Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Sarcoma Measures

Version 1.1

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Introduction

1.1 Aim of the Manual for Cancer Services

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and patient/carer representation, provides important information about the quality of clinical teams and a national benchmark of cancer services across the country.

National quality measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services (e.g. chemotherapy, radiotherapy). It is intended that the National Cancer Intelligence Network (NCIN) clinical reference groups will review the measures within the manual for cancer services annually to ensure they are clinically relevant and it is intended that the measures will underpin the NICE Quality Standards relating to cancer.

An independent evaluation of the National Cancer Peer Review Programme demonstrated strong support for the programme to continue, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when data becomes available.

In response to this the number of measures has been reduced by over one third in 2008 and more recently by a further 10%. In addition "Clinical Lines of Enquiry" (CLE) have been introduced, based on outputs/outcomes to support the Manual for Cancer Services. The revised process for peer review will be implemented in April 2011 but the measures contained within this manual will remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Adherence to the measures in the manual for cancer service is not mandatory for the NHS but it is used by the National Cancer Peer Review Programme as part of the assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality.

1.2 Background and Context

Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy sets out how the future direction for cancer will be aligned with Equity and Excellence: Liberating the NHS in addition to meeting its stated aim to saving an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive information about cancer services for individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

1.3 Measures within the National Cancer Peer Review Manual

The peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, 'Clinical Lines of Enquiry' have been introduced and it is intended these outcome indicators will form part of the measures along with a reduced number of structure and process measures.

The development of cancer measures is an ongoing process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new initiatives such as Iapco, information prescriptions.

The relationship between the NICE Improving Outcomes Guidance and Quality Standards and the Manual for Cancer Services is explained in more detail in appendix A.

1.4 Reviewing the Measures

The National Cancer Peer Review (NCPR) Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The NCPR programme has been keen to take the opportunity to reduce the burden on the NHS in line with the efficiency gains asked of all NHS organisations. The revised methodology will reduce the burden on the service without substantially impacting on the quality assurance process.

Appendix A

Interpretation of the National Manual for Cancer Services

1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes Guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive and far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated.

It may use influential and important ideas and models, which are however complex or not precisely definable, such as "network-wide patient care pathways" or "culturally-sensitive information". It always contains useful and necessary value judgements which use words like "sufficient", "appropriate", "robust" and "comprehensive", but it often has to leave unanswered the key question - what exactly is it which makes the issue under examination "sufficient", "appropriate", "robust" and "comprehensive" or not? It uses concepts which, although crucial, may not be measurable. It ranges widely from things which everybody gets right as a matter of course already through to principles which, if taken literally, nobody would comply with ever.

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset, guidance would not inspire, lead, motivate or guide and would probably be almost unreadable. The Manual for Cancer Services has to take a different approach. It is written for and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit; state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous measures - in order to be developmental - not just arbitrarily moving the goal posts.

All this results in the rather esoteric style of the manual. Please judge the measures on their merits in the light of the above and not in comparison to the guidance.

1.2 "The Responsibility for Assessment Purposes"

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task - this can be delegated according to local discretion, unless it is clear that a given task really is limited to ascertain group.

1.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

1.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is under taken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

1.5 "Quality" Aspects of Cancer Service Delivery

Many of the measures expect that policies, procedures, job descriptions and other documents will be in place. In reviewing compliance with the measures (for instance measure met or not) during validation, verification and visits, reviewers will look only for the presence of such documents, unless aspects of the content are specified in the wording of the measure. Where some aspect of the content is specified then this will be taken into account in determining compliance. As part of the improvement of cancer services, reviewers may comment on the content of documents and agreements but this will not affect the determination of compliance.

Work is ongoing to enable us to subject more of the "quality" aspects of cancer service delivery to objective measures for future rounds of peer review.

Many reviewers have a legitimate and valuable contribution to make by way of comments on areas which are a matter of opinion rather than fact or authoritative and evidence based measures. This recognises the qualitative as well as quantitative approach to reviews. This contribution can be made by way of a textual report in addition to the objective recording of compliance against the measures. This report is separate from the review against the measures and is inevitably more subjective and open to debate. However, there are many ways in which it can add to the overall picture gained from the peer review.

1.6 Structure of the Measures

Each measure has a three part number, for example 11-1A- 201j.

- The first part indicates the year the measure was first issued, for example 11 is 2011.
- The second part relates to a particular topic see below, for example 1A.
- The third part is made up of a unique measure number in the topic and where relevant a suffix letter indicating a specific tumour and cross cutting services, for example 201j (see below).

Index of Suffix Letters

a - Generic to all tumour sites
b - Breast specific
c - Lung specific
d - Colorectal specific
e - Gynaecology specific
f - UGI specific
g - Urology specific
h - Haematology specific
i - Head and Neck specific
j - Skin specific
k - Brain and CNS specific
l - Sarcoma specific
r - Specialist Palliative Care specific
s - Chemotherapy specific
t - Radiotherapy specific
u - User Group specific
v - Rehabilitation specific
w - Complementary Therapy specific
x - Psychological Support specific
y - Acute Oncology
z - Teenage and Young Adults specific

Each network will be made up of several localities/trusts and several NSSGs / cross cutting groups, each with multiple MDTs and services. These MDTs and services will each need to demonstrate compliance with the relevant quality measures. A network overview will be developed by bringing together the findings relating to individual MDTs and services as well as those concerning network organisation and structures.

Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at http://www.cquins.nhs.uk.

SARCOMA MEASURES

Introduction

The sarcoma Improving Outcomes Guidance (the IOG) refers to a sarcoma 'centre'. There has deliberately been no attempt to rigorously define such a centre for the purpose of the measures in terms of, for instance, minimum levels of staff or the amount or nature of the facilities, since there is no evidence base or national consensus for this. Thus, if the term 'centre' occurs it is for convenience of description only. There are no peer review compliance issues which depend on the achievement of a cancer measures definition of 'centre status'. There are however a number of requirements in the measures involving issues which people often really have in mind when they loosely use the term 'centre'. These issues include agreed protocols and patient pathways; MDT viability and an agreed location for a sarcoma service. These issues are all sufficiently defined or specified for the purpose of compliance with these measures and the peer review.

The Shape of the Service

It is acknowledged that sarcoma centres (and therefore sarcoma MDTs) may not all cover both of the tumour types, bone and soft tissue and the areas covered by the various centres and MDTs will not always be coterminous with existing cancer networks. A sarcoma MDT may cover more than one, or parts of more than one network. There should be certain agreements prior to the review and, (because of the way peer review is organised,) outside the review and not subject to the measures. These are between firstly, the specialised commissioning groups - SCGs (and by the national specialised commissioning group - NSCG, in the case of primary bone sarcomas), to determine the areas which are covered by sarcoma MDTs for each tumour type of the two types, soft tissue sarcomas and primary bone sarcomas. Such areas will be determined by SCGs/NSCG on the basis of the existing and desired distribution of staff, facilities, expertise and directions of patient flow. Secondly there should be agreement between the Network Boards and the relevant SCG/NSCG to decide which SCG/NSCG will be responsible for overseeing the sarcoma service configuration for the network.

As well as the functions of the MDT in dealing with individual patients, there are overall site-specific co-ordinating functions needed by the sarcoma service across the whole area agreed by the SCG.This may involve the function of more than one MDT and of related elements such as chemotherapy services, radiotherapy departments, nominated treatment clinicians and, where relevant, soft tissue sarcoma diagnostic clinics. This function has been fulfilled for all other tumour sites, by an overarching body other than the MDT, although some of its members will be drawn from the MDT. This is usually known for the purpose of peer review as a network site specific group or NSSG. However, because the functional area covered by such a group for sarcomas may be more than one network, in this case it will be known, for the purpose of peer review, as a sarcoma advisory group or SAG. Any name may be used for this group in practice locally, provided it is put forward for review against the relevant set of measures.

Ground Rules for Networking

In order to preserve transparent and effective networking for sarcoma treatment and to avoid a 'free for all' with destructive competition between teams, it is necessary to apply the following ground rules for networking. (These include what, in measures for other cancer sites, are known as Team Criteria). A number of the measures will require adherence to the relevant ground rules.

1) A MDT should declare which type of team it is, out of:
   - A soft tissue sarcoma, only, MDT.
   - A combined soft tissue sarcoma and bone sarcoma MDT.
     Note: There are currently no 'bone only MDTs' and it is not envisaged that there should be and there are no measures which apply particularly to this theoretical situation.
2) A sarcoma MDT should be the only sarcoma MDT for its declared tumour types for the catchment area which refers it those tumour types. That catchment area may encompass more than one or parts of more than one cancer network. It should not be confined to less than one cancer network.
3) A sarcoma MDT should be associated with only one Sarcoma Advisory Group (SAG) for a given tumour type which it deals with.
4) A SAG should be the only SAG for each of its tumour types for the catchment area it serves for that tumour type. NB: The SAG's catchment area for a given tumour type is made up of the sum of all the

catchment areas of the MDTs which are associated with the SAG for that tumour type.

5) A SAG should only be established in a network which hosts a sarcoma MDT and a sarcoma resection service and an MDT and its resection service should be in the same network.
6) Every part of each cancer network should be covered by a sarcoma MDT for each of the two tumour types. The number of MDTs which are involved with this coverage depends on the local arrangements within the constraints of the ground rules specified here.
7) A MDT dealing only with soft tissue sarcomas should receive at least 100 newly diagnosed cases of this group for discussion per year.
8) A combined MDT should receive at least 100 newly diagnosed cases of soft tissue sarcoma and 50 newly diagnosed cases of primary bone sarcoma for discussion per year.
   Note: 'New cases' are defined as new cases referred for diagnosis and initial treatment planning or initial treatment planning when diagnosis has been made elsewhere. The total can be made up of both adult and children's cases where this is relevant to the MDT.

Reviewing the Sarcoma Network

i) The establishment and location of sarcoma MDTs either in the cancer network under review or in a neighbouring network and its relationship to a possible wider sarcoma supranetwork; and, where relevant, the establishment of SAGs and agreeing the location of soft tissue sarcoma diagnostic clinics, are the responsibility for peer review purposes of the Chair of the Network Board and are reviewed under topic 1A - cancer networks - sarcoma measures, compliance counting towards the review of the Network Board.
ii) The provision of hospital clinical leads, implementation of measures on designated practitioners, the hospitals role in the patient pathways and, where relevant, the provision of soft tissue sarcoma diagnostic clinics are the responsibility for peer review purposes of the chair of the locality/trust group and are reviewed under topic1D - functions of the locality/trust group-, compliance counting towards the review of that group.
iii) Functions of the SAG, are the responsibility for peer review purposes of the Chair of the SAG and are reviewed under topic 1C Functions of network site specific groups, compliance counting towards the review of the SAG.
iv) The sarcoma MDT-applying the MDT measures as adapted for each of the formats of a sarcoma MDT, depending on the declared tumour types covered by the team - is the responsibility for peer review purposes of the lead clinician of the MDT and is reviewed under topic 2L the sarcoma MDT, compliance counting towards the review of the MDT.

TOPIC 11-1A-1I - NETWORK BOARD MEASURES FOR SARCOMA

INTRODUCTION

The responsibility for review purposes for measures 11-1A-101I to 11-1A-107I lies with the Chair of the Network Board. Some measures have a limited applicability which is stated in the individual measure. Otherwise, they are applicable to all networks.

