

## UK LUNG CANCER COALITION

### THE DREAM MDT FOR LUNG CANCER: A GREEN PAPER FOR DELIVERING WORLD CLASS LUNG CANCER CARE

#### Introduction

Clinical guidelines are an important part of the drive to improve standards of care. However, by the nature of their production, they are often out of date, can only make recommendations based on very firm published evidence and tend to concentrate on the technical elements of treatment. The Clinical Advisory Group of the UK Lung Cancer Coalition (UKLCC), whilst accepting the authority and role of such documents was keen to go beyond standard guidelines and to describe an 'aspirational' approach to the treatment and management of lung cancer: the sort of care that they would wish for members of their own family.

Lung cancer is a disease with a very wide range of symptoms, speed of growth and patterns of local and distant spread. Many patients also have co-morbidities such as COPD and ischaemic heart disease. It is the combination of all these factors, together with the individual circumstances of a patient and their families which means that every patient poses a unique challenge to the clinical team charged with their care.

The National Lung Cancer Audit has revealed that wide variations persist in lung cancer treatment and care within the UK, whilst international studies have found that survival rates lag behind other comparable EU countries.<sup>1</sup> Multi-disciplinary teams have been at the heart of delivering improved care for many cancers. However, in the UK there are insufficient specialists to service effectively the large number of lung cancer MDTs, of which there are currently around 240. There is also a spectrum of expertise and varying depth of specialist thoracic interest across these MDTs. Unfortunately, some healthcare professionals still have a nihilistic view of what outcomes can be achieved for patients with lung cancer, which is compounded by patients with low expectations who may be reluctant to demand better care.

The UKLCC believes that in order to reach its goal of doubling lung cancer survival, the lung cancer community must work together to ensure that all areas are delivering world class care. We are therefore looking to develop a consensus document setting out how effective multi-disciplinary teams - the 'dream MDT' - can improve the quality of care for lung cancer patients.

This Green Paper was developed by the UKLCC's clinical advisory group, representatives of each specialist field involved in lung cancer care, who were brought together to identify a 'gold standard' of practice based on, but not constrained by, the highest level of evidence. Throughout we have tried to keep the needs of the patient at the heart of the dream MDT and ensure that our recommendations cover the whole patient pathway rather than focusing solely on the diagnostic MDT meeting. The recommendations should challenge lung cancer practice to strive to exceed, rather than simply meet, NICE guidelines.

We are now seeking the views of the lung cancer community on this guide for how a world class MDT should operate. We would like to hear your thoughts on whether our recommendations are aspirational enough, whether they cover all the key qualities of an effective MDT, and whether there are any omissions. We will then consider how to incorporate the views of respondents to produce a guide on running '*The Dream MDT for Lung Cancer*'.

We have posed the following questions for organisations or individuals who would like to submit their views on this UKLCC Green Paper.

Q1. In general, do you support the recommendations set out in *'The Dream MDT for Lung Cancer: A Green Paper for Delivering World Class Lung Cancer Care'*?

Q2. Do you have any comments on specific recommendations? If so, please reference which recommendation your comments relate to.

Q3. If you do not agree with any of the recommendations then please explain what you would change and why.

Q4. Are there any areas not covered by the recommendations which you think should be

included in 'A Green Paper for Delivering World Class Lung Cancer Care'?

Q5. Which of these recommendations should be prioritised?

Q6. Do you have any other comments on *'The Dream MDT for Lung Cancer: A Green Paper for Delivering World Class Lung Cancer Care'*?

Consultation Document

Please send your responses to Tricia Bryant, UKLCC Secretariat, at [tricia@redhotirons.com](mailto:tricia@redhotirons.com) by **24 February 2012**.

Please also fill in the following details about your organisation:

Organisation	
Title (e.g. Dr, Mr, Ms, Prof)	
Name	
Job title or role	
Address and post code	
Telephone number	
Email address	
Are you happy to be named as a consultee to the Dream MDT for Lung Cancer: A Green Paper for Delivering World Class Lung Cancer Care'?	

