coordinator/secretary role needs different amounts of time depending on team workload. See the appendix ……for an illustration of the responsibilities of this role. The co-ordinator and secretarial role may be filled by two different named individuals or the same one. It need not occupy the whole of an individual's job description. The responsibilities/job description are not subject to assessment save as per the standard.* | *The name of each core team member agreed by the lead clinician of the MDT.* |

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| | *There may be additional core members agreed for the team besides those listed above. This is not subject to assessment.* | |
| **MDT MEETINGS** | | |
| Standard<br>Level 1* | The MDT should hold its meetings, as described in standard …, weekly and record core members' attendance. | The programme of dated meetings.<br><br>Attendance records of the meetings. |
| Standard<br>Level 1* | Core members or their arranged "cover" (see standard …) should attend at least half of the number of meetings. | The attendance record of the MDT.<br><br>*Note:*<br>*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 judgments on this matter and should highlight in their report where this commitment is lacking.* |
| **Introduction**<br><br>This next standard is essentially the same as the previous standard but set at a lower priority level with the attendance at two thirds instead of one half. | | |
| Standard<br>Level 1 | Core members or their arranged "cover" (see standard …) should attend at least two thirds of the number of meetings. | The attendance record of the MDT.<br><br>*Note:*<br>*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 judgments on this matter and should highlight in their report where this commitment is lacking.* |
| Standard | The MDT should agree cover | Written arrangements agreed |

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| Level 1* | arrangements for each core member.<br><br>*Note:*<br>*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.*<br><br>*It is recommended, however that where an MDT has a single core member who is a consultant palliative medicine specialist, cover arrangements are agreed with a consultant palliative medicine specialist from another team.* | by the lead clinician of the MDT.<br><br>*Note:*<br>*The actual arrangements and judgements on their appropriateness are not subject to assessment save as in the note opposite.* |
| **EXTENDED TEAM** | | |
| Standard<br>Level 1* | If they are not already offered as core team members the named team for the extended MDT should include:<br><br>• Clinical psychologist.<br>• Social worker.<br>• At least one person agreed as representing care for patients' and carers' rehabilitation needs.<br>• At least one person agreed as representing care for patients' and carers' spiritual needs.<br>• At least one person agreed as representing bereavement care to families and carers.<br>• Oncologist.<br>• Anaesthetist with expertise in nerve blocking and neuro-modulation techniques.<br>• Pharmacist.<br><br>*Note:*<br>*The MDT may wish to name additional extended team members. These are not subject to assessment. For illustrative purposes only, additional team members which have been recommended include; dietician, speech and language therapist, providers of complementary therapies and* | The name of each extended team member agreed by the lead clinician of the MDT.<br><br>*Note:*<br>*The exact constitution of the extended team and judgements over its appropriateness are not subject to assessment save as per the standard.* |

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| | *creative activities.* | |
| **OPERATIONAL POLICIES** | | |
| Standard<br>Level 1* | 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. | Minutes of at least one meeting agreed by the lead clinician of the MDT to illustrate the recording of at least some operational policies. |
| Standard<br>Level 1* | There should be an operational policy, whereby all new patients to whom any members of the MDT intend to offer care or advice should be discussed by the team at the first available team meeting, as per standard …<br><br>*Note:*<br>*The MDT may in its network referral guidelines, intend to discuss patients at additional times to the above i.e. in addition to when they are newly presenting to the team. This is not assessed under this standard, but is addressed by the referral guidelines.* | The written operational policy agreed by the lead clinician of the MDT.<br><br>*Note:*<br>*The contents of the policy are not subject to assessment save as per the standard.* |
| Standard<br>Level 1* | There should be an operational policy whereby, a single named key worker for the patient's care at a given time is appointed from the MDT members, for each individual patient, and the name of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is appointed should be that of the nurse MDT member(s).<br><br>*Note:*<br>*For information:- according to the NICE palliative care guidance the key worker is a member of the team responsible for the lead on co-ordination within the team of care of an individual patient and acting in the capacity of single common administrative contact for the patient, carers and MDT.* | The written policy agreed by the lead clinician of the team.<br><br>*Note:*<br>*The contents of the policy are not subject to assessment save as per the standard.* |
| Standard<br>Level 1 | The above policy should have been implemented for patients who came under the MDTs care after | Assessors should spot check some of the relevant patients' case notes. |