These measures should be read in conjunction with the introduction to the sarcoma measures.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

THE SHAPE OF SARCOMA SERVICES

Configuration of a Network Hosting a Sarcoma Resection Service and MDT

11-1A-101I In relation to soft tissue sarcomas of the limbs and trunk wall, the Network Board should agree with the relevant SCG(s),

- that its network may host a soft tissue sarcoma MDT and a service for curative resection of soft tissue sarcomas;
- the location of the service for curative resection of sarcomas;
- the location (host hospital) of the sarcoma MDT;
- whether the soft tissue sarcoma MDT and the resection service will deal with retroperitoneal sarcomas and, if not, the MDT and resection service to which they will be referred and in which network.

In relation to primary bone sarcomas, if its network is to host an MDT which includes bone sarcomas in its remit and a service for the curative resection of bone sarcomas, the Network Board should agree this, and their locations with the NSCG.

This configuration should fulfil the ground rules for networking (see the introduction to the sarcoma measures).

Compliance: The named resection services and MDTs, with their locations and the sarcoma groups they deal with, agreed by the Chair of the Network Board and a representative of the SCG(s) and, where relevant, the NSCG.

Agreement should be obtained from the chair of any other network board to which patients are to be referred.

The reviewers should enquire whether this configuration fulfils the ground rules for networking (see the introduction to the sarcoma measures).

ESTABLISHMENT OF SARCOMA ADVISORY GROUP(S)

Applicable only to networks hosting a Sarcoma MDT and a service for curative resection of sarcomas.

Establishment of Sarcoma Advisory Group(s)

11-1A-102I The Network Board should agree with the relevant SCG(s) (and, in relation to primary bone sarcomas, the NSCG) the number of SAGs it will establish and the tumour types each one will cover out of soft tissue and bone sarcomas or both. This arrangement of SAGs should fulfil the relevant ground rules for networking in the introduction to the sarcoma measures.

For each of the SAGs, the Network Board should fulfil the following:

- The SAG should have the following membership:
  - the MDT lead clinician from each MDT associated with it;
  - at least one nurse core member of a MDT associated with it;
  - there should be a named chair drawn from the above membership;
  - two user representatives;
  - one of the NHS-employed members of the SAG should be nominated as having specific responsibility for users' issues and information for patients and carers;
  - a member of the SAG should be nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into

the function of the SAG;
- named secretarial/administrative support;
- a NCSG representative responsible for bone sarcoma services
  Note: Applicable only to SAGs covering bone sarcoma.

There should be terms of reference agreed for the SAG which include that the SAG should be recognised as:

- the primary source of clinical opinion on the tumour types dealt with by the SAG for the networks associated with that SAG for those tumour types;
- the group to whom those networks delegate corporate responsibility for thosetumour types for co-ordination and consistency across the networks on cancer policy, patient pathways, practice guidelines, audit, research and service improvement;
- the group consulting with the relevant 'cross cutting' groups of those networks on issues regarding the SAG's tumour types, involving chemotherapy, radiotherapy, cancer imaging, histopathology, laboratory investigation and specialist palliative care.

Notes:

- *There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.*
- *If the local user group do not wish to or are unable to provide a user representative but there is an agreed mechanism for obtaining user advice then the measure will be deemed to have been complied with.*
- *There may be additional points in the agreed terms of reference. Recommendations may be found in appendix 2.*
- *The name 'Sarcoma Advisory Groups' was used for convenience for the purpose of peer review. There were groups functioning under this name prior to the publication of these measures. Whatever a pre-existing group (if any) was called, and whatever its pre-existing membership or terms of reference were, each relevant network should put forward a group for review against these measures and those in the section dealing with the function of the SAG. Similarly, groups for this purpose, formed subsequent to the publication of these measures may be known by other local names as long as they are put forward for review against the relevant measures.*

Compliance: The number of SAGs with the tumour types covered by each, agreed by the Chair of the Network Board and a representative of the SCG(s) and, where relevant, the NSCG.

The reviewers should enquire whether they meet the relevant ground rules for networking in the introduction to the sarcoma measures.

The named members and chair of each SAG, agreed by the Chair of the Network Board.

The terms of reference of each SAG, agreed by the Chair of the Network Board and the Chair of the SAG.

Notes:

See below for measures requiring agreement to the SAG arrangements from networks who do not host a MDT and resection service and who are not themselves responsible for establishing a SAG.

MDT PROVISION FOR NETWORKS NOT HOSTING A SARCOMA MDT

Applicable only to networks without a sarcoma MDT and resection service.

MDT Provision for Networks not Hosting a Sarcoma MDT

11-1A-103I The Network Board should agree with the relevant SCG(s) and, in relation to primary bone tumours, the NSCG:

- The sarcoma MDTs in which networks and for which tumour types, the network will be associated with.

Note:

This should be specified for each part of the network, if different parts are associated with different sarcoma MDTs in other networks.

The above configuration should fulfil the relevant ground rules for networking in the introduction to the sarcoma measures.

Compliance: The named team, its location, and the teams they will associate with, for which tumour types, agreed by the Chair of the Network Board and a representative of the SCG(s).

The reviewers should enquire whether this configuration fulfils the ground rules for networking.

Location of Sarcoma Diagnostic Clinics

11-1A-104l The Network Board should, in consultation with the SAG, agree the following with the relevant SCG(s);

- whether the network should provide a soft tissue sarcoma diagnostic clinic within one or more of its hospitals;
- if it is agreed to provide such clinics, their locations (host hospitals) should be agreed;
- if it is agreed that the network should **not** provide such clinics, the named clinics in other named networks, to which the network's patients are to be referred, should be agreed.

Note:

The number of clinics in a given network is not subject to review.

A given clinic may be within a hospital which also hosts a sarcoma resection service or a hospital which doesn't.

There should be no more than one such clinic in any given hospital.

Compliance: **Either**, the named diagnostic clinics in the network, with their host hospitals, agreed by the Chair of the Network Board and a representative of the SCG(s);

or, the agreement not to host any clinics and the location of the named clinics for referral in other networks, agreed by the Chair of the Network Board under review and relevant SCGs, and the Chairs of any Network Boards of the networks receiving the referrals.

DESIGNATION OF TREATMENT DELIVERY SERVICES (Measures 11-1A-105l to 11-1A-106l)

Designated Chemotherapy Services

11-1A-105l The Network Board should agree which and only which of its chemotherapy services should be authorised to deliver chemotherapy regimens for the treatment of (i) soft tissue sarcoma and (ii) bone sarcoma, in the network. This agreement should be made in consultation with the relevant SAG(s), the Network Chemotherapy Group (NCG) and the network board(s) of the network(s) hosting the relevant sarcoma MDT(s) if the network under review does not host them.

Notes:

- *A given service may be authorised to treat one or both out of soft tissue or bone sarcomas.*
- *Such an authorised service and its NCG will be required as part of the Chemotherapy measures, to agree area-wide sarcoma-specific chemotherapy regimens with the relevant SAGs.*

Compliance: The named service(s) for each of soft tissue and bone sarcoma, agreed by the Chair of the Network Board under review and the chair of the board hosting the relevant sarcoma MDTs if not the network under review.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Designated Radiotherapy Departments	
11-1A-106I	The Network Board should agree which and only which of its radiotherapy departments should be authorised to deliver radical (including adjuvant) radiotherapy courses for the treatment of (i) soft tissue sarcoma and (ii) bone sarcoma, in the network. This agreement should be made in consultation with the relevant SAG(s), the Network Radiotherapy Group (NRG) and the network board(s) of the network(s) hosting the relevant sarcoma MDT(s) if the network under review does not host them. *Notes:* • *A given department may be authorised to treat one or both out of soft tissue or bone sarcomas.* • *Such an authorised department and its NRG will be required as part of the radiotherapy measures, to agree area-wide sarcoma-specific dose/fractionation regimens with the relevant SAGs.* • *There is no restriction for the purpose of peer review, on the site of delivery of palliative radiotherapy.*
Compliance:	The named department(s) for each of soft tissue and bone sarcoma, agreed by the Chair of the Network Board under review and the chair of the board hosting the relevant sarcoma MDTs if not the network under review.
Molecular Biology/Cytogenetic Facilities	
11-1A-107I	The Network Board should nominate which laboratories the network will use for cytogenetic and molecular biology investigations on sarcoma cases.
Compliance:	The named laboratories.

TOPIC 11-1C-1I - SARCOMA ADVISORY GROUP MEASURES

INTRODUCTION

Where agreements or other interactions are needed with a Network Board to comply with any of these measures, the board in question should be agreed with the relevant SCG(s) prior to the peer review/self assessment. This would be expected to be the Network Board held responsible for establishing the SAG under review, as agreed with the SCG, see Network Board Measures for sarcomas.

Pathways, guidelines and agreements should apply area-wide, according to the areas for sarcomas agreed with the SCGs. Similarly, distribution of pathways etc. should be area-wide.

The responsibility for these measures for the purposes of peer review lies with the Chair of the Sarcoma Advisory Group (SAG).

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Sarcoma Advisory Group Meetings	
11-1C-101I	The SAG should meet regularly and record attendance. *Note:* *The attendance of MDT representatives is reviewed as part of each MDT's measures.*
Compliance:	A list of meeting dates and attendance records in the last 12 months.
Annual Review, Work Programme and Annual Report	
11-1C-102I	The Chair of the SAG should have an annual review with the network lead clinician and/or an appropriate member of the Network Board. The SAG should have agreed an annual work programme with the board. The SAG should have produced an annual report for the board.
Compliance:	Documentation sufficient to show that a review meeting took place with the Network Lead clinician and/or appropriate member of the Network Board. The annual work programme agreed by the Chair of the Network Board. The annual report agreed by the Chair of the SAG and the Chair of the Network Board. *Note:* *This meeting should be face to face. An email is not an acceptable mechanism for the review.*
AREA WIDE MINIMUM DATASETS (Measures 11-1C-103I and 11-1C-104I)	
Area Wide Minimum Dataset for Soft Tissue Sarcoma	
11-1C-103I	The SAG should agree an area-wide minimum dataset (MDS) which covers at least the latest approved cancer dataset at www.isb.nhs.uk. The SAG may wish to agree additional data items such as: • the cancer waiting times monitoring, including Going Further on Cancer Waits in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Service; • the National Sarcoma Dataset. The MDS must include all items required for the national contract; any additional items should use definitions and codes taken from the National Cancer Dataset and the NHS Data Dictionary. The SAG should agree a network-wide policy specifying: • which team should collect which portion of the MDS; • when each data items should be captured on the patient pathway; • how the data will be stored and managed within local data systems.

Compliance: The MDS agreed by the Chair of the SAG.

The policy agreed by the Chair of the SAG.

Note:

The SAG for their compliance with this measure should, in consultation with the MDTs, agree the MDS and the individual MDTs, for compliance with their relevant measure, should agree to collect it.

Area Wide Minimum Dataset for Bone Sarcoma

11-1C-104I The SAG should agree an area-wide minimum dataset (MDS) which covers at least the latest approved cancer dataset at www.isb.nhs.uk.

The SAG may wish to agree additional data items such as:

- the cancer waiting times monitoring, including Going Further on Cancer Waits in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Service;
- the National Sarcoma Dataset.

The MDS must include all items required for the national contract; any additional items should use definitions and codes taken from the National Cancer Dataset and the NHS Data Dictionary.

