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**Section 2 – Clinical Indicators / Lines of Enquiry**

**Service Profile**
National Cancer Peer Review and the Manual for Cancer Services

1 Introduction

The National Cancer Peer Review Programme provides important information about the quality of clinical teams and a national benchmark of cancer services across the country. It 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 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 supports the National Cancer Peer Review quality assurance programme for cancer services and enables quality improvement both in terms of clinical and patient outcomes. The Manual includes national quality measures for site specific cancer services together with cross cutting services such as chemotherapy and radiotherapy.

The Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Robert Francis Jan 2013) said the creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review. Whilst peer review will have a specific relevance in cases of practitioners where there may be concerns about substandard performance, it has a far more fundamental role in changing behaviour to ensure a consistent and caring culture throughout the healthcare services. Peer review therefore needs to be a key part of the delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and of improvement. Among the recommendations made is recommendation 49, Enhancement of monitoring and the importance of inspection, which states;

Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential.

The Care Quality Commission should consider its monitoring in relation to the value to be obtained from:

- The Quality and Risk Profile;
- Quality Accounts;
- Reports from Local Healthwatch;
- New or existing peer review schemes;
- Themed inspections.
1.1 National Cancer Measures

The development of cancer measures is a dynamic 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 developments and initiatives in treatment and patient care;
• reflect the NHS Commissioning Board specialised service specifications.

1.2 Clinical Indicators/Outcomes

Peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, clinical indicators have been introduced and form part of the review process along with a reduced number of structure and process measures.

2 Interpretation of the National Manual for Cancer Services

2.1 Guidance Compared to Cancer Measures

National 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, 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. Without this underlying type of mind-set 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 the specific purpose of being used to assess a service; to aid self assessment and team development; to be fair compared to visits to other services elsewhere and to past and future visits to the same service. Therefore, the measures have to:

• be objective
• be measurable
• be specific, clear and unambiguous
• be verifiable
• state who exactly is responsible for what
• be discriminating
• be achievable
• be developmental – encourage continuous quality improvement and not