### How this Green Paper was developed

A panel of senior clinicians was assembled, each representing particular specialisms involved in the care of lung cancer patients, from the time of first suspicion of the diagnosis through to palliative care. The members of this group were:

Dr Mick Peake – *Consultant Respiratory Physician, Glenfield Hospital, Leicester, and National Clinical Lead for Lung Cancer*

Dr David Bellamy – *Retired GP with a specialist interest in respiratory medicine*

Professor Michael Lind – *Professor of Medical Oncology, The University of Hull*

Dr John Reynolds – *Consultant Radiologist, Birmingham Heartlands Hospital*

Dr Robert Rintoul – *Consultant Chest Physician, Department of Thoracic Oncology, Papworth Hospital NHS Foundation Trust*

Dr Mike Snee – *Consultant Clinical and Medical Oncologist, St. James's University Hospital*

Mr Richard Steyn – *Consultant Thoracic Surgeon, Birmingham Heartlands Hospital*

Mr John White – *Lead Macmillan Lung Cancer Nurse Specialist, Leeds Teaching Hospitals NHS Trust*

Dr Dean Fennell – *Consultant Senior Lecturer in Medical Oncology, Queen's University, Belfast and Cancer Research UK Clinician Scientist*

Professor Stephen Spiro – *Professor of Respiratory Medicine, University College London Hospitals*

Professor Keith Kerr – *Consultant Pathologist, Aberdeen Royal Infirmary*

Dr Andrew Wilcock – *Palliative medicine, Nottingham University Hospitals NHS Trust*

Dr Ian Williamson – *Consultant Respiratory Physician, Gwent Healthcare NHS Trust*

During a roundtable meeting the group discussed the key characteristics of a 'dream MDT' for lung cancer. Following this meeting, each clinician was asked, taking into account published national and international guidelines and any high quality recently published evidence, to write a description of the nature of the 'ideal' service they would wish one of their loved ones to experience if they were unfortunate enough to develop lung cancer. The result is best seen as an expert consensus document and is intended to stimulate discussion amongst the lung cancer community on how an effective MDT can help to deliver aspirational lung cancer care which improves outcomes for patients.

## The Dream MDT

We believe that patients' perspectives and needs should be kept at the forefront of the dream MDT. Patients have highlighted that their main priorities are:

- *Informed choice*: being able to make real informed choices about treatment based on authoritative and clear explanations of the options.
- *Continuity of care*: a consistent, accessible point of contact to avoid feeling abandoned by the system, particularly after hospital care.
- *Holistic support*: help and support with distressing physical, psychological, social, spiritual and financial needs.
- *Support for carers*: addressing their information and support needs which may differ from the patient.

Clinicians do tend to focus on treating the disease, and should focus more on treating the patient in the context of their environment. Social workers, while not needing to be present at the MDT meeting itself, should be linked more closely into the MDT in order to ensure patients' and carers' practical needs are addressed.

**Recommendation 1 : The clinical MDT should be supported by an extended team that includes, for example, allied health professionals and social workers, to ensure patients' and carers' practical needs are addressed. This should be put in place from suspected or confirmed diagnosis, and work with the clinical MDT during investigation, active treatment, into chronic care and follow up**

### Lung Cancer Nurse Specialist (CNS) Support

Many CNSs meet patients at the point of diagnosis but in the dream lung cancer MDT they should be involved pre-diagnosis. Lung CNSs work differently to those caring for patients with other cancers, supporting patients from initial presentation through investigations to treatment, into palliation and supportive care, and are critical to ensuring continuity of care.

This pathway crosses multiple specialities and the lung CNS is essential for ensuring continuity of care in what can be a swift, confusing and short patient journey. CNSs serve important roles as links between clinicians from different specialities acting as advocates and liaising between specialities (including primary care and palliative care teams). They also have an important training and teaching role, especially with junior doctors and non-specialist nurses.