The SAG should agree a network-wide policy specifying:

- which team should collect which portion of the MDS;
- when each data items should be captured on the patient pathway;
- how the data will be stored and managed within local data systems.

Compliance: The MDS agreed by the Chair of the SAG and a representative of NSCG

The policy agreed by the Chair of the SAG.

Note:

The SAG for their compliance with this measure should, in consultation with the MDTs, agree the MDS and the individual MDTs, for compliance with their relevant measure, should agree to collect it.

PATIENT PATHWAYS (measures 11-1C-105I to 11-1C-113I)

Introduction

It is recognised that rehabilitation and psychological support services play a role at various parts of the patient pathway and therefore, reference to rehabilitation and psychological support has not been specified in individual pathway measures. Rather, it is expected that the role will be stated and agreed wherever relevant in the pathways.

THE PRESENTATION PATHWAY: SOFT TISSUE SARCOMAS OF THE LIMB AND TRUNK WALL

Introduction

The presentation pathway for soft tissue sarcomas of the limbs and trunk wall will be defined for the purpose of these measures as dealing with the pathway of referral from all aspects of primary care to the sarcoma diagnostic clinic. It also covers the pathway of referral to the clinic when a patient presents to a hospital doctor who is not a member of a sarcoma MDT or part of the diagnostic clinic. It covers the referral of newly presenting patients and patients presenting with symptoms suggestive of recurrence.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual acute Trust and commissioner, for compliance with its relevant measure, should agree to it and add locally relevant content and distribute it to their relevant referrers.

The Presentation Pathway: Soft Tissue Sarcomas of the Limb and Trunk Wall

11-1C-105I The SAG should, in consultation with the MDTs and diagnostic clinic leads, agree an area-wide presentation pathway for potential soft tissue sarcomas of the limbs and trunk wall, which specifies at least the following:

Note: Masses which are clinically judged to be lymph nodes would normally be expected to be referred initially to the relevant site specific MDT, depending on their anatomical site and accompanying clinical features. Neck lumps are expected to be referred to the already established 'neck lump' clinics.

- those diagnostic clinics, out of all those agreed for the area, which are agreed as able to perform biopsies of suspected sarcomas;
  Note: This is following a judgment by the SAG on whether the relevant surgical staff of the clinic have the necessary expertise relating to the requirements of specifically, sarcoma biopsies.
- the investigations other than biopsy which may be or are expected to be carried out by the diagnostic clinic prior to referral to the sarcoma MDT;
- the contact points of the locally relevant diagnostic clinics for primary care /hospital doctors, for referral of newly presenting patients;
- the contact points for primary care/ hospital doctors to refer back known patients with symptoms suspicious of recurrence.
  Note: Referral of suspected recurrences may be to a diagnostic clinic or a core member of a sarcoma MDT.

Compliance: The pathway, agreed by the Chair of the SAG.

THE PRESENTATION PATHWAY: BONE SARCOMAS

Introduction

The presentation pathway for bone sarcomas will be defined for the purpose of these measures as dealing with the pathway of referral from all aspects of primary care to the bone sarcoma centre. It also covers the pathway of referral to the centre when a patient presents to a hospital doctor who is not a member of the bone sarcoma MDT. It covers the referral of newly presenting patients and patients presenting with symptoms suggestive of recurrence.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual sarcoma MDT acute trust and commissioner, for compliance with its relevant measure, should agree to it and add locally relevant content and distribute it to their relevant referrers.

The Presentation Pathway: Bone Sarcomas

11-1C-106l The SAG should, in consultation with the MDT(s), agree an area-wide presentation pathway for bone sarcomas which specifies at least the following:

- that patients with X-rays or other images (including incidental findings) which are thought to be possibly indicative of a primary bone sarcoma, should be referred directly to the bone sarcoma MDT which is associated with the patient's network;
- that patients with clinical symptoms or signs suspicious of a primary bone sarcoma should be referred directly to the bone sarcoma MDT;
- that patients diagnosed post-operatively with a previously unsuspected bone sarcoma should be referred directly to the bone sarcoma MDT;
- the contact number for referral to the MDT;
- that biopsy of suspected patients should only be carried out by the bone sarcoma MDT;
- that all small cell sarcomas should have molecular/cytogenetic testing;
- the contact points for primary care/ hospital doctors to refer back known patients with symptoms suspicious of recurrence.

Compliance: The pathway agreed by the Chair of the SAG.

THE DIAGNOSTIC PATHWAY FOR SOFT TISSUE SARCOMAS REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process of investigation to establish and confirm the diagnosis, staging and assessment for treatment once the patient has been referred to the sarcoma service. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers the process for a new diagnosis and for a recurrence. For their compliance with this measure, the SAG should in consultation, produce the pathway

and each individual acute trust and MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs.

The Diagnostic Pathway for Soft Tissue Sarcomas, Referred to the Sarcoma Service

11-1C-107I The SAG should, in consultation with the trust leads for sarcomas and MDT(s) agree an area-wide diagnostic pathway for soft tissue sarcomas which specifies at least the following:

- that all biopsies should be referred either directly or for a confirmatory opinion, to a specialist sarcoma pathologist (SSP);
- that all small cell sarcomas should have molecular/cytogenetic testing;
- the imaging modalities and their specific indications;
- the laboratory and histopathological/histochemical investigations and their specific indications;
- which part of the investigational protocols may be carried out by the initial referring body, which may be carried out by the sarcoma diagnostic clinic and which should be carried out by the MDT;
- any aspects of the process which differ between a new diagnosis and that of a recurrence.

Note:

A SSP is defined as a histopathologist who has successfully taken part in the relevant sarcoma national EQA scheme and is a core member of a sarcoma MDT.

Compliance: The pathway agreed by the Chair of the SAG.

THE DIAGNOSTIC PATHWAY FOR BONE SARCOMAS

Introduction

This is defined for the purpose of peer review as covering the process of investigation to establish and confirm the diagnosis, staging and assessment for treatment once the patient has been referred to the bone sarcoma MDT. It covers the process for a new diagnosis and for a recurrence. For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs.

The Diagnostic Pathway for Bone Sarcomas

11-1C-108I The SAG should, in consultation with the trust leads for sarcomas and the BSMDT agree an area-wide diagnostic pathway for bone sarcomas which specifies at least the following:

- the imaging modalities and their specific indications;
- the laboratory and histopathological/histochemical investigations and their specific indications;
- that the histology should be reviewed by a SSP prior to treatment planning decisions being taken;
- which part of the investigational protocols may be carried out by the initial referring body and which should be carried out by the MDT;
- any aspects of the process which differ between a new diagnosis and that of a recurrence.

Compliance: The pathway agreed by the Chair of the SAG.

THE TREATMENT PATHWAY FOR SOFT TISSUE SARCOMAS REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process of active treatment delivery up to, but not including, referral for follow up. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers this process whether it is with radical or palliative intent and whether it is for treatment of a first presentation or of a recurrence. It also covers the situation where the treatment plan is to offer palliative and supportive care only, rather than

active tumour removal or cytoreductive therapy.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs and services.

The Treatment Pathway for Soft Tissue Sarcomas Referred to the Sarcoma Service

11-1C-109I The SAG should, in consultation with the sarcoma MDT(s) agree an area-wide treatment pathway for soft tissue sarcomas which specifies at least the following:

- which team from the, sarcoma MDT, teenage and young adults MDT (TYAMDT), or specialist palliative care MDT (SPCMDT) is responsible for which aspects of care;
- at which stages in the pathway, the patient should be referred between teams;
- clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques);
  Note: Details of chemotherapy algorythms are dealt with in a separate measure, and radiotherapy protocols are dealt with in topic 3T, the radiotherapy measures.
- that the treatment planning decision for initial management and for any active treatment of at least any local recurrence and first distant recurrence, should be made only after discussion at the sarcoma MDT.

Compliance: The pathway agreed by the Chair of the SAG.

THE TREATMENT PATHWAY FOR BONE SARCOMAS

Introduction

This is defined for the purpose of peer review as covering the process of active treatment delivery up to, but not including, referral for follow up. It covers this process whether it is with radical or palliative intent and whether it is for treatment of a first presentation or of a recurrence. It also covers the situation where the treatment plan is to offer palliative and supportive care only, rather than active tumour removal or cytoreductive therapy.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs and services.

The Treatment Pathway for Bone Sarcomas

11-1C-110I The SAG should, in consultation with the bone sarcoma MDT agree an area-wide treatment pathway for bone sarcomas which specifies at least the following:

- which team from the, bone sarcoma MDT, TYAMDT, or SPCMDT is responsible for which aspects of care;
- at which stages in the pathway, the patient should be referred between teams;
- clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques);
  Note: Details of chemotherapy algorythms are dealt with in a separate measure, and radiotherapy protocols are dealt with in topic 3T, the radiotherapy measures;
- that the treatment planning decision for initial management and for any active treatment of at least any local recurrence and first distant recurrence, should be made only after discussion at the bone sarcoma MDT.

Compliance: The pathway agreed by the Chair of the SAG.

THE FOLLOW UP PATHWAY FOR SOFT TISSUE SARCOMA REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process, following completion of an episode of active treatment, from and including the referral to whoever is undertaking follow up. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers follow up until this ends and includes the process of referral back to the MDT when

recurrence is diagnosed by the follow up clinic.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual sarcoma MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs.

The Follow Up Pathway for Soft Tissue Sarcoma Referred to the Sarcoma Service

11-1C-111I The SAG should, in consultation with the acute trust leads for sarcoma and sarcoma MDT(s), agree an area-wide follow up pathway for soft tissue sarcomas which specifies at least the following:

- what the roles are, in the follow up process, of clinics outside the sarcoma centre and the sarcoma MDT;
- the contact points for referral back with recurrence.

Compliance: The pathway agreed by the Chair of the SAG.

THE FOLLOW UP PATHWAY FOR BONE SARCOMA

Introduction

This is defined for the purpose of peer review as covering the process, following completion of an episode of active treatment, from and including the referral to whoever is undertaking follow up. It covers follow up until this ends and includes the process of referral back to the MDT when recurrence is diagnosed by the follow up clinic.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual bone sarcoma MDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs.

The Follow Up Pathway for Bone Sarcoma

11-1C-112I The SAG should, in consultation with the acute trust leads for sarcoma and bone sarcoma MDT agree an area-wide follow up pathway for bone sarcomas which specifies at least the following:

- what the roles are, in the follow up process, of clinics outside the sarcoma centre and the bone sarcoma MDT;
- the contact points for referral back with recurrence.

Compliance: The pathway agreed by the Chair of the SAG.

SHARED CARE PATHWAY FOR SOFT TISSUE SARCOMAS PRESENTING TO THE SITE SPECIALISED MDTS

Introduction

For their compliance with this measure, the SAG should, in consultation with the relevant NSSGs (including those in referring networks in the SAG's area), produce the soft tissue sarcoma shared care pathway for at least the list of cancer sites specified in the measure below and the sarcoma MDT, the NSSGs and their associated site-specific MDTs, for compliance with their relevant measures, should agree to abide by it and add locally relevant detail.

