Joint Trust Guideline for the Management of Thyroid Nodules in Adults

Document Control:

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V2	08/08/2017	Dr K Dhatariya Dr F Swords Consultant Endocrinologist	Include what to do with PET positive nodules, and to incorporate some minor changes from the UK National Guidelines on Thyroid Cancer, and the US guidelines on Thyroid Nodules And Thyroid Cancer Particularly around a New Imaging Classification.
V2.1	19/05/2020	Dr K Dhatariya Consultant Endocrinologist	No clinical changes. Trust template updated.
V2.2	27/07/2020	Dr K Dhatariya Consultant Endocrinologist	Reviewed. No clinical changes.
V3	October 2023	Dr K Dhatariya Consultant Endocrinologist	Document transferred to new Procedural Document Template

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

These guidelines were written at the request of the East Anglia Thyroid Cancer Multi Disciplinary Team. This comprises of Endocrinologists, Oncologists, Endocrine Surgeons, Histopathologists, Nuclear Medicine, and Radiologists from the Norfolk and Norwich University Hospital, Ipswich Hospital, Queen Elizabeth Hospital, King's Lynn and James Paget Hospital in Great Yarmouth.

They were written after an update of the current relevant literature. Several drafts were distributed amongst the members of the East Anglia Thyroid Cancer Multi Disciplinary Team.

This version endorsed by: Consultant endocrinologists at NNUH, and members of the East Anglia Thyroid Cancer Multi Disciplinary Team.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospital and James Paget Hospital; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

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Quick Reference Guide 1 - Pathways on managing a single thyroid nodule

Royal College of Pathologists (Thy) vs Bethesda (USA) and SIAPEC-IAP (Italy) classifications

Thy 3b = Thy 3f

All lesions classified as Thy 3, 4 or 5 should be discussed at the next thyroid cancer multi-disciplinary team meeting

Quick Reference Guide 2 - Pathways on managing a single thyroid nodule

All lesions classified as Thy 3, 4 or 5 should be discussed at the next thyroid cancer multi-disciplinary team meeting

If the single nodule or the nodules in a MNG are classified at U2 on ultrasound, but the patient finds the goitre cosmetically unappealing, or there are symptoms of tracheal compression or dysphagia, then consider referral to ENT for consideration of total / hemi thyroidectomy

Quick reference guide 3 - Guidelines for US staging and FNA of thyroid nodules

The ultrasound "U" classification of thyroid nodules has been developed by the British Thyroid Association as part of their 2014 guidelines on the management of thyroid cancer. It allows for stratifying thyroid nodules as benign, suspicious or malignant based on ultrasound appearances termed U1-U5.

Classification

U1 (normal)

no nodules

U2 (benign)

hyperechoic or isoechoic with a halo

cystic change with ring down artefact (colloid)

microcystic or spongiform appearance

peripheral egg-shell calcification

peripheral vascularity

U3 (indeterminate)

solid homogenous markedly hyperechoic nodule with halo (follicular lesions)

hypoechoic with equivocal echogenic foci or cystic change

mixed or central vascularity

U4 (suspicious)

solid hypoechoic (compared with thyroid)

solid very hypoechoic (compared with strap muscles)

hypoechoic with disrupted peripheral calcification

lobulated outline

U5 (malignant)

solid hypoechoic with a lobulated or irregular outline and microcalcification

papillary carcinoma

solid hypoechoic with a lobulated or irregular outline and globular calcification

medullary carcinoma

intranodular vascularity

taller than wide axially (AP > TR)

characteristic associated lymphadenopathy

US appearances that are indicative of benign nodules (U1-2) should be regarded as reassuring. No need to perform an FNA UNLESS the patient has a statistically high risk of malignancy e.g. if it is large (usually ≥4 cm), in which case capsular or vascular invasion can then occur, transforming an adenoma to carcinoma.