CNSs provide holistic assessment for patients, covering physical, emotional, social, spiritual, sexual, financial and everyday life needs, triaging to other services if needed. Lung CNSs have a special role to play in communicating information and enabling patients to take a full role in decisions around their care, and patients often tell the lung cancer CNSs things that they will withhold from their doctor. Data from the National Lung Cancer Audit have also revealed the influence that CNSs may have in supporting patients to choose active treatment.

**Recommendation 2: All lung cancer patients should be able to access lung CNS support when they need it throughout their whole patient journey to support their holistic needs**

**Recommendation 3: Lung cancer CNSs should be involved with pre-diagnosis care of suspected lung cancer patients**

CNSs should be patient advocates at MDT meetings and throughout the pathway. This is especially important as patients may transfer rapidly between a surgeon, radiotherapist and chemotherapist, when their initial treatment is being evaluated. This frequently causes confusion to the patient as to who is in charge. CNSs influence the smooth running of the pathway for the patient, especially in complex cases, and should be able to access other clinical services quickly if needed. However, they should not be deployed as a general administrator.

In some cases, patients may revert to the tertiary centres to seek out information or support. There is a burden of workload and it is not uncommon for follow-up clinics to be seeing 30 or 40 people, some of whom probably don't need to be seen but could be supported at home through outreach services. There is a potential for nurse-led clinics for patients after active treatment to provide a holistic assessment and to co-ordinate any care needs which may prevent unnecessary hospital admissions or facilitate a planned admission to an appropriate speciality.

However, it must be recognised that the lung CNS workforce is already overstretched with, on average, every lung CNS having an annual case load of 132 patients, compared with, for example, breast cancer where that figure is only 82. In small units with only one full-time or part-time CNS there are therefore issues around providing effective cover for leave and training. It is therefore crucial that the lung CNS role is protected in the face of financial cutbacks across the NHS and pressure for CNSs to take on general ward duties.

**Recommendation 4: Lung CNSs need to work closely with an MDT coordinator / tracker to ensure they are not taking on unnecessary administrative roles**

**Recommendation 5: Despite the financial pressures facing the NHS, the role of the lung CNS in ensuring optimal care for patients must be protected**

### **Primary Care**

Patients with lung cancer often fail to identify or ignore symptoms, meaning that they present late, with an average of three months' delay before seeking help. Action is therefore needed to increase public awareness of the early symptoms of lung cancer.

In the UK, each GP sees on average fewer than 2 patients with a new presentation of lung cancer each year. They may confuse lung cancer symptoms with much commoner conditions with a similar presentation such as COPD, persistent wheeze, or cough, or fail to connect less common symptoms (e.g. fatigue or weight loss) with the disease. Action is still needed to improve patient and GP awareness and new risk assessment tools may help to trigger alerts and speed early referral.<sup>2</sup>

Practice in Scandinavia indicates the importance of access to diagnostics for early diagnosis, and there is a small but significant group of patients (perhaps 3,500 a year) who if diagnosed earlier could be successfully treated. Primary care physicians should also be well informed and have a low threshold for referral of patients for investigation as soon as there is any reasonable level of suspicion of a diagnosis of lung cancer. GPs should

review the diagnostic pathway of every new lung cancer patient they see, to assess whether lessons could be learnt to shorten any diagnostic delay in the future.

GPs should have access to high quality electronic decision support systems and rapid, open access to chest x-rays. Chest x-rays should be a routine part of the diagnostic work up of COPD patients and repeated when there is any unexplained change in the symptoms.

NICE recommends urgent referral for a chest x-ray (CXR) if a patient has persistent symptoms for 3 weeks and even then not all CXRs are abnormal (5-10% may not show any evidence of a tumour). Small tumours or those in upper zones or positioned behind overlying structures can be easily missed on chest x-rays. Whilst CXR may be an acceptable first test it should not be relied upon to exclude a diagnosis of lung cancer and the threshold for having access to a CT scan should be significantly lower than at present in the UK.