Shared Care Pathway for Soft Tissue Sarcomas Presenting to Site Specialised MDTs

11-1C-113I The SAG should, in consultation with the relevant NSSGs produce the shared care pathway for soft tissue sarcomas presenting to site specialist MDTs, which should specify at least the following:

- which individual MDT or clinic out of the site specialist MDT, sarcoma MDT and specialist clinics, should deal with these cases for which parts of the patient's pathway;
- clinical guidelines (how a given patient should be clinically managed, usually at the level of which modality of treatment is indicated, rather than detailed regimens or surgical techniques.)
  Note: Details of chemotherapy algorythms are dealt with in a separate measure, and radiotherapy protocols are dealt with in topic 3T, the radiotherapy measures;
-

that all newly presenting cases of soft tissue sarcoma, if not diagnosed initially by an SSP should be sent for histological review by an SSP and in the case of upper GI sarcomas, the histology of all proposed cases of GIST are reviewed by one of the designated GIST pathologists, for the area. (Measure 11-1C-119I)

- the pathway as it should apply to retroperitoneal sarcomas.

The pathway should apply to at least the following:

- Upper GI sarcomas.
- Gynaecological sarcomas.
- Head and neck, soft tissue sarcomas.
- Skin sarcomas.
- Breast sarcomas.
- Lung sarcomas.
- Urological sarcomas.

Compliance: The pathway agreed by the Chair of the SAG and the chairs of the NSSGs corresponding to the list of sites and the networks involved.

AREA AUDIT

Introductory Notes

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

Area Audit

11-1C-114I

The SAG should agree an area audit project, with the Network Board.

The SAG should annually review the progress of the area audit project or discuss the results of the completed area audit project.

Note:

Where national audits have been developed these should be part of the area audit programme.

Additional projects may be agreed.

Compliance: The project agreed by the Chair of the SAG and the Chair of the Network Board.
Written confirmation of an annual review sufficient to show compliance with the measures.
Note:
An agreed summary is sufficient provided it shows compliance with the measure

Proposals for Service Delivery Plan

11-1C-115I

The SAG should agree proposed service developments for its cancer site, for the three contracting years, as advice to the board, for the network proposed service delivery plan.

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

Discussion of Clinical Trials

11-1C-116I

The SAG should discuss at least annually, the report on clinical trials from each of its MDTs (see relevant MDT measures).

The following should be present at the discussion:

- the Chair of the SAG or a nominated representative;
- the SAG research lead;
- the lead clinician of the MDT or nominated representative from that MDT;
- the clinical lead of the research network or a nominated representative from the research network.

A programme for improvement for clinical trial entry for the MDT should be agreed at the

discussion.

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

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

Notes:

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

Designated Chemotherapy Practitioners

11-1C-117I The SAG should name the oncologists other than those who are core members of a sarcoma MDT, who and only who, should be responsible for the delivery of any chemotherapy to (i) soft tissue sarcoma patients and (ii) bone sarcoma patients, in the SAG's catchment area.

They should each be named as a member of a relevant extended sarcoma MDT.

They should have specified time in their job plans for the care of patients with the relevant sarcoma including time worked in a designated department (see topic1D).

Notes:

- *They may be consultant medical oncologists or clinical oncologists.*
- *A given oncologist may be designated as able to treat one or both out of soft tissue sarcoma and bone sarcoma.*
- *Although palliative chemotherapy should be delivered under the care of a designated oncologist, it need not be carried out only in a designated chemotherapy department.*

Compliance: The named oncologists, for soft tissue and bone sarcoma, agreed by the Chair of the SAG and each oncologist's clinical director.

The job plans and the membership lists of the relevant extended MDTs.

Designated Radiotherapy Practitioners

11-1C-118I The SAG should name the oncologists other than those who are core members of a sarcoma MDT, who and only who, should be responsible for the delivery of any radiotherapy, to (i) soft tissue sarcoma patients and (ii) bone sarcoma patients, in the SAG's catchment area.

They should each be named as a member of a relevant extended sarcoma MDT.

They should have specified time in their job plans for the care of patients with the relevant sarcoma including time worked in a designated department (see topic1D).

Notes:

- *They should be consultant clinical oncologists.*
- *A given oncologist may be designated as able to treat one or both out of soft tissue sarcoma and bone sarcoma.*
- *Although palliative radiotherapy should be delivered under the care of a designated oncologist, it need not be carried out only in a designated radiotherapy department.*

Compliance: The named oncologists, for soft tissue and bone sarcoma, agreed by the chair of the SAG and each oncologist's clinical director.

The job plans and the membership lists of the relevant extended MDTs.

Designated GIST Histopathologists

11-1C-119I The SAG should, in consultation with the network cancer pathology groups of the networks involved, name the consultant histopathologists who and only who, should be responsible for the final reporting and reviewing of the histological diagnosis of GIST in

the SAG's catchment area.

They should each be a core member of an MDT which is named in the area shared care pathway for upper GI soft tissue sarcoma, as dealing with the confirmation of diagnosis and the treatment planning decision on these patients.

They should each have taken part in either the national sarcoma histopathology EQA or the national GI histopathology EQA.

Compliance: The named pathologists, agreed by the Chair of the SAG and each pathologist's clinical director.

The core membership lists of the relevant MDTs.

Documentary up to date confirmation of participation in the EQA.

CHEMOTHERAPY TREATMENT ALGORITHMS

Introduction

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

Chemotherapy Treatment Algorithms

11-1C-120I The SAG, in consultation with the Network Chemotherapy Group (NCG) should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.

Notes:

- *The intention is **not** to require a single mandatory regimen for each clinical indication. It is to prevent individual practitioners having unorthodox, obsolete and unpredictably varying practice, which is against the opinion of their peers within the network.*
- *The SAG should produce the algorithms for its compliance with this measure and the chemotherapy multi-professional team should produce a compatible list of algorithms for the SAG's cancer site for their own service (measure 11-3S-122).*
- *The chemotherapy multi-professional team should agree lists with all the SAGs relevant to their practice, for compliance with their measure.*
- *The network algorithm for a particular clinical situation may have a number of alternative regimens of which the multi-professional team need only agree those which it intends to use in its service. The multi-professional team need only address those clinical indications which are applicable to the scope of its practice. The key requirement is that all the algorithms on the multi-professional team list are compatible with the SAG agreed list.*
- *This exercise should include oral chemotherapy.*

- *This measure is assessed as part of the responsibility of each SAG, but from the NCG's point of view regarding the management of this process, the algorithms don't all need to be updated at the same time. It would seem sensible, however, to update all those for a given cancer site, at the same time.*

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

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

The TYACN Pathway for Initial Management

11-1C-121I The SAG should agree, with the chair of the relevant TYACNCG, the TYACN patient pathway for initial management, including any features specific to the SAG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

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

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

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

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

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

11-1C-122I The SAG should agree, with the chair of the relevant TYACNCG the TYACN patient pathway for follow up on completion of first line treatment including any features specific to the SAG's cancer site and their host adult cancer network and incorporating their relevant MDT contact numbers.

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

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

The reviewers should check that it fulfils the features above.

The reviewers should enquire as to the distribution process.

Note:

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

TYACN PATIENT PATHWAYS FOR CASES INVOLVING NHS SPECIALISED SERVICES

Introduction

This measure is applicable only to Gynae NSSGs and Sarcoma Advisory Groups as there are no clear NSSG-type arrangements for ocular oncology or proton beam therapy.

TYACN Patient Pathways for Cases Involving NHS Specialised Services

11-1C-123I The SAG should agree, with the chair of the relevant TYACNCG, the relevant TYACN patient pathway for cases involving NHS Specialised Services.

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The pathway, agreed by the Chair of the SAG and the chair of the relevant TYACNCG. The reviewers should enquire as to the distribution process. *Note:* *The TYACNCG should, for compliance with their relevant measure, produce the pathway and the SAG, for compliance with this measure, should agree to abide by it,add local contact points and distribute it. The TYA MDT for compliance with its relevant measure, should agree it with the TYACNCG.*

TOPIC 11-1D-1I - FUNCTIONS OF THE LOCALITY/TRUST GROUP

The responsibility for the first of these measures lies with the trust cancer lead clinician and the responsibility for the subsequent measures lies with the trust lead clinician for sarcomas. The measures should be applied to each locality/trust in the network under review.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Trust Lead Clinicians for Sarcomas	
11-1D-101I	There should be a named lead clinician for sarcomas for the trust. They should be at consultant level. They should have specified time and a list of responsibilities for the role, agreed with the trust cancer lead clinician. *Notes:* *A list of suggested responsibilities for the role, for illustration only, may be found in appendix 1.* *The role need not be full time and the actual specified time is not subject to review.* *The role may be fulfilled by the trust cancer lead clinician themselves, in which case this proposal and the specified time for the role should be agreed with the Chair of the Network Board.*
Compliance:	The named lead, agreed by the trust cancer lead clinician. The specified time and list of responsibilities agreed by the trust cancer lead clinician and the trust lead clinician for sarcomas. *Note:* *See the special compliance requirements for the case where the role is taken by the trust cancer lead clinician.*
PATIENT PATHWAYS **Introduction** These measures should be read in conjunction with their relevant counterparts in topic1C 'Functions of the Sarcoma Advisory Group'. For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual acute trust, for compliance with this measure, should agree to it and add locally relevant content.	
The Presentation Pathway for Soft Tissue Sarcomas of the Limbs and Trunk Wall	
11-1D-102I	The trust should agree the presentation pathway and its role in it and provide local contact points. The trust should ensure the distribution of the presentation pathway to primary care practices in its catchment area.
Compliance:	The pathway with local contact points, agreed by the trust lead clinician for sarcomas. The reviewers should enquire as to the distribution process. *Note:* *Minor shortcomings in the completeness of distribution, should not prevent compliance with this measure.*
The Presentation Pathway for Bone Sarcomas	
11-1D-103I	The trust should agree the presentation pathway and its role in it and provide local contact points. The trust should ensure the distribution of the presentation pathway to primary care practices in its catchment area.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

The reviewers should enquire as to the distribution process.

Note:

Minor shortcomings in the completeness of distribution, should not prevent compliance with this measure.

The Diagnostic Pathway for Soft Tissue Sarcomas

11-1D-104l The trust should agree the diagnostic pathway and its role in it and provide local contact points, including named MDTs.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

The Diagnostic Pathway for Bone Sarcomas

11-1D-105l The trust should agree the diagnostic pathway and its role in it and provide local contact points, including named MDTs.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

The Follow Up Pathway for Soft Tissue Sarcomas

11-1D-106l The trust should agree its role, if any in the follow up pathway and provide local contact points.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

The Follow Up Pathway for Bone Sarcomas

11-1D-107l The trust should agree its role, if any in the follow up pathway and provide local contact points.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

PROVISION OF THE DIAGNOSTIC CLINIC FOR SOFT TISSUE SARCOMAS OF THE LIMBS AND TRUNK WALL (Measures 11-1D-108l to 11-1D-110l).

Applicable only to the localities hosting those hospitals which are agreed as requiring to provide a diagnostic clinic.

Provision of The Diagnostic Clinic for Soft Tissue Sarcomas of the Limbs and Trunk Wall

11-1D-108l The hospital should hold a clinic which:

i) should be identified on the hospital outpatient department clinic list or timetable as a clinic for new patients with potential soft tissue sarcoma of the limbs and trunk wall;
ii) should have the patients to be referred to the clinic defined by the two week referral guidelines for soft tissue sarcomas of the limbs and trunk wall. (*CG27 Referral for suspected cancer: NICE guideline*);
iii) should be identified in the agreed area presentation pathway with a local contact point for GP and hospital doctor referrals of the above patients;
iv) should have bookable clinic slots identified for the above patients;
v) should be part of the work plan or timetable of at least the cancer nurse specialist and designated doctor identified in measures 11-1D-109l and 11-1D-110l;
vi) should be the only such clinic run by the host hospital.