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| | publication of these standards and who are under their care at the time of the peer review visit. | |
| Standard<br>Level 1 | The core imaging specialist should regularly report on imaging of the primary care site or sites of the MDT, by modalities agreed as in standard …. | The assessors should enquire as to the working practice of the core members' imaging department. |
| Standard<br>Level 1 | **24-Hour Telephone Advice Service**<br>The MDT should agreed to the palliative care network's service specification for the 24-hour telephone advice service (see standard …) and specify the staff members which it provides for the relevant rota. | The service specification agreed by the lead clinician of the MDT specifying the staff provided for the relevant rota. |
| Standard<br>Level 1 | **0900-1700 Hours Visiting Service**<br>The MDT should agree to the palliative care network's service specification for the 0900-1700 hours visiting service (see standard …) and specify the staff members which it provides for the relevant rota. | The service specification agreed by the lead clinician of the MDT specifying the staff provided for the relevant rota. |
| **SPECIALIST PALLIATIVE CARE MDT NURSE MEMBER STANDARDS** | | |

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**Introduction**

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

(i) The modern change to MDT working has created and then highly developed the specific role of nurse MDT member, with its related activities which, in full measure, go to make up the role of cancer nurse specialist. The roles of the medical specialties in the MDT have not been so profoundly influenced or so extensively developed by their MDT membership itself, compared to that of the MDT nurse member. The role definitions and training requirements of nurse MDT members are not very well "officially" established outside the MDT world in contrast to the well defined medical specialties with their formal national training requirements (e.g. there were thoracic surgeons and palliative care physicians, before there were established lung MDTs and specialist palliative care teams).

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

(ii) There has been a marked desire to incorporate training in communication skills into these nursing standards. However this is balanced by an equally marked difficulty in defining the boundaries of what might be considered as communication skills. Related to this is the problem that nursing courses in general oncology, cancer site specific oncology and specialist palliative care may overlap considerably with training in communication skills. Both these difficulties are addressed in the standards.

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| Standard<br>Level 1* | The MDT should have at least one core nurse member who should have enrolled in, or be undertaking, a programme of study in nursing practice which has been accredited for at least 20 level III CAT points and which incorporates module(s) in specialist palliative care.<br><br>*Notes:*<br>*For this round of peer review, core nurse MDT members who have previously completed ENB courses which include module(s) in specialist palliative care are considered to be compliant with this standard and standard ….*<br><br>*Nurses who are enrolled in or undertaking training for qualifications which may be of equal or greater academic professional standing to that defined in the standard and which include specialist palliative care, may be considered compliant and they should discuss this with the assessors.*<br><br>*It is strongly recommended that if there is more than one core nurse member in the MDT, they should all be compliant with this standard. This is not subject to assessment, however.*<br><br>*It is anticipated that for subsequent peer review rounds, all core nurse members will need to be compliant with this standard.* | The assessors should enquire of course start dates and the courses being undertaken. |
| Standard<br>Level 1 | The MDT should have at least one core nurse member who should have successfully completed a programme of study in nursing practice which has been accredited for at least 20 level III CAT points and which incorporates module(s) in specialist palliative care.<br><br>*Notes:*<br>*Compliance with this standard automatically confers compliance with standard…..*<br><br>*It is strongly recommended that if there is more than one core nurse member in the MDT, they should all be compliant with* | The certificate of successful completion of the course. |

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| | *this standard. This is not subject to assessment, however.*<br><br>*Nurses who already hold qualifications which may be of equal or greater academic/professional standing to those defined in the standard and which include specialist palliative care may be considered compliant and they should discuss this with the assessors. This includes qualifications which pre-date the CAT points system.* | |
| Standard<br>Level 1* | The MDT should have at least one core nurse member who should have enrolled in or be undertaking a course in communication skills, which is accredited for CAT points.<br><br>*Notes:*<br>*Nursing courses compliant with standard … would be considered compliant with this standard if they contained module(s) in communication skills (as defined below) which are accredited for CAT points.*<br><br>*For the purposes of peer review, courses in the following areas of practice, accredited for CAT points are compliant, as well as courses covering generic communication skills:*<br><br>*Counselling, breaking bad news, bereavement counselling and courses in the practice of any of the psychological therapies.*<br><br>*Nurses who are enrolled in, or undertaking training in those areas leading to first or higher degrees, will be compliant (as these will be accredited for CAT points).*<br><br>*It is strongly recommended that if there is more than one core nurse member in the MDT, they should all be compliant with this standard. This is not subject to assessment, however. It is anticipated that for subsequent peer review rounds, all core nurse members will need to be compliant with this standard.* | The assessors should enquire of course start dates and the courses being undertaken. |