**Recommendation 6: Where a chest x-ray is normal and clinical suspicion of a diagnosis of lung cancer remains, GPs should have locally agreed arrangements to have access to CT scans**

**Recommendation 7: Any chest x-ray or CT scan suggesting the possibility of a lung tumour, or a nodule greater than 9mm in diameter should directly trigger an appointment in a rapid access lung cancer clinic**

GPs could be better linked into the MDT given that they are an important point of contact and information for patients and carers. GPs should receive sufficient information from the hospital to determine what has and has not been discussed, and to be able to answer questions from patients and carers. It is important that GPs are informed about what isn't appropriate for the patient, as well as what is. More time at consultation and copying patients into correspondence would also be a valuable change to practice.

**Recommendation 8: A greater focus should be given to preparation for discharge, and improving transfer of care between secondary and primary/community care. GPs need to be kept informed on where patients and their families are in their patient journeys**

**Recommendation 9: A template feedback form from diagnostic MDT to primary care should be created to smooth transfer of care**

### **Primary – Secondary care interface**

Reports of all chest x-rays and CT scans where the possibility of a lung cancer diagnosis is raised should be sent urgently both to the referring clinician and to the lung cancer team, or should automatically trigger a referral. Where the chest x-ray is suspicious of a lung tumour, a contrast-enhanced CT scan of the chest, neck and upper abdomen should be carried out and be available at the first clinic visit.

The interval between referral from the GP to first being seen in the specialist clinic should be as short as possible – ideally no more than a week. Patients should be told why they are being referred and be given access to a clinical nurse specialist from the time of referral.

### **Respiratory Medicine**

Referrals should be directed to a single specialist, rapid access, diagnostic clinic led by a respiratory physician with adequate training, experience and interest in thoracic oncology. Whilst acknowledging that there is no evidence to set a minimum number of cases per year to make a clinician or a team viable, we believe that patients would prefer to be cared for by clinicians who are dealing with lung cancer as a major part of their everyday working life. Thus, physicians in smaller units should not look after low numbers of patients 'to keep their hand in'. Care should be configured around the needs of patients and achieving best outcomes, rather than the wishes of physicians. In order to avoid deskilling physicians in hospitals with smaller numbers of patients, interested physicians should be involved in MDTs wherever possible (e.g. using videoconference technology).

**Recommendation 10: All suspected lung cancer cases should be dealt with by a respiratory physician with a specialist interest in lung cancer**

Waiting time targets (for England but not applicable in Wales) dictate that a patient must be seen in secondary care within 14 days from primary care referral. While this target has generally been fairly well met, patients do not always have their CT scan before their secondary care consultation, rendering this less useful and adding an additional appointment to the patient journey. In a number of leading centres (including Leeds, Leicester, Hull, Birmingham and Cambridge) dedicated rapid access clinics have been created. The patient has a CT scan prior to seeing the chest physician, or at the same visit. The radiologist reviews the scan, and meets with the physician, surgeon, CNS and radiologist to discuss the findings in a diagnostic and planning MDT meeting prior to the face to face meeting with the patient in clinic. This results in a very much more rapid and co-ordinated diagnostic and staging pathway and one where it is possible to give the patient a great deal more information early in the course of their care.

**Recommendation 11: Patients with a suspected lung cancer should be assessed at a dedicated rapid access clinic. Patients should have their CT scan before their respiratory consultation to provide sufficient time for the respiratory physician and radiologist to examine the scan results in a diagnostic MDT meeting prior to the first face to face meeting in clinic**

Patients should undergo the minimum number of investigations to establish an accurate tissue diagnosis, the stage of disease stage and their fitness for treatment. This approach would improve patient experience, save time and potentially reduce the cost to the NHS. For example, CT scans should cover the neck as well as the chest and thorax, and be available in clinic (as they are in breast clinics). Bronchoscopy should only be carried out after CT scan and every effort should be made to derive both a tissue diagnosis and disease stage from a single invasive investigation. Where there is mediastinal lymphadenopathy on CT scan consideration should always be given to how the enlarged nodes can be sampled, either by neck ultrasound, TransBronchial Needle Aspiration or Ultrasound guided node biopsy (EBUS or EUS). Encouraging greater use of PET-CT straight after early CT for patients with a good performance status would help to more accurately identify patients suitable for treatment with potential curative intent.