Note:

The clinic may be run as a standalone clinic or may be part of an existing clinic as long as in the latter case, the conditions in sections (i)-(vi) can be seen to be fulfilled for patients with potential soft tissue sarcomas of the limbs and trunk wall.

Compliance: The clinic booking rules.

The outpatient department schedule /timetable.

The presentation pathway.

The timetable/job plan of the cancer nurse specialist and the designated clinician.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Designated Clinician for the Sarcoma Diagnostic Clinic

11-1D-109I

There should be a single named designated clinician for the diagnostic clinic, who should be a consultant, with programmed activities specified for the diagnosis of patients with soft tissue sarcoma of the limbs and trunk wall.

The designated clinician should have a list of responsibilities for the position, agreed with the cancer lead clinician of the host trust. The list should include the following;

- ensuring that systems are in place for the diagnosis and onward referral of patients referred with symptoms of soft tissue sarcoma of the limbs and trunk wall, and that this is to enable cancer waiting time targets to be achieved;
- ensuring that if a patient is given the initial diagnosis of malignancy by a member of the diagnostic clinic, the patient's GP is informed of the diagnosis by the end of the following working day;
- should attend a minimum of 2 meetings of the SMDT per year.

Compliance: The named designated clinician of the clinic, agreed by the cancer lead clinician of the host trust.

The work plan or timetable of the designated clinician.

The list of responsibilities, agreed by the designated clinician and the cancer lead clinician of the host trust.

Notes:

The number of programmed activities is not subject to review. They would need to include time for the diagnostic clinic to comply with the measure.

There may be other responsibilities agreed as part of the list. These are not subject to review.

It is likely, although not mandatory, that in the case of a hospital hosting a diagnostic clinic for soft tissue sarcomas, the person who fulfils the role of trust lead clinician for sarcomas, fulfils the role of designated clinician for the diagnostic clinic as well. In this case, the list of responsibilities should be adjusted accordingly.

Similarly, in the case of a hospital hosting a sarcoma MDT, the roles could be fulfilled by the lead clinician of the MDT, providing the person was reviewed against the relevant measures as well as the requirements of the MDT lead clinician.

Diagnostic Clinic Cancer Nurse Specialist

11-1D-110I

There should be at least one nurse, designated for the diagnostic clinic, with time specified in their timetable or job plan, for the diagnosis of patients with soft tissue sarcoma of the limbs and trunk wall.

The nurse should have successfully completed a programme of study in their specialist area of practice, giving at least 20 credits at 1st degree level or equivalent.

Notes:

The course in the specialist area of practice may be either:

- *a course in oncology for nurses or;*
- *a course in nursing aspects related to sarcoma or;*
- *a course combining elements of both the above.*

It is strongly recommended that if there is more than one nurse designated for the diagnostic service, they should all be compliant with this measure.

The nurse should agree a list of responsibilities with the cancer lead clinician of the trust and the nurse's line manager, which includes ensuring that written material is provided for patients and carers.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
Compliance:	The named nurse, with their timetable or job plan. Written confirmation of successful completion of the course of study. The list of responsibilities, agreed by the cancer lead clinician of the trust and the line manager. *Note:* *Additional responsibilities may be agreed as well as those specified in the measure. This is not subject to review.*
Required MDT Membership of Surgeons Treating Sarcomas	
11-1D-111l	If there is any consultant surgeon in the trust who is responsible for the elective excision of trunk and limb soft tissue sarcomas or bone sarcomas, they should be a core member of a sarcoma MDT. Any surgeons who are responsible for treating sarcomas in special sites should be core members of a relevant site-specific MDT or a sarcoma MDT. *Notes:* *The word 'elective' is used since some patients may be treated for their cancer by non-MDT members in emergency situations where the diagnosis is unforeseen.* *A different measure on this issue applies to non surgical consultant oncologists engaged in a sarcoma practice (see measures 11-1C-117l and 11-1C-118l).* *From the point of view of the peer review, it is not mandatory for a given trust to have any surgeons with the above responsibility, but if there are any, they should meet the requirements in this measure.*
Compliance:	The reviewers should enquire of the working practice of surgeons in the trust.
Required MDT Membership or Network Designation of Oncologists Treating Sarcomas	
11-1D-112l	Each consultant non surgical oncologist in the trust, who is responsible for the elective delivery of cytoreductive non surgical treatment (e.g. elective chemotherapy or radiotherapy) to patients with trunk or limb soft tissue sarcomas or bone sarcomas, should be a core member of a sarcoma MDT or should be one of the area's designated sarcoma oncologists. Oncologists who are responsible for the delivery of such treatment to patients with sarcomas in special sites should fulfil the above requirements or be core members of a relevant site-specific MDT. *Notes:* *The word 'elective' is used since some patients may be treated for their cancer by non-MDT members in emergency situations where the diagnosis is unforeseen.* *From the point of view of the peer review, it is not mandatory for a given trust to have any designated sarcoma oncologists with the above responsibility, but if there are any, they should meet the requirements in this measure.*
Compliance:	The reviewers should enquire of the working practice of non surgical oncologists in the trust.

TOPIC 11-2L-1- SARCOMA MULTIDISCIPLINARY TEAM (MDT)

Introduction

When is a Team a Team and when is it not a Team?

The measures review a variety of aspects of the team, both structure and function, but the key question which underlies all this is who exactly constitutes the MDT from the point of view of the peer review? Which group of people should be put forward for review against these measures and who is it who is held compliant or not compliant?

This is best answered from the patient's point of view. If you were a patient who would you consider to be your MDT?

Primarily it is that group of people of different health care disciplines, which meets together at a given time (whether physically in one place, or by video or tele-conferencing) to discuss a given patient and who are each able to contribute independently to the diagnostic and treatment decisions about the patient. They constitute that patient's MDT.

The way the MDT meeting itself is organised is left to local discretion such that different professional disciplines may make their contributions at different times, without necessarily being present for the whole meeting in order to prevent wastage of staff time. The key requirement is that each discipline is able to contribute independently to the decisions regarding each relevant patient.

The responsibility for review purposes for the first measure lies with the cancer lead clinician of the host trust of the MDT.
The responsibility for review purposes for the subsequent measures lies with the lead clinician of the MDT.
If a team is put forward for review which does not meet the relevant ground rules for networking, it should be identified as a major issue in the report, but should still be reviewed against the relevant set of measures.

Sarcoma MDTs

This section of the measures should be applied to both an MDT dealing with soft tissue sarcomas only and an MDT dealing with soft tissue and bone sarcomas. For the most part, the whole of each individual measure applies to both types of team. In the small number of cases where either a measure or parts of a measure apply only to one type of team, this is stated in the text. There are currently no 'bone only MDTs' and it is not envisaged that there should be and there are no measures which apply particularly to this theoretical situation.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
MDT STRUCTURE	
Lead Clinician and Core Team Membership	
11-2L-101	There should be a single named lead clinician for the sarcoma MDT who should then be a core team member. The lead clinician of the MDT should have agreed the responsibilities of the position with the lead clinician of the host trust. *Note:* *The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience of superior clinical ability.* The MDT should provide the names of the core team members for named roles in the team as follows: • two sarcoma surgeons with a relevant surgical practice, for each of the two sarcoma subdivisions, soft tissue and bone that the MDT deals with; *Note: For example, for a STS/ bone sarcoma MDT, if only one of the two surgeons had a practice in bone sarcoma, then a third surgeon, who had such a practice, would be necessary. A given individual can be accepted for both the STS and bone roles provided they have a practice in both. In this case, the 5 sessions (see measure 11-2L-112) can be made up of care for both STS and bone sarcoma patients.*

- two imaging specialists;
- two oncologists, at least one of which should be named as having responsibility for radiotherapy and at least one of which should be named as having responsibility for chemotherapy;
  Note: It can be seen that one clinical oncologist plus one medical oncologist or two clinical oncologists may fulfil the above requirement. Both oncologists may have responsibility for the same modality and a given clinical oncologist may have responsibility for both modalities.
- two histopathologists;
- two clinical nurse specialists who should be put forward for review against the MDT nurse measures in this section;
- an MDT coordinator/secretary;
- an NHS- employed member of the core or extended team should be nominated as having specific responsibility for users' and carers' issues and information;
- a member of the core team should be nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT;
- each clinical core member should have sessions specified in the job plan for the care of patients with sarcoma and attendance at MDT meetings.

Notes:

- *Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant.*
- *Clinical sessions should be defined as relevant to their professional group.*
- *The co-coordinator/secretary roles need different amounts of time depending on team workload, see appendix 2 for an illustration of the responsibilities of this role. The co-ordinator and secretarial 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.*
- *There may be additional core members agreed for the team besides those listed above.*

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

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

Note:

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

The name of each core team member with their role, agreed by the lead clinician of the MDT.

The job plans of the relevant specialists.

Note:

The reviewers should record in their assessment each case where the post(s) needed to provide the minimum core membership for a given listed role in the measure is unfilled or non-existent or existing posts cannot provide the service. This does not refer to mere holiday or sickness absence, or less than two thirds attendance, and it refers only to the core member roles listed in the measure, not to additional roles that the MDT has decided locally to include as core members. The reviewers should identify the particular missing roles and identify the particular MDT in the report.

Level 2 Practitioners for Psychological Support

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

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *The relevant discipline include medical, surgical, nursing and allied health*

professionals

- *If the MDT has one or more clinical core members who are trained to level 3 or 4, the team is deemed to be automatically compliant with this measure.*
- *The definition of the levels may be found in appendix 1 of the Psychological support measures.*

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

Support for Level 2 Practitioners

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

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

Attendance at Sarcoma Advisory Group Meetings

11-2L-104 The lead clinician of the MDT or representative should attend at least two thirds of the SAG meetings.

Compliance: The attendance record of the SAG.

MDT Meetings

11-2L-105 The team should hold its meetings weekly, record core members' attendance and have a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting. (Guidance only - e.g. letters, emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting).

Compliance: Attendance records of the meetings.
Written procedure agreed by the lead clinician of the MDT.

MDT Agreed Cover Arrangements

11-2L-106 The MDT should agree named cover arrangements for each core member.

Notes:

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

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

Core Members (or cover) Present for At Least 2/3 of Meetings

11-2L-107 Core members or their arranged cover (see measures **11-2L-101** and **11-2L-106**) should attend at least two thirds of the number of meetings.

Compliance: Attendance record of the MDT.

Notes:

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

OPERATIONAL POLICIES

Annual Meeting to Discuss Operational Policy

11-2L-108 Besides the regular meetings to discuss individual patients, the team should meet at least annually to discuss, review, agree and record at least some operational policies.

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

Policy for all Patients to be Reviewed by MDT

11-2L-109 There should be an operational policy for the team which specifies that all patients will be reviewed by the MDT at least:

- Post initial diagnosis, pre- potential tumour resection.
- Post tumour resection, pre-, potential adjuvant treatment.
- On diagnosis of first distant metastasis or any local recurrence in the absence of distant metastases.
- Any other times as are agreed in the area-wide patient pathways.