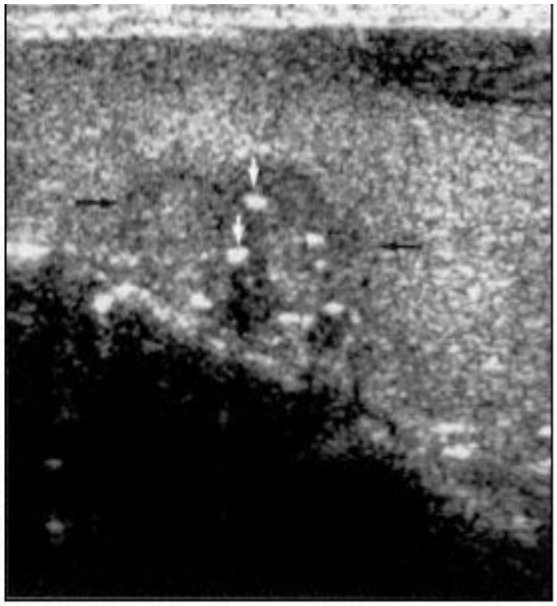
US appearances that are equivocal, indeterminate or suspicious of malignancy (U3-5), should always prompt an US guided FNAC.

Nodules with Thy2 cytology but indeterminate or suspicious US features should undergo repeat FNAC for confirmation.

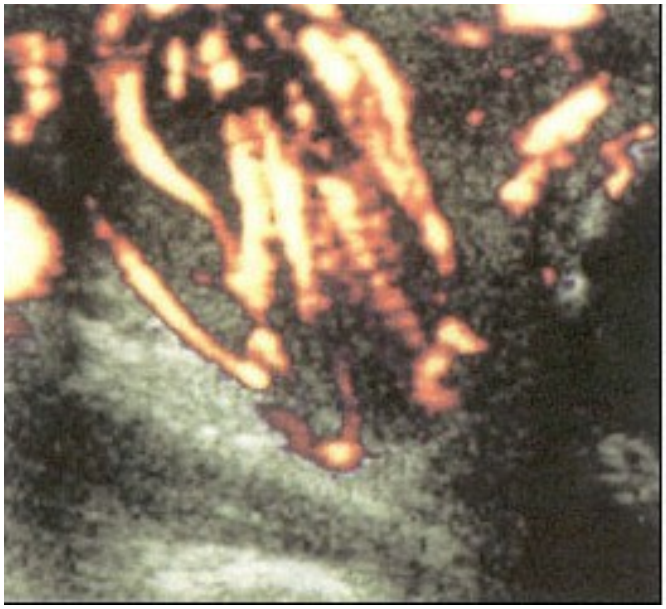
Nodules detected by PET-CT with focal FDG activity should be investigated with ultrasound and FNAC.

FNA if:

1) There is a history of rapid enlargement (suggests lymphoma/anaplastic thyroid cancer)
2) There is slow but progressive growth – suggests malignant involvement
3) There is punctate calcification on ultrasound- suggestive of papillary thyroid cancer (see examples below)



4) There is invasion of other structures i.e., oesophagus, trachea or strap muscles, or pathological lymphadenopathy
5) Solid hypoechoic nodules > 1cm
6) There is type III vascularity (striking intranodular flow on doppler) – see image below



Consider FNA if there is a

1) Family history of papillary thyroid cancer, medullary thyroid cancer or MEN2 in first degree relatives
2) Previous history of neck irradiation

AVOID FNA in the following cases:

1) Thyrotoxic patients (malignancy is very uncommon in an autonomous nodule/toxic gland
2) Patients presenting with acute pain and tenderness (suggests haemorrhage into a nodule)
3) Multinodular goitre (unless there are suspicious features as described in the previous section) There is no need to FNA the dominant nodule if there are no worrying features
4) Comet tail or ring calcification on ultrasound

5) Spongiform isoechoic nodules or purely cystic lesions

1. Introduction

1.1. Rationale

These guidelines aim to provide a rational algorithm to ensure that nodules can be quickly and appropriately managed without unnecessary over-investigation, whilst minimising the risk of missing a thyroid malignancy (see pages 4 and 5).

1.2. Objective

These guidelines have been developed to ensure that there is consistency in diagnosis and management amongst the different specialities to which thyroid nodules may present.