**Recommendation 12: The diagnostic pathway should be refined to encourage use of fewer, but higher value tests, likely to provide the diagnosis and stage of the disease in one step**

Dedicated chest physicians should take control of diagnostic and staging pathways.

**Recommendation 13: Each patient should be assigned a dedicated chest physician with a specialist commitment to lung cancer to manage their care through the whole pathway**

Lung cancer management is becoming increasingly complex and some of the most difficult problems (e.g. the treatment of limited stage Small Cell Carcinoma, the management of Stage IIIA/IIIB Non-Small Cell Lung Cancer, the radical treatment of patients with early stage NSCLC and poor lung function, etc.) are relatively uncommon and so may be seen quite irregularly. To manage such patients optimally it is of fundamental importance that all members of the MDT are both highly specialised and are able to attend the MDT meetings regularly. It is not possible to achieve this in every hospital.

**Recommendation 14: Specialist regional lung cancer MDTs should be established to deal with specified complex management problems**

**MDT Meeting Structure**

All patients should have their case discussed by a MDT made up of a full range of expert clinicians from the fields of: respiratory medicine, thoracic surgery, pathology, radiology, medical and clinical oncology, palliative care and lung cancer nursing. These individuals should be required to attend MDT meetings as part of their job description. No MDT should be chaired by a clinician without a strong interest in lung cancer. It is recommended that there should be a two stage MDT process – one diagnostic and one treatment focussed.

Meetings themselves benefit from a clear structure, with firm chairmanship to allow all voices to be heard in an amicable, collegiate atmosphere free from intimidation. Discussions should start with a succinct presentation with a clear question for the meeting – not just ‘can we review the radiology’. The case details should be presented by someone who knows the patient, is familiar with their history and views and so is able to answer further questions.

Technology now allows decisions and data to be added in real time at the MDT meeting to regional and national data submissions. A written summary of the MDT discussion should be available to all team members and provided to and discussed with the patient at their next visit. Clearly defined roles would enable follow up actions to be carried out smoothly, such as who is responsible for booking follow up investigations and/or clinic appointments – in the best units a patient ‘tracker’ is responsible for such things. A dedicated MDT coordinator and IT support are also vital.

Patients and carers want to know that the MDT meeting is happening, and wish to have face-to-face time with a clinician afterwards to understand what the recommended next steps are and what decisions they now need to make. The clinical advocacy of the CNS is vital in this process.

The National Cancer Action Team’s report on ‘Characteristics of high quality MDTs’ also provides a useful reference point.

**Recommendation 15: The MDT should be properly supported and work as a two-stage process – one diagnostic and one treatment-focused**

**Radiology**

MDTs need ready access to more than one radiological opinion but, as in other specialities, radiologists are stretched and few MDTs benefit from more than one specialist thoracic radiologist at their meetings. Radiological involvement in the referral pathway into rapid access clinic improves this. Trusts should fully recognise the importance of adequate time for radiologists to prepare for each MDT meeting by allocating sessional time. At the

MDT meeting itself PACS, suitable projection facilities and low-level lighting should be made available to allow proper radiographical presentation.