Note:

This policy does not apply to soft tissue patients presenting to a site-specific MDT. This situation is covered by the agreed shared care pathway.

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

Policy for Communication of Diagnosis to GP

11-2L-110 The MDT should have an agreed policy whereby after a patient is given a diagnosis of cancer, the patient's general practitioner (GP) is informed of the diagnosis by the end of the following working day.

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

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

Operational Policy for Named Key Worker

11-2L-111 There should be an operational policy whereby a single named key worker for the patient's care at a given time is identified by the MDT members for each individual patient and the name and contact number of the current key worker is recorded in the patient's case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s).

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

Notes:

For information: according to the NICE palliative care guidance, a key worker is a person who, with the patient's consent and agreement, takes a key role in co-ordinating the patient's care and promoting continuity, e.g. ensuring the patient knows who to access for information and advice. This is not intended to have the same connotation as the key worker in social work.

It may be necessary to agree a single key worker across both a cancer site specific MDT and the specialist palliative care MDT for certain patients.

Compliance: The written policy agreed by the lead clinician of the MDT.
Reviewers should spot check some of the relevant patients' case notes.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

OPERATIONAL POLICIES FOR CORE MEMBERS PRACTICE

Surgical Core Members Practice

11-2L-112 Core surgical members of the MDT should have 5 PAs per week specified for the care of patients with sarcoma.

Note:

The PAs may be a combination of direct clinical care PAs and supportive PAs.

Compliance: The job plans of the named core members.

Note:

For compliance all core members should be compliant.

Oncology Core Members Practice

11-2L-113 Core oncology members of the MDT should have 3 PAs per week specified for the care of patients with sarcoma.

Note:

The PAs may be a combination of DCC PAs and SPAs.

Compliance: The job plans of the named core members.

Note:

For compliance all core members should be compliant.

Core Histopathology Member Taking Part in an EQA scheme

11-2L-114 The core histopathology member(s) of the MDT should have taken part in the national soft tissue sarcoma EQA, for STS MDTs and both the bone sarcoma and soft tissue sarcoma EQA for combined MDTs.

Note:

Compliance with this requirement and core membership of a sarcoma MDT, constitute the definition of an SSP, for the purpose of the measures and peer review.

Compliance: Documentary evidence to show completion of this EQA.

Note:

For compliance all core members should be compliant.

MDT NURSE SPECIALIST MEASURES (Measures 11-2L-115 to 11-2L-116)

Introduction

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

The modern change to MDT working has created and then highly developed the specific role of 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 members. The role definitions and training requirements of nurse MDT members are not 'officially' established outside the MDT world in contrast to the well-defined medical specialties with their formal national training requirements.

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

Core Nurse Members Completed Specialist Study

11-2L-115 Each core nurse specialist should have successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent.

Compliance: Confirmation of successful completion of the course/module.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Agreed List of Responsibilities for Core Nurse Members

11-2L-116

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

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

Notes:

Additional responsibilities to those in this measure may be agreed.

'Management' in this context does not mean clerical tasks involving the documentation on individual patients, i.e. this responsibility does not overlap with the responsibility of the MDT co-ordinator.

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

Attendance at National Advanced Communications Training Programme

11-2L-117

At least those core members of the team who have direct clinical contact with patients should have attended the national advanced communications skills training.

Notes:

- *This measure applies only to those disciplines which have direct clinical contact and which are named in the list in the MDT structure measure for core membership.*
- *Also, it applies only with regard to members who are in place, i.e. if a team lacks a given core member from that list it should still be counted as compliant with this measure provided those members who are in place, comply.*
- *The relevant disciplines include medical, surgical, nursing and allied health professionals.*
- *The reviewers should record which core members of those relevant are non-compliant.*

Compliance: Written confirmation of the MDT members who have attended the national advanced communication skills training programme.

Extended Team Membership

11-2L-118

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

The named extended team for the MDT should include:

- an AHP agreed as providing contact with rehabilitation services;
- a health professional who is a core member of a specialist palliative care team;
- a health professional core member of each of the following types of MDT in the sarcoma MDT's area, to act as contact person when needed.
  - Upper GI
  - Gynaecology
  - Head and neck
  - Skin
  - Breast

- Lung
- Urology

Compliance: The name of each extended team member with their role, agreed by the lead clinician of the MDT.

PROVIDING PATIENT CENTRED CARE

Patients' Permanent Consultation Record

11-2L-119

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

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

Note:

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

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

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

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

Note:

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

Patients' Experience Exercise

11-2L-120

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

The exercise should at least ascertain whether patients experienced or were offered:

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

Notes:

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

Exercises which have been completed during the previous two years should have been presented and discussed at an MDT meeting and the team should have implemented at least one action point arising from the exercise.

Compliance: The results of the exercise.

A report of the actions taken.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

Patient Written Information

11-2L-121

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

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

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

Notes:

- *The information prescription should be tailored to the patients/carers needs based on an information needs assessment. Information may be generated and dispensed outside of the clinic environments within an information centre where a clear operational policy between the clinic and information centre is in place which identifies how clinic records are updated and that facilities and resources within the information centre are appropriate to providing such a service.*
- *The information prescription should be composed of information from the national pathways supplemented with national and local accredited information.*

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

Notes:

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

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

Treatment Planning Decision

11-2L-122

The core MDT at their regular meetings should agree and record individual patient's management plans. A record should be made of the plan. The record should include:

- the identity of patients discussed;
- the stage in the patient's pathway at which the MDT discussion is taking place (e.g. for illustration, post-biopsy pre-definitive surgery, post-op pre-adjuvant treatment, recurrence);
- the diagnosis;
- the multidisciplinary management decision relevant to that stage in the pathway; i.e. to which modalities of treatment and/or supportive and palliative care, they are to be referred for consideration.

Compliance: Anonymised examples of the record of a meeting and individual anonymised treatment plans.

Notes:

Only exactly what is required in the list above is necessary for evidence. Detailed minutes of the content of discussions over patients are not required for evidence. For the purposes of evidence for peer review, patient specific information should be anonymised.

PATIENT PATHWAYS (measures 11-2L-123 to 11-2L-131)

Introduction

These measures should be read in conjunction with their relevant counterparts in section 1C Functions of the SAG.

THE PRESENTATION PATHWAY FOR SOFT TISSUE SARCOMAS OF THE LIMBS AND TRUNK WALL

Introduction

The presentation pathway for soft tissue sarcomas of the limbs and trunk wall will be defined for the purpose of these measures as dealing with the pathway of referral from all aspects of primary care to the sarcoma diagnostic clinic. It also covers the pathway of referral to the clinic when a patient presents to a hospital doctor who is not a member of a sarcoma MDT or part of the diagnostic clinic. It covers the referral of newly presenting patients and patients presenting with symptoms suggestive of recurrence.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual acute Trust and commissioner, for compliance with its relevant measure, should agree to it and add locally relevant content and distribute it to their relevant referrers.

The Presentation Pathway for Soft Tissue Sarcomas of the Limbs and Trunk Wall

11-2L-123 The MDT should agree the presentation pathway and its role in it and provide local contact points.

Compliance: The pathway with local contact points, agreed by the trust lead clinician for sarcomas.

THE PRESENTATION PATHWAY: BONE SARCOMAS
Applicable only to MDTs dealing with bone sarcoma

Introduction

The presentation pathway for bone sarcomas will be defined for the purpose of these measures as dealing with the pathway of referral from all aspects of primary care to the bone sarcoma centre. It also covers the pathway of referral to the centre when a patient presents to a hospital doctor who is not a member of the bone sarcoma MDT. It covers the referral of newly presenting patients and patients presenting with symptoms suggestive of recurrence.

For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual sarcoma MDT acute trust and PCT, for compliance with this measure, should agree to it and add locally relevant content and distribute it to their relevant referrers.

The Presentation Pathway: Bone Sarcomas

11-2L-124 The MDT should agree its role in the area presentation pathway for bone sarcomas and add any locally relevant content.

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

THE DIAGNOSTIC PATHWAY FOR SOFT TISSUE SARCOMAS REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process of investigation to establish and confirm the diagnosis, staging and assessment for treatment once the patient has been referred to the sarcoma service. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers the process for a new diagnosis and for a recurrence. For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with this measure, should agree to it and add any locally relevant content including named MDTs. The MDT measure includes a check on implementation of the molecular genetic/cytogenetic testing of small cell sarcomas.

The Diagnostic Pathway for Soft Tissue Sarcomas Referred to the Sarcoma Service

11-2L-125 The MDT should agree its role in the area diagnostic pathway for soft tissue sarcomas and add any locally relevant content.

The MDT should be performing molecular genetic/cytogenetic testing on small cell sarcomas.

Compliance: The pathway, agreed by the lead clinician of the MDT.
The reviewers should spot check randomly selected pathology reports on small cell

sarcoma cases for molecular genetic/cytogenetic testing.

THE DIAGNOSTIC PATHWAY FOR BONE SARCOMAS
Applicable only to MDTs dealing with bone sarcoma

Introduction

This is defined for the purpose of peer review as covering the process of investigation to establish and confirm the diagnosis, staging and assessment for treatment once the patient has been referred to the bone sarcoma MDT. It covers the process for a new diagnosis and for a recurrence. For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with this measure, should agree to it and add any locally relevant content including named MDTs.

The Diagnostic Pathway for Bone Sarcomas

11-2L-126 The MDT should agree its role in the area diagnostic pathway for bone sarcomas and add any locally relevant content.

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

THE TREATMENT PATHWAY FOR SOFT TISSUE SARCOMAS REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process of treatment delivery up to, but not including, referral for follow up. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers this process whether it is with radical or palliative intent and whether it is for treatment of a first presentation or of a recurrence. It also covers the situation where the treatment plan is to offer palliative and supportive care only, rather than active tumour removal or cytoreductive therapy.

For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with this measure, should agree to it and add any locally relevant content including named MDTs and services.

The Treatment Pathway for Soft Tissue Sarcomas Referred to the Sarcoma Service

11-2L-127 The MDT should agree its role in the area treatment pathway for soft tissue sarcomas and add any locally relevant content.

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

THE TREATMENT PATHWAY FOR BONE SARCOMAS
Applicable only to MDTs dealing with Bone Sarcomas

Introduction

This is defined for the purpose of peer review as covering the process of active treatment delivery up to, but not including, referral for follow up. It covers this process whether it is with radical or palliative intent and whether it is for treatment of a first presentation or of a recurrence. It also covers the situation where the treatment plan is to offer palliative and supportive care only, rather than active tumour removal or cytoreductive therapy.

For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual acute trust and MDT, for compliance with this measure, should agree to it and add any locally relevant content including named MDTs and services.

The Treatment Pathway for Bone Sarcomas

11-2L-128 The MDT should agree its role in the area treatment pathway for bone sarcomas and add any locally relevant content.

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

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

THE FOLLOW UP PATHWAY FOR SOFT TISSUE SARCOMAS REFERRED TO THE SARCOMA SERVICE

Introduction

This is defined for the purpose of peer review as covering the process, following completion of an episode of active treatment, from and including the referral to whoever is undertaking follow up. It recognises that some sarcomas with site-specific presentations will be managed according to the agreed area shared care pathways. It covers follow up until this ends and includes the process of referral back to the MDT when recurrence is diagnosed by the follow up clinic.