1.3. Scope

1.3.1. Broad recommendations

- **All patients with a thyroid lump should be seen in a dedicated thyroid lump clinic – this should be the first point of contact upon referral to hospital.**
- All patients require a history and examination, and thyroid function tests (to include TSH and fT4 and fT3 where indicated) prior to ultrasound scanning.
- **Ultrasound scanning is the first line recommended investigation of a thyroid nodule.**

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
TFT	Thyroid function tests
US	Ultrasound
FNAC	Fine Needle Aspiration Cytology
FNA	Fine Needle Aspiration
MNG	Multinodular Goitre
ENT	Ear Nose Throat
FDG	Fludeoxyglucose
PET-CT	Positron Emission Tomography – Computerised Tomography
TSH	Thyrois Stimulating Hormone
fT4 / fT3	Free T4, free T3
PET	Positron Emission Tomography
USS	Ultrasound scan
CT	Computerised Tomography
U&E	Urea and electrolytes
LFT	Liver function tests
FBC	Full blood count

2. Responsibilities

These guidelines were written at the request of the East Anglia Thyroid Cancer Multi Disciplinary Team. This comprises of Endocrinologists, Oncologists, Endocrine Surgeons, Histopathologists, Nuclear Medicine, and Radiologists from the Norfolk

and Norwich University Hospital, Ipswich Hospital, Queen Elizabeth Hospital, King's Lynn and James Paget Hospital in Great Yarmouth.

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3. Policy Principles

3.1. Background

A thyroid nodule is a discrete lesion within the thyroid gland that is palpably and / or ultrasonographically distinct from the surrounding thyroid parenchyma. Up to 50% of the adult population may have thyroid nodules, with palpable thyroid nodules are very common, being present in approximately <15% of the population. Up to 35% of thyroid glands removed at post mortem or at surgery, contain clinically unimportant (i.e. < 1.0 cm) papillary carcinomas.

The incidence of nodules rises with age with a lifetime risk of 5 to 10% of developing a palpable thyroid nodule. About 50% of nodules are solitary, with another 25% being the dominant nodule within a multinodular goitre. Nodules may be filled with either colloid or fluid. They may be neoplastic or inflammatory. Women are 4 times more likely to develop solitary nodules than men. Incidence also increases in areas of iodine deficiency. Whilst the fear amongst patients is that a thyroid lump may be malignant, the results of several case series looking at the results of Fine Needle Aspiration (FNA) cytology have shown that approximately 70% of nodules biopsied were benign, 25% were indeterminate or suspicious, and only 5% were definitely malignant. The risk of malignancy is the same for palpable or non-palpable nodules (i.e. picked up on US scanning only).

The natural history of thyroid nodules is such that with no intervention, up to 35% may disappear on their own.

Approximately 15 to 25 % of all nodules are either purely cystic or complex (i.e. partly cystic and partly solid). On aspiration, the presence of blood in the fluid is NOT an indicator of malignant potential.

Nodules found during pregnancy should follow the normal algorithm. Surgery, when necessary, should be delayed until the 2nd trimester.

3.2. Management

Clinicians should be *highly* suspicious of thyroid cancer if the patient presents with any of the following:

a) If there is a personal or family history of medullary thyroid cancer, multiple endocrine neoplasia (in which case measure a calcitonin level), or familial polyposis.

b) Rapid growth of the lump.

c) Age of either < 20 or > 70 years old.

d) An irregular nodule that may be very firm or hard.

e) Nodule 'fixed' to underlying anatomical structures.

f) Change in the voice.

g) Regional (ipsilateral) lymphadenopathy.

h) Distant metastasis.

i) Symptoms of compression or infiltration, including dysphagia, dysphonia, hoarseness, dyspnoea, stridor, new snoring or cough.

j) Exposure to fallout from Chernobyl prior to 14 years of age or other ionising radiation.

k) Findings of vocal cord palsy on examination.

Clinicians should be *moderately* suspicious of thyroid cancer if the patient presents with any of the following:

a) Male sex.

b) History of head and neck irradiation, or total body irradiation for bone marrow transplantation.

c) A nodule of > 4.0 cm in diameter or partially cystic.

d) Recurrent cysts.

e) Nodules with positive uptake on PET scan.

3.3. Guidelines for Solitary Thyroid Nodule

1 Thyroid function testing is a key part of the assessment of a patient with a thyroid nodule.

2 A thyroid ultrasound is the most accurate method to evaluate thyroid nodules and is the procedure of choice in initial evaluation of the thyroid lump.