**Recommendation 16: Each MDT should be able to draw on a team of specialist thoracic radiologists, and ideally two should be present at each meeting**

**Recommendation 17: All imaging should be reported by a specialist radiologist and should have local agreement on the wording of reports and recommendations to clinicians**

**Recommendation 18: Adequate preparation time should be set aside before and after the MDT meeting and radiologists should be given adequate notice of cases**

### **Pathology**

The role of the pathologist is to provide timely accurate diagnostic and staging information. The pathologist's presence at the MDT meeting is critical and they should be full and regular members of the MDT. The lung MDT pathologist should have specialist thoracic expertise as well as access to super-specialist opinion as and when necessary. This specialist resource is limited in the UK, estimated at around 40-50 consultants. This identifies a need for specialist training and fellowships.

It is important to have the facilities to present pathology results properly in the MDT room, linking pathology and radiology information systems as well as linking back to old pathology results. Dual projection of pathology and radiology is also desirable as it enables easy comparison. Pathological sub-classification of NSCLC should be pursued wherever possible together with EGFR mutation testing for all non-squamous cancers.

**Recommendation 19: Lung MDT pathologists should have specialist thoracic expertise and access to super-specialist opinion as and when necessary**

### **Surgery**

Currently there are issues over lack of access to surgery and to specialist thoracic surgeons, as well as significant variations in practice and resection rates between units. There are only around 70 specialist thoracic surgeons in the UK supporting around 240 MDTs, making it impossible to offer year round cover. Peer review of surgical opinion in the MDT is vital to prevent drifts in practice and inappropriate decisions being made.

Different models operate in different parts of the country to help address this shortage of specialist thoracic surgeons. In some areas a hub and spoke model of cross-working may be appropriate, whilst increased use of video-conferencing would also help to manage requirements of smaller centres and reduce travel time. There needs to be more robustness on configuring models that meet patients' rather than Trusts' interests. An immediate necessity is that all surgeons who are core members of an MDT should have a clear thoracic specialist interest - a minimum one full day thoracic operating, minimum one full MDT per week and a thoracic surgical outpatient clinic with lung nurse specialist support present at clinic.

Surgeons need to be involved in preparation and review of CXRs and CT scans. In addition, surgeons need more time to spend with each patient and carer in the surgical consultation. However, they may not be best placed to undertake follow up and long term care.

**Recommendation 20: All MDTs should have a thoracic surgeon as a core member. He or she should be present at, or have adequate cover for, all meetings**

**Recommendation 21: All surgical core members of a lung MDT should have a clear thoracic specialist interest (a minimum one full day thoracic operating, minimum one full MDT per week and a thoracic surgical outpatient clinic with lung nurse specialist support present at clinic)**

**Recommendation 22: All patients with a disease identified as borderline for treatment (3A or 3B), or who are borderline fit for surgery, should have their case assessed by at least one specialist thoracic surgeon within a specialist MDT**

**Recommendation 103: High quality video-conferencing should be available wherever required to improve working between specialist centres and DGHs**

**Recommendation 24: Thoracic surgeons should not work as single surgeons in a cardiac unit**

### **Medical and Clinical Oncology**

Medical oncologists provide detailed expertise on chemotherapy and should be able to provide important advice on integrating new therapeutic advances.

Although the unique expertise of clinical oncologists is their knowledge of radiotherapy techniques, many have wide experience in the use of chemotherapy allowing them to manage combination chemo-irradiation.

Both clinical and medical oncologists should have expertise in clinical trials and an understanding of translational research, which should be part and parcel of the information available to the dream MDT. Currently many oncologists treat a wide range of cancer types and may not be fully up to date with regard to the management of lung cancer. Specialism in thoracic oncology is a requirement for any high quality service and there should be at least two oncologists per MDT – one medical and one clinical. In order to optimise and personalise radiotherapy, wider access should be given to PET-CT, stereotactic targeted therapies and other recent or more advanced techniques.

Patients for whom radical radiotherapy or combination chemotherapy are possible therapeutic options should be seen within a week of diagnosis by an oncologist with wide experience in these treatments and rapid access to the full range of radiotherapy techniques and planning facilities, including the options of CHART, IMRT and online imaging with cone beam CT.