For their compliance with their relevant measure, the SAG should in consultation, produce the pathway and each individual STSMDT, for compliance with this measure, should agree to it and add any locally relevant content including named MDTs.

The Follow Up Pathway for Soft Tissue Sarcoma Referred to the Sarcoma Service

11-2L-129 The MDT should agree its role in the area follow up pathway for soft tissue sarcomas and add any locally relevant content.

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

THE FOLLOW UP PATHWAY FOR BONE SARCOMAS
Applicable only to MDTs dealing with Bone Sarcomas

Introduction

This is defined for the purpose of peer review as covering the process, following completion of an episode of active treatment, from and including the referral to whoever is undertaking follow up. It covers follow up until this ends and includes the process of referral back to the MDT when recurrence is diagnosed by the follow up clinic.

For their compliance with this measure, the SAG should in consultation, produce the pathway and each individual BSMDT, for compliance with its relevant measure, should agree to it and add any locally relevant content including named MDTs.

The Follow Up Pathway for Bone Sarcomas

11-2L-130 The MDT should agree its role in the area follow up pathway for bone sarcomas and add any locally relevant content.

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

Shared Care Pathways for Soft Tissue Sarcomas Presenting to Site Specialised MDTs

11-2L-131 The MDT should agree its role in the shared care pathways for soft tissue sarcoma presenting to at least the following site specific MDTs:

- Upper GI
- Gynaecology
- Head and neck
- Skin
- Breast
- Lung
- Urology

The MDT should add any locally relevant detail.

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

SHARED CARE PATHWAYS FOR SOFT TISSUE SARCOMAS PRESENTING TO SITE SPECIALISED MDTS

Introduction

For their compliance with their relevant measures, the SAG should, in consultation with the relevant NSSGs (including those in referring networks in the SAG's area), produce the soft tissue sarcoma shared care pathway for the cancer site in question and the sarcoma MDT, the NSSGs and their associated site-specific MDTs, for compliance with these measures, should agree to abide by them and add locally relevant detail.

Agreed Collection of Minimum Dataset

11-2L-132 The MDT should be recording its agreed part of the sarcoma MDS, according to the area data collection specification, in an electronically retrievable form.

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

Note:

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

AREA AUDIT

Introductory Notes

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

Area Audit

11-2L-133 The MDT should agree to participate in the area audit project, agreed with the SAG.

The MDT should annually review the progress of the project or present the results of the completed area audit project to the SAG for discussion at one of their meeting.

Note:

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

Compliance: The project agreed by the lead clinician of the MDT and chair of the SAG.

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

Discussion of Clinical Trials

11-2L-134 The MDT should produce a report at least annually on clinical trials, for discussion with the SAG. The report should include;

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

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

Note:

For compliance with this measure the MDT should produce a proposed programme for improvement and, at the discussion with the SAG, settle on a mutually agreed programme between the participants of the meeting.

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

- Leukaemia
- Lymphoma
- Germ cell malignancy

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE	
	• Bone and/or soft tissue sarcoma • Brain and CNS malignancy • Malignant melanoma The MDT should produce a report on clinical trials, covering the above points, for TYA patients, for discussion with the teenage and young adults' cancer network co-coordinating group (TYACNCG). The MDT should agree a final programme for improvement for TYA clinical trials with the TYACNCG. *Note:* *The TYACNCG's current list of trials and studies suitable for TYAs may not include any of those malignancies dealt with by the MDT under review, in which case this is not applicable for the current assessment in question.*
Compliance:	The report, agreed by the lead clinician of the MDT. The reviewers should check that the contents fulfil the points above. The programme for improvement, agreed by the lead clinician of the MDT and the clinical lead for the cancer research network. Where relevant, the clinical trials report for TYA patients, agreed by the lead clinician of the MDT, and the programme for improvement agreed by the lead clinician of the MDT, the Chair of the TYACNCG and the clinical lead for the cancer research network.

MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

MDT Case Numbers for Discussion

11-2L-135

The MDT should record the number of cases it deals with per year.

Note:

The number should be calculated as follows:

- *they should be cases of sarcoma presenting to the MDT for the first time in the patient's case history;*
- *they should be cases which were discussed and had a treatment planning decision. (This includes a decision to give no further definitive treatment or to offer only supportive and palliative care);*
- *the number should be averaged over the two complete calendar years prior to the peer review/self assessment.*

The number should be:

- For an MDT dealing only with soft tissue sarcoma, at least 100 cases.
- For an MDT dealing with both soft tissue and bone sarcoma, at least 100 cases of soft tissue sarcoma and at least 50 cases of bone sarcoma.

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

Joint Treatment Planning for TYAs

11-2L-136

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

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

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

Notes:

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

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

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

Note:

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

APPENDIX 1

Trust Lead Clinician

Purpose of the Role

The purpose of the role is to provide leadership and support to medical colleagues in the provision of specialist sarcoma care within their trust and in collaboration with the Sarcoma MDT. He/she will be expected to work in partnership with the sarcoma centre and SAG to contribute to the strategic development of sarcoma services within the trust and sarcoma supranetwork.

The Role of the Lead Clinician is to:

Coordinate care for patients with sarcoma within the host hospital's catchment area. This will include:

1) Agreeing policies with the SAG including:
    - presentation pathways;
    - diagnostic pathways;
    - treatment pathways;
    - follow up pathways.
2) Agreeing the provision of services including:
    - diagnostic clinics;
3) Liaising with the sarcoma centre to:
    - establish a pathway for management of patients with sarcoma;
    - establish the process for registration of all new patients diagnosed within the trust's catchment area;
    - establish for each patient, in discussion with the SMDT, responsibility for each component of the patient pathway.

Symptoms Suggesting Suspicion of Soft Tissue Sarcoma

Soft tissue mass:

- > 5cm
- Increasing in size
- Deep to the deep fascia
- Painful
- Recurrent after previous excision

Algorithm for investigating a soft-tissue mass.
(THE JOURNAL OF BONE AND JOINT SURGERY - VOL. 92-B, No. 11, NOVEMBER 2010)

R. J. Grimer, T. W. R. Briggs

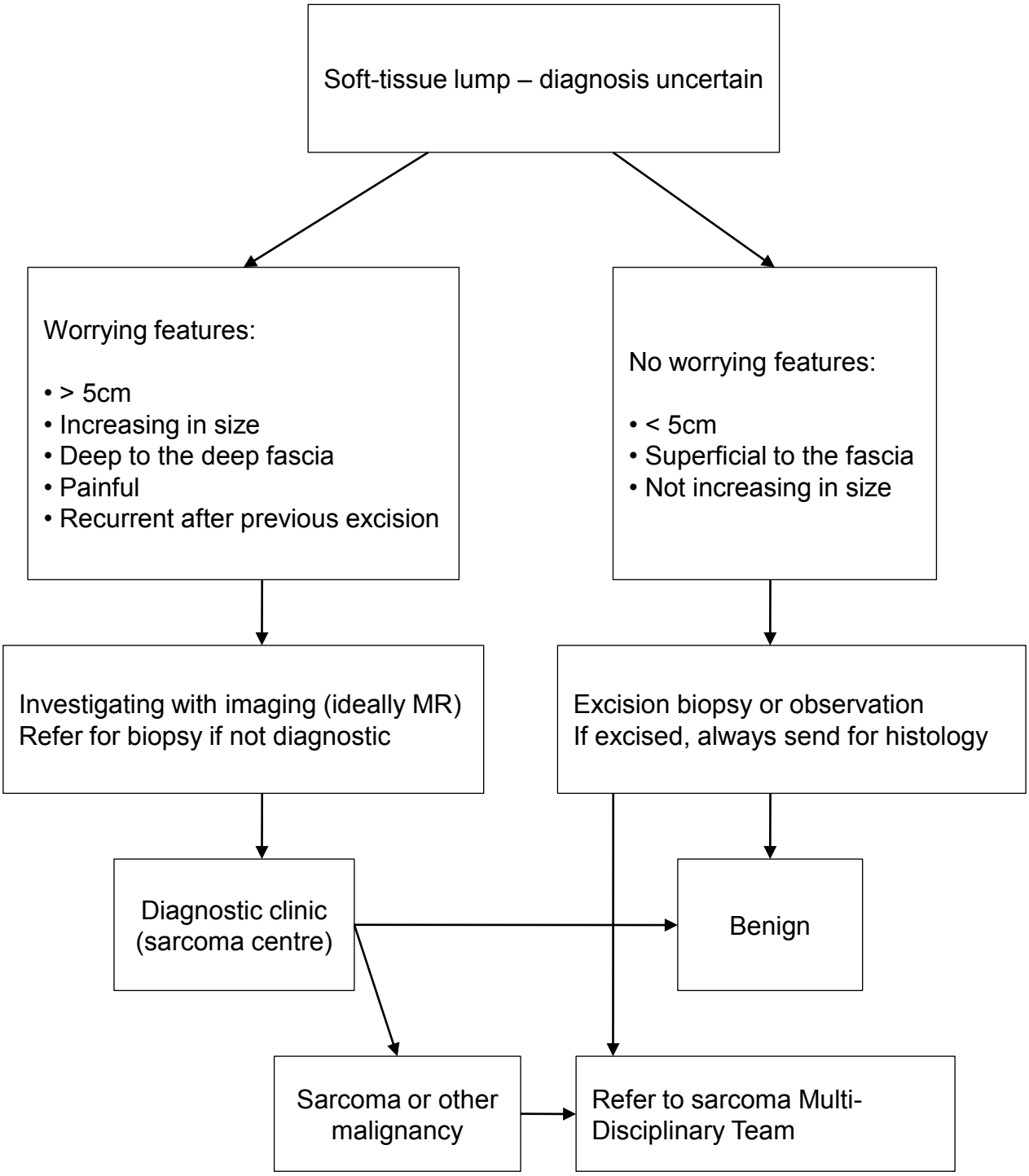


Fig. 1

Algorithm for investigating a suspicious bone lesion.
(THE JOURNAL OF BONE AND JOINT SURGERY - VOL. 92-B, No. 11, NOVEMBER 2010)