Nodules with benign features (U2) on US do not require an FNA UNLESS there is a significant risk of cancer. Clinical assessment is required to determine their optimum follow up. So, small stable lesions with no worrying features on US or on clinical history may be discharged.

Larger lesions, those with ongoing growth, and those with any of the characteristics associated with increased risk (a-k above) may undergo an initial FNA due to increased clinical suspicion and should be offered interval follow up even if Thy2– typically with a repeat US in 6 months. If the nodule remains stable with benign features on repeat USS the patient may be reassured this is benign. Surgery or radioactive iodine may be offered for nodules causing compressive or significant cosmetic symptoms, while smaller, euthyroid and asymptomatic nodules do not require long term follow up or treatment.

3 Ultrasound guided FNA is indicated for nodules with any suspicious characteristics (U3 or above) – see page 4.

Nodules with indeterminate or suspicious (U3 or above) ultrasound characteristics but apparently benign Thy2 cytology need careful assessment with consideration of repeat US and FNA prior to discharge.

All FNA results of Thy 3 or above require discussion at the thyroid MDT. However, the management of certain nodules (e.g., <1cm U3) may be altered after such discussions.

NB. Currently, NNUH does not perform radiofrequency ablation of thyroid nodules. It does also not perform molecular analyses for prognostic and management purposes. Over time, however, this may change.

3.3.1. Special Circumstances

Abnormal TFTs

Abnormal thyroid function test results do not alter the above pathway – i.e. thyrotoxicosis does not rule out the presence of a malignancy, but it is very rare and needs specific treatment. FNAC is recommended only if the clinical suspicion for thyroid malignancy is high in the presence of thyroid dysfunction.

If hypothyroidism is present with benign FNAC, then treat appropriately with thyroxine and reassess the nodule at three months. A raised TSH does not preclude malignancy and so an ultrasound with FNA if indicated is still recommended because the rate of malignancy in nodules is similar in thyroid glands involved in Hashimoto's disease as in normal glands.

If hyperthyroidism is present then long term treatment is generally with radioiodine rather than anti-thyroid drugs. Thyroid uptake scanning should be performed in patients presenting with a solitary nodule. If this confirms the presence of a hot nodule, the patient can be offered radio-iodine and no further imaging or evaluation is required unless the nodule fails to shrink after treatment. However, if the uptake scan shows no uptake, then the nodule still requires evaluation on its own merits, with ultrasound and FNA if indicated at presentation. If the FNA is benign, then the patients should be reassessed at three –six months in the usual way, and if the nodule is smaller, discharge to the GP for follow up.

Thyroxine suppression therapy to try and shrink nodules is no longer recommended due to the long term effects on bone (osteopenia /osteoporosis) and cardiovascular physiology (atrial fibrillation).

Pregnancy

Thyroid nodules found for the first time in pregnancy should be treated in exactly the same way as in the non-pregnant individual. If a Thy 3, 4 or 5 lesion is detected on FNA in pregnancy, then surgery is recommended. There is no consensus as to whether this should be carried out during or after pregnancy, however it should always be done after 24 weeks of gestation to minimise the risk of miscarriage. Thyroid cancer discovered during pregnancy does not act more aggressively than in non-pregnant women, and delaying treatment does not adversely affect outcomes.

PET positive thyroid nodules

With increasing use of PET scanning, more asymptomatic thyroid nodules are being detected with positive FDG uptake. These patients do have an increased risk of thyroid malignancy - up to 30% if there is focal and intense SUV uptake and so PET positive thyroid nodules would usually require evaluation through the thyroid lump clinic and assessment by US and FNA. However, if the patient has a life expectancy of less than 5 years assessment may not be clinically appropriate.

Incidentally found thyroid nodules on other imaging

Increasingly, thyroid nodules are being incidentally found on other imaging, e.g. chest CT. These do not need routine follow up or assessment unless there are any suspicious features in the history or examination. A thyroid US is the initial investigation of choice.