**Recommendation 25: Every lung cancer patient should have access to dedicated thoracic oncologists – both medical and clinical**

Following surgery all patients should have an MDT discussion with consideration made to adjuvant chemotherapy and radiotherapy if indicated. Informed consent to treatment should include what the likely survival benefit will be and what the alternatives are, recognising and clearly conveying that patients' response to treatments vary. It is imperative that efforts are made to create the right setting for a full discussion with patients, enabling them to ask the questions they want supported with clear information and CNS input. For all patients completing any first line therapy, an MDT discussion should take place to consider further therapies.

## **Recommendation 26: There should be an MDT discussion following completion of first-line treatment**

### **Borderline Case Management**

In general 6-8% of lung cancer patients are clearly operable and of low risk, 50% have advanced cancer and 35-40% are borderline cases. Given that lung is a common cancer there is potential for improving and extending thousands of patients' lives by focusing clinicians on this borderline group. There are currently huge variations in resection rates and other radical therapy rates between different teams and areas of the country. The regular collection of data and review of treatment and outcomes is a vital element of a high quality service.

## **Recommendation 27: Every MDT should collect a minimum data set for every patient, contribute to the National Lung Cancer Audit and publish an annual report including resection rates, other treatments given and patient outcomes**

### **End of Acute Phase**

Patients often feel 'abandoned' after the initial period of intensive investigation and first line treatment, with little understanding of what the future holds. Within one month of the end of treatment the patient and a close carer should be invited to attend a 'stock-take' clinic to assess their current problems, their understanding of what has happened to them to date, what to look for in the future and to be given a clear and single point of contact if problems arise. The CNS is best placed to carry this out, but may require support from allied health care professionals, social workers and psychologists.

## **Recommendation 28: Patients should never be left without knowledge of what the next step is in their care pathway**

## **Recommendation 29: A clinical stock-take/end of treatment assessment should be held, when the CNS has sufficient time to go through what the patient knows, their prognosis, treatment options, point of contact and financial details**

### **Supportive and palliative care**

Providing effective supportive and palliative care requires patients and their carer's holistic needs to be identified, including for rehabilitation. Thus, it is recommended that the SPARC questionnaire, or an equivalent tool, be used to assess patients' needs. These should form the basis for care plans and referral to other services for specialist support.

## **Recommendation 30: SPARC or an equivalent tool should be used to assess patients' needs. The results should be the basis for care plans and referral to other services for specialist support**

It is important to recognise and be realistic about the likely outcome for lung cancer patients. Healthcare professionals should have an open discussion with the patient about where they want to die when an end is in sight. Some doctors are still hesitant to initiate a discussion, and it is also noted that careful handling is needed when patients and carers have different views on wanting to know a prognosis.

Palliative care practitioners are thinly spread, and this presents problems with securing specialist input at the MDT meeting. A focus on building the palliative care workforce is therefore required. It is also vital that there are smooth links between the palliative care team and primary and community care.

## Research and clinical trials

Research is central to any high quality team. This will most commonly involve the entry of patients into national clinical trials (i.e. NCRN 'badged' studies) and all MDTs should have available a list of all such trials that are open for recruitment and consider whether trial entry is an option that can be offered to every patient that is discussed. Links with translational and more basic research are to be encouraged and it is important that links are established between units which carry out such research and those which are more clinically oriented.

**Recommendation 31: Every MDT discussion should include an assessment of which trials individual patients may eligible for**

---

<sup>1</sup> 'Cancer survival in Australia, Canada, Denmark, Norway, Sweden & the UK, 1995-2007', *The Lancet* 377: 127-138, MP Coleman, D Forman, H Bryant, et al., 2011

<sup>2</sup> 'The CAPER studies: five case-control studies aimed at identifying and quantifying the risk of cancer in symptomatic primary care patients', *British Journal of Cancer* 101, S80-S86, Hamilton W et al., 2009