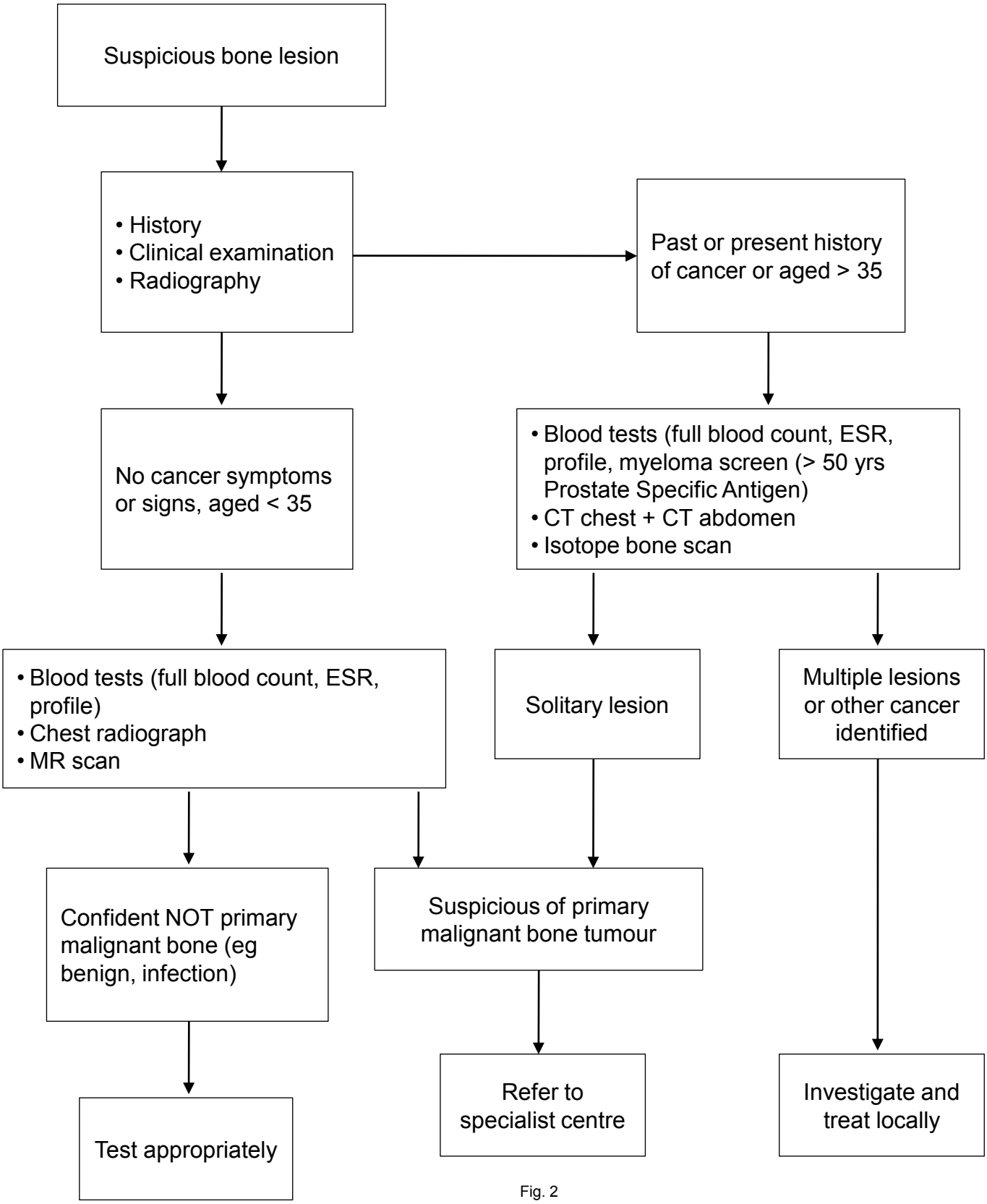


Fig. 2

APPENDIX 2

Role of the SAG

Membership

The SAG should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all sarcoma leads from the relevant constituent organisations in the network.

Service Planning

SAGs should ensure that service planning:

- is in line with national guidance/standards (including reconfiguration where necessary);
- covers the whole care pathway;
- promotes high quality care and reduces inequalities in service delivery;
- takes account of the views of patients and carers;
- takes account of opportunities for service and workforce redesign;
- establishes common guidelines, including clear referral guidelines.

SAGs should:

- recommend priorities for service development to the SCG;
- ensure decisions become integrated into constituent organisational structures and processes.

Service Improvement/Redesign

- all SAGs and individual cancer teams should commit to service improvements;
- process mapping and capacity and demand analyses should become part of the norm;
- SAGs should develop/approve high quality information for patient, for use across the network.

Service Quality Monitoring and Evaluation

SAGs should:

- agree on priorities for common data collection (in line with national priorities e.g. for waiting times and cancer registries) but go beyond this where possible;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;
- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure actions following peer review are implemented;
- report identified risks/untoward incidents to ensure learning is spread.

Workforce Development

NDSGs should:

- consider the overall workforce requirements for the SAG;
- consider the education and training needs of teams and, where appropriate, of individuals;
- liaise with the network board and with the workforce development confederation to ensure that
- appropriate workforce numbers and CPD are available;
- promote links between teams through rotation of staff;
- develop common recruitment/retention strategies;

- take account of opportunities for skill mix changes.

Research and Development

SAGs should agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Annual Work Plan and Report

SAGs should:

- draw the above together in an annual work plan in the context of a prioritised clinical governance;
- development plan, for approval by the network board;
- ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training;
- provide an annual report of activity to feed health economy clinical governance reporting processes.

The Responsibilities of MDT members

Responsibilities of the MDT lead clinician

- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met;
- to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
- to ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
- to ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that MDT meeting and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- ensure that target of 100% of cancer patients discussed at the MDT is met;
- provide link to SAG either by attendance at meetings or by nominating another MDT member to attend;
- lead on or nominate lead for service improvement;
- organise and chair annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members);
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported;
- ensure target of communicating MDT outcomes to primary care is met.

Responsibilities of the MDT Co-ordinator

- facilitate and co-ordinate the functions of the multidisciplinary team meetings;
- ensure the appropriate proportions of patients are discussed at MDTs;
- help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed, ensuring patients' diagnoses, investigations, and management and treatment plans are completed and added to the patient's notes;
- managing systems that inform GP's of patient's diagnosis, decisions made at outpatient appointment etc;
- working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;
- working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;

- undertake demand and capacity studies where appropriate;
- report changes to MDTs on a monthly basis;
- data collection and recording of data;
- to manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
- keep comprehensive diary of all team meetings;
- record attendance at meetings;
- take minutes at the multidisciplinary meetings, type notes back in the required format and distribute to all concerned;
- the post holder will be expected to be instrumental in the development of databases to capture patient information and report this to the clinicians on a weekly basis;
- inform lead cancer manager of waiting times for patients when these exceed appropriate targets;
- ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
- ensure all correspondence, notes, x-rays, results, etc are available for the meetings;
- ensure action plans for patient care are produced with agreed reviews;
- assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;
- ensure members or their deputy are advised of meetings and any changes of date, venue, etc.

Role of the SAG

Membership

The SAG should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all sarcoma leads from the relevant constituent organisations in the network.

Service Planning

SAGs should ensure that service planning:

- is in line with national guidance/standards (including reconfiguration where necessary);
- covers the whole care pathway;
- promotes high quality care and reduces inequalities in service delivery;
- takes account of the views of patients and carers;
- takes account of opportunities for service and workforce redesign;
- establishes common guidelines, including clear referral guidelines.

SAGs should:

- recommend priorities for service development to the SCG;
- ensure decisions become integrated into constituent organisational structures and processes.

Service Improvement/Redesign

- all SAGs and individual cancer teams should commit to service improvements;
- process mapping and capacity and demand analyses should become part of the norm;
- SAGs should develop/approve high quality information for patient, for use across the network.

Service Quality Monitoring and Evaluation

SAGs should:

- agree on priorities for common data collection (in line with national priorities e.g. for waiting times and cancer registries) but go beyond this where possible;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;

- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure actions following peer review are implemented;
- report identified risks/untoward incidents to ensure learning is spread.

Workforce Development

NDSGs should:

- consider the overall workforce requirements for the SAG;
- consider the education and training needs of teams and, where appropriate, of individuals;
- liaise with the network board and with the workforce development confederation to ensure that
- appropriate workforce numbers and CPD are available;
- promote links between teams through rotation of staff;
- develop common recruitment/retention strategies;
- take account of opportunities for skill mix changes.

Research and Development

SAGs should agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Annual Work Plan and Report

SAGs should:

- draw the above together in an annual work plan in the context of a prioritised clinical governance;
- development plan, for approval by the network board;
- ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training;
- provide an annual report of activity to feed health economy clinical governance reporting processes.

The Responsibilities of MDT members

Responsibilities of the MDT lead clinician

- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met;
- to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
- to ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
- to ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that MDT meeting and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- ensure that target of 100% of cancer patients discussed at the MDT is met;
- provide link to SAG either by attendance at meetings or by nominating another MDT member to attend;
- lead on or nominate lead for service improvement;
- organise and chair annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members);
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported;

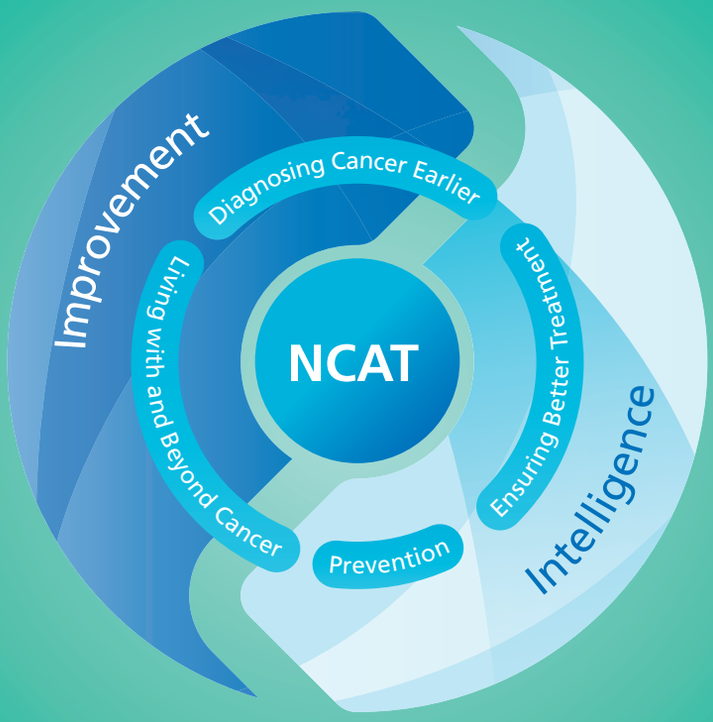
- ensure target of communicating MDT outcomes to primary care is met.

Responsibilities of the MDT Co-ordinator

- facilitate and co-ordinate the functions of the multidisciplinary team meetings;
- ensure the appropriate proportions of patients are discussed at MDTs;
- help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed, ensuring patients' diagnoses, investigations, and management and treatment plans are completed and added to the patient's notes;
- managing systems that inform GP's of patient's diagnosis, decisions made at outpatient appointment etc;
- working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;
- working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;
- undertake demand and capacity studies where appropriate;
- report changes to MDTs on a monthly basis;
- data collection and recording of data;
- to manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
- keep comprehensive diary of all team meetings;
- record attendance at meetings;
- take minutes at the multidisciplinary meetings, type notes back in the required format and distribute to all concerned;
- the post holder will be expected to be instrumental in the development of databases to capture patient information and report this to the clinicians on a weekly basis;
- inform lead cancer manager of waiting times for patients when these exceed appropriate targets;
- ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
- ensure all correspondence, notes, x-rays, results, etc are available for the meetings;
- ensure action plans for patient care are produced with agreed reviews;
- assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;
- ensure members or their deputy are advised of meetings and any changes of date, venue, etc.

ADDENDUM - Amendments to measures April 2012

Measure number	Comment
11-1C-116I	Revised research measure
11-1C-120I	Chemotherapy Algorithm generic measure for NSSGs
11-1C-121I	The TYACN Pathway for Initial Management
11-1C-122I	The TYA Pathway for Follow Up on Completion of First Line Treatment
11-1C-123I	TYACN Patient Pathways for Cases Involving NHS Specialised Services
11-1D-109I	Revised measure
11-2L-136	Joint Treatment Planning for TYAs
11-2L-134	Revised research measure



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