Diagnostic category	Risk of malignancy (%)
Non-diagnostic for cytological diagnosis (Thy1/Thy1c)/Unsatisfactory	0−10
Non-neoplastic (Thy2/Thy2c)/Benign	0−3
Neoplasm possible – atypia/non-diagnostic (Thy 3a)/Atypia of undetermined significance or follicular lesion of undetermined significance	5−15
Neoplasm possible - suggesting follicular neoplasm (Thy 3f)/Follicular neoplasm or suspicious for a follicular neoplasm	15−30
Suspicious of malignancy (Thy4)	60−75
Malignant (Thy5)	97−100

All lesions classified as Thy 3, 4 or 5 should be discussed at the next thyroid cancer multi-disciplinary team meeting.

4. References

1. Perros P, Colley S, Boelaert K, Evans C, Evans RM, Gerrard GE, Gilbert JA, Harrison B, Johnson SJ, Giles TE, Moss L, Lewington V, Newbold KL, Taylor J, Thakker RV, Watkinson J, Williams GR British Thyroid Association Guidelines for the Management of Thyroid Cancer CLINICAL ENDOCRINOLOGY VOLUME 81 SUPPLEMENT 1 JULY 2014
2. Bryan R. et al 2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer: The American Thyroid Association Guidelines Task Force on Thyroid Nodules and Differentiated Thyroid Cancer Thyroid. 2016 Jan 1; 26(1): 1–133.
3. A L Mitchell, A Gandhi, D Scott-Coombes, P Perros Management of thyroid cancer: United Kingdom National Multidisciplinary Guidelines J Laryngol Otol. 2016 May; 130(Suppl 2):
4. AACE/AME Thyroid Nodule Force. AACE/AME medical guidelines for clinical practice for the diagnosis and management of thyroid nodules. Endocr Pract 2006; 12(1):63-102.
5. Gharib H. Thyroid nodules and multinodular goitre. Cooper DS ed. *Medical management of thyroid disease*. New York, Marcel Dekker Inc., 2001: 187-225.
6. Hegedus L, Bonnema SJ, Bennedbaek FN. Management of simple nodular goiter: Current status and future perspectives. *Endocr Rev* 2003; 24**:** 102-132.
7. Hegedus L. The thyroid nodule. *N Eng J Med* 2004; 351**:** 1764-1771.
8. Hermus AR, Huysmans DA. Treatment of benign nodular thyroid disease. *N Engl J Med* 1998; 338**:** 1438-1447.

9. Mazzaferri EL. Management of a solitary thyroid nodule. *N Eng J Med* 1993; 328**:** 553-559.
10. Mortensen JD, Woolner LB, Bennett WA. Gross and macroscopic findings in clinically normal thyroid glands. *J Clin Endocrinol Metab* 1955; 15**:** 1270-1280.
11. Singer PA, Cooper DS, Daniels GH, Ladenson PW, Greenspan FS *et al.* Treatment guidelines for patients with thyroid nodules and well-differentiated thyroid cancer. American Thyroid Association. *Arch Intern Med* 1996; 156**:** 2165-2172.
12. Welker MJ, Orlov D. Thyroid nodules. *Am Fam Physician* 2003; 67**:** 559-566.
13. British Thyroid Association. Guidelines for the management of thyroid cancer in adults. Royal College of Physicians. March 2002
14. Radioiodine in the management of benign thyroid disease. Clinical guidelines. Royal College of Physicians. June 2007
15. Cooper DS, Doherty GM, Haugen BR *et al.* Management guidelines for patients with thyroid nodules and differentiated thyroid cancer. *Thyroid* 2006; 16**:**1-34.
16. Kuma K, Matsuzuka F, Yokozawa T, Miyauchi A, Sugawara M. Fate of untreated benign thyroid nodules: Results of long-term follow-up. *World J Surg* 1994; 18(4)**:**495-498.
17. Gharib H, Papini E. Thyroid nodules: clinical importance, assessment, and treatment. *Endocrinol Metab Clin North Am* 2007; 36(3)**:**707-735.
18. Alexander EK, Heering JP, Benson CB *et al.* Assessment of nondiagnostic ultrasound-guided fine needle aspirations of thyroid nodules. *J Clin Endocrinol Metab* 2002; 87(11):4924-4927
19. Cesur M, Corapcioglu D, Bulut S *et al.* Comparison of palpation-guided fine-needle aspiration biopsy to ultrasound-guided fine-needle aspiration biopsy in the evaluation of thyroid nodules. *Thyroid* 2006; 16(6):555-561.
20. Khalid AN, Quraishi SA, Hollenbeak CS, Stack BC. Fine-needle aspiration biopsy versus ultrasound-guided fine-needle aspiration biopsy: Cost-effectiveness as a frontline diagnostic modality for solitary thyroid nodules. *Head Neck* 2009; 30(8):1035-1039.
21. Ogilvie JB, Piatigorsky EJ, Clark OH. Current status of fine needle aspiration for thyroid nodules. *Adv Surg* 2006; 40(9):223-238.
22. Orija IB, Pineyro M, Biscotti C, Reddy SS, Hamrahian AH. Value of repeating a nondiagnostic thyroid fine-needle aspiration biopsy. *Endocr Pract* 2009; 13(7):735-742.
23. Sidoti M, Marino G, Resmini E *et al.* The rational use of fine needle aspiration biopsy (FNAB) in diagnosing thyroid nodules. *Minerva Endocrinol* 2006; 31(2):159-172.
24. Cross P, Chandra A, Giles T *et al.* G089. Guidance on the reporting of thyroid cytology specimens. Royal College of Pathologists. November 2009. http://www.rcpath.org/resources/pdf/g089guidanceonthereportingofthyroidcytologyfinal.pdf