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| Standard<br>Level 1 | The MDT should have at least one core nurse member who has successfully completed a course in communication skills which is accredited for CAT points.<br><br>*Notes:*<br>*Nursing courses compliant with standard… would be considered compliant with this standard if they contained module(s) in communication skills (as defined below) which are accredited for CAT points.*<br><br>*For the purposes of peer review, courses in the following areas of practice, accredited for CAT points are compliant, as well as courses covering generic communication skills.*<br><br>*Counselling, breaking bad news, bereavement counselling and courses in the practice of any of the psychological therapies.*<br><br>*Nurses who have previously obtained training qualifications in any of these areas and which pre-date the CAT points system and which may be of equal or greater academic/professional standing than those outlined in this standard, may be compliant and they should discuss this with the assessors. It is strongly recommended that if there is more than one core nurse member in the MDT, they should all be compliant with this standard. This is not subject to assessment, however. It is anticipated that for subsequent peer review rounds all core nurse members will need to be compliant with this standard.*<br><br>*Compliance with this standard automatically confers compliance with standard ….* | The certificate of successful completion of the course. |
| Standard<br>Level 1* | The MDT should have agreed a list of responsibilities with each of the core nurse members of the team, which includes the following:<br><br>• Contributing to the multi-disciplinary discussion and patient | The list of responsibilities agreed by the lead clinician of the MDT and the core nurse members. |

| *STANDARD & LEVEL* | *STANDARD* | *DEMONSTRATION OF COMPLIANCE* |
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| | assessment/care planning decision of the team at their regular meetings.<br>• Providing expert palliative care nursing advice and support to other health professionals providing palliative care.<br>• Involvement in clinical audit.<br>• Leading on patient communication issues and co-ordination of the patient's pathway for patients referred to the team; acting as the key worker or being responsible for nominating the key worker for the patient's dealings with the team.<br><br>*Note:*<br>*Additional responsibilities to those in this standard and the next standard may be agreed. This is not subject to assessment.* | |
| Standard<br>Level 1 | The MDT should have agreed a list of responsibilities with at least one of the core nurse members of the team, which, in addition to the items listed in standard …., includes:<br><br>• Contributing to the management of the service (see note below).<br>• Utilising research in the nurse's specialist area of practice.<br><br>*Notes:*<br>*"Management" in this context does not mean clerical tasks involving the documentation of individual patients i.e. this responsibility does not overlap with the responsibility of the MDT co-ordinator.*<br><br>*A list of responsibilities containing all the elements in this and the previous standard would encompass all of the four domains of specialist practice required for the role of nurse specialist.*<br><br>*Additional responsibilities to those in this and the previous standard may be agreed. This is not subject to assessment.* | The job description agreed by the lead clinician of the MDT and the relevant core nurse member. |

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| **FUNCTIONS OF THE TEAM** | | |
| Providing Patient Centred Care | | |
| **Introduction**<br><br>See also, the following standards which deal with this issue, but are included elsewhere:<br>• The network policy on information for patients (standard ……)<br>• Operational policy on the key worker (standard …. and for specialist palliative care MDTs standard …).<br>• Distribution of communication guidelines to all MDT members (standard ….)<br>• Distribution to all MDT members of the guidelines on patient assessment and palliative and supportive care in specific situations (standard …..)<br>• The team member nominated to have responsibility for information for patients' and users' issues (standard …) | | |
| Standard<br>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 an MDT to discuss problems or concerns. | Written arrangements agreed by the lead clinician of the MDT. |
| Standard<br>Level 1* | The MDT should have started to offer patients the opportunity of a permanent record or summary of at least a consultation at which the treatment options of their diagnosis were discussed.<br><br>*Note:*<br>*The MDT may, in addition, offer a permanent record of consultations undertaken at other stages of the patient's journey. This is not subject to assessment.* | The assessors should enquire of the working practice of the team and see examples of records given to patients.<br><br>*Note:*<br>*The detailed contents and methods of obtaining it or providing it are not subject to assessment. It is recommended however, that they are available in languages and formats understandable by patients including local ethnic minorities and patients who are not fully able. This may necessitate the provision of visual and audio material.* |