25. Yang J, Schnadig V, Logrono R, Wasserman PG. Fine-needle aspiration of thyroid nodules: a study of 4703 patients with histologic and clinical correlations. *Cancer* 2007:111:306−15.

26. Yassa L, Cibas ES, Benson CB, Frates MC, Doubilet PM, Gawande AA, Moore FD, Kim BW, Nosé V, Marqusee E, Reed Larsen P, Alexander EK. Long-term assessment of a multidisciplinary approach to thyroid nodule diagnostic evaluation. *Cancer* 2007:111:508−16.

27. Kwak JY, Han KH, Yoon JH, Moon HJ, Son EJ, Park SH *et al.* Thyroid imaging reporting and data system for US features of nodules: A step in establishing better stratification of cancer risk. *Radiology* 2011; **260**(3)**:**892-899.

28. Gharib H, Papini E, Paschke R, Duick DS, Valcavi R, Hegedus L *et al.* American Association of Clinical Endocrinologists, Associazione Medici Endocrinologi, and European Thyroid Association Medical Guidelines for clinical practice for the diagnosis and management of thyroid nodules. *Endocr Pract* 2013; **16**(Suppl 1)**:**1-43

29. Ja Seong Bae,et al. Incidental thyroid lesions detected by FDG-PET/CT: prevalence and risk of thyroid cancer; *World J Surg Oncol*. 2009 **7**: 63.

30. Xie C, Cox P, Taylor N, LaPorte S. Ultrasonography of thyroid nodules: a pictorial review. Insights into imaging. 7 (1): 77-86.

31. Alexander EK, Cibas ES. Diagnosis of thyroid nodules. *Lancet Diab Endocrinol*. 2022;10(7):533-539

32. Alexander EK, Doherty GM, Barletta JA. Management of thyroid nodules. *Lancet Diab Endocrinol*. 2022;10(7):540-548

33. Wadsley J, Balasubramanian SP, Madani G, et al. Consensus statement on the management of incidentally discovered FDG avid thyroid nodules in patients being investigated for other cancers. Clinical Endocrinology 2023. https://doi.org/10.1111/cen.14905.

5. Audit of the process

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Reduction in numbers of 'blind FNAC' carried out and a reduction in numbers of Thy1 aspirates, with a concurrent rise in early thyroid cancer detection	Audit by radiology to determine how many they are doing Also, by histology to determine where the samples have come from	Radiology Histopathology	Radiology	Annually

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action.

6. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Medical	**Department**	Endocrinology
Name of person completing form	Dr K Dhatariya	**Date**	11th October 2023

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	None	None	None	No
Pregnancy & Maternity	None	None	None	No
Disability	None	None	None	No
Religion and beliefs	None	None	None	No
Sex	None	None	None	No
Gender reassignment	None	None	None	No
Sexual Orientation	None	None	None	No
Age	None	None	None	No
Marriage & Civil Partnership	None	None	None	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.