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| Standard<br>Level 1* | The MDT should have undertaken or be undertaking a survey of its patients' experience of the services offered by the team.<br><br>The survey should at least ascertain whether patients were offered:<br>• A key worker.<br>• The MDT's information for patients (written or otherwise).<br>• The opportunity of a permanent record or summary of a consultation at which their treatment options were discussed.<br><br>*Note:*<br>*There may be additional items in the survey. This is not subject to assessment but it is recommended that other aspects of their experience are covered.* | The survey results (complete or in progress).<br><br>*Note:*<br>*The content of the results are not subject to assessment save as per standards…. and …..* |
| Standard<br>Level 1 | If the survey in ….. 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<br>Level 1 | If the survey in …. has been completed and presented 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<br>Level 1* | The MDT should provide written material for patients which includes:<br><br>• Information about patient self-help groups if available and complying with the network quality criteria.<br>• Information about the services offering psychological, social and spiritual/cultural support, if available. | The written (visual and audio if used - see note below) material.<br><br>*Notes:*<br>*Its contents and format are not subject to assessment save as per the standard. It is <u>recommended</u> however that it is available in languages and formats understandable by patients including local ethnic minorities and those who are not fully able.*<br><br>*This may necessitate* |

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| | | *the provision of visual and audio material.* |
| Standard<br>Level 1* | There should be a checklist in each patient's case notes addressing whether the patient has been offered:<br>• A key worker.<br>• The MDTs information for patients (written or other formats).<br>• The opportunity of a permanent record or summary of a consultation at which their treatment options were discussed.<br><br>*Note:*<br>*The checklist may cover other issues. This is not subject to assessment.* | The assessors should see examples of case notes showing the checklist filled in. |
| **Assessment and Care Planning** | | |
| Standard<br>Level 1* | The MDT at their regular weekly meetings should record the following on at least the newly referred patients to the team.<br><br>• Patient identity.<br>• Diagnosis of underlying disease or cancer type.<br>• The assessed needs of the patient in relation to at least the following areas:<br><br>(i) Physical.<br>(ii) Psychological.<br>(iii) Social.<br>(iv) Spiritual.<br>(iv) Information needs.<br>(v) Carer(s) identity.<br><br>• A reference to the assessed needs of the patient's carers.<br>• A care plan for the patient (and, if identified by the MDT as requiring it, a plan for the carers) naming those members of the core and/or extended team, or other agencies who are intended to contribute to the care.<br><br>*Note:*<br>*The MDT may choose to discuss patients at other stages in their pathway, and in relation to other specifically identified areas of need. This is not assessed in this* | Examples of a record of a meeting.<br><br>*Note:*<br>*Only exactly what is specified in the list opposite is necessary for evidence. Minutes of discussions over patients are not required.*<br><br>*For assessment purposes, patient-specific information should be anonymised.* |

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| | *standard. These issues are addressed under referral guidelines and clinical guidelines.* | |
| **Referral Guidelines** | | |
| **Introduction**<br><br>The guidelines and arrangements identified in standards … to … are essentially about referring a patient to different aspects of the palliative care service and between different parts within the service. They are therefore classed as the palliative care equivalent of referral guidelines. The network, for its compliance with standards …. to ….. should produce network-wide guidelines and the individual MDT, for its compliance with standards ….. to …. should agree to abide by the relevant parts of them. | | |
| Standard<br>Level 1* | **Use of Core Services**<br>The MDT should agree guidelines with the network for those core palliative care services which the team covers (out of: inpatient care, day care facilities, outpatient clinic and community-based care). The guidelines should deal with:<br><br>• Patient referral criteria.<br>• Where relevant, admission and discharge criteria.<br>• Local contact points for each service. | The written guidelines agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |
| Standard<br>Level 1* | **24-Hour Telephone Advice Service**<br>The MDT should agree the network guidelines for its 24-hour telephone advice service with their locally relevant information. | The written network guidelines, agreed by the lead clinician of the MDT and the area lead clinician (or network palliative care group chair where the team and area lead are the same individual).<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |
| Standard<br>Level 1* | **0900-1700 Hours Visiting Service**<br>The MDT should agree the network guidelines for its 0900-1700 visiting service, with their locally relevant information. | The written network guidelines, agreed by the lead clinician of the MDT and the area lead clinician (or network palliative care group chair where the team and |

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| | | area lead are the same individual).<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |
| Standard<br>Level 1* | **MDT Review and Discussion**<br>The MDT should agree guidelines with the network, stating the criteria which determine the need for MDT review/discussion of a given patient at the weekly team meeting. | The written guidelines agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |
| Standard.<br>Level 1* | **Care Co-ordination**<br>The MDT should agree with the network, the arrangements by which the palliative care of a given patient may be co-ordinated across the different core services, localities and specialist teams which they may need to access.<br><br>The arrangements should make reference to the role of the key worker, identified in standard ….<br><br>It is strongly recommended that the referral guidelines and arrangements make reference to the concept of the patient care pathway and the key stages of it, at which assessment for palliative and supportive care might be needed:<br><br>• Time of diagnosis.<br>• Commencement of the definitive treatment of the disease.<br>• Completion of the primary treatment plan.<br>• Disease recurrence or relapse.<br>• The point of recognition of incurability. | The written arrangements agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The contents of the arrangements are not subject to assessment save as per the standard.* |

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| | • *End of life care.*<br>• *Other times requested by the patient.*<br><br>*It is difficult to set a precise standard around the incorporation of this complex model into guidelines. Therefore it is not in the wording of the standards themselves, in order to avoid debates between assessors and those being assessed, over what constitutes an acceptable, patient care pathway.* | |
| **Clinical Guidelines** | | |
| **<u>Introduction</u>**<br><br>Standards …. and …. are essentially about how to offer palliative and supportive care to a given patient in a given situation, rather than being about patient referrals. They are therefore classed as the palliative care equivalent of clinical guidelines. The network for its compliance with standards …. to …. should produce network-wide guidelines and the individual MDT, for its compliance with standards …. To … should agree to abide by them. | | |
| Standard<br>Level 1* | **Patient Needs Assessment**<br>The MDT should agree with the network, guidelines for patient assessment in relation to the following areas of potential need:<br><br>• Physical.<br>• Psychological.<br>• Social.<br>• Spiritual.<br>• Carers' needs.<br>• Information needs. | The written guidelines, agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |
| Standard<br>Level 1* | **Palliative Care in Specific Situations**<br>The MDT should agree with the network, guidelines for palliative care of a given patient, in at least the following situations:<br><br>• Control of specific named symptoms.<br>• Palliative interventions for common symptom emergencies.<br>• Care of dying patients and their carers.<br><br>*Note:*<br>*The MDT may agree additional clinical guidelines with the network, to those listed above. This is not subject to assessment.* | The written guidelines, agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The contents of the guidelines are not subject to assessment save as per the standard.* |

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| | It is strongly recommended that the referral guidelines and arrangements make reference to the concept of the patient care pathway and the key stages of it, at which assessment for palliative and supportive care might be needed:<br><br>• Time of diagnosis.<br>• Commencement of the definitive treatment of the disease.<br>• Completion of the primary treatment plan.<br>• Disease recurrence or relapse.<br>• The point of recognition of incurability.<br>• End of life care.<br>• Other times requested by the patient.<br><br>It is difficult to set a precise standard around the incorporation of this complex model into guidelines. Therefore it is not in the wording of the standards themselves, in order to avoid debates between assessors and those being assessed, over what constitutes an acceptable, patient care pathway. | |
| **Data Collection** | | |
| Standard<br>Level 1 | The MDT should agree as an operational policy, to collect the national palliative care minimum dataset (MDS) on each of its patients. | The MDS, agreed by the lead clinician of the MDT. |
| Standard<br>Level 2 | The MDT should have started to record the MDS for each patient on proformas or in an electronically retrievable form. | Assessors should examine examples of the recorded data on individual patients. |

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| **Network Audit** | | |
| **Introduction**<br><br>For assessment purposes a "network audit project" is an audit project related to palliative care which is to be carried out by all specialist palliative care MDTs in the network, each team's results being identified.<br><br>The minimum progress needed for compliance (since audit is a long and multi-stage process) is that at least one audit project is agreed with the network palliative care group with sources of funding where necessary, agreed with commissioners or other sources. The MDT should agree to participate in the audit projects for its compliance and the network group should produce the projects with consultation, and with agreed funding for the network for its compliance with standard ….. | | |
| Standard<br>Level 1* | The MDT should agree at least one network audit project with the network palliative care group, which is the project or one of the projects identified in standard …. | The named written project with named sources of funding where necessary, agreed by the lead clinician of the MDT and the network palliative care group chair.<br><br>*Note:*<br>*The nature or appropriateness of the project is not subject to assessment save as per the standard. The assessors may wish to comment in their report, however.* |
| Standard<br>Level 2 | The MDT should have presented the results of at least one completed network audit project, to a meeting of the network palliative care group.<br><br>*Note:*<br>*Compliance with standard … automatically confers compliance in addition, with standards …. and ….* | An extract of the minutes of the relevant meeting of the network palliative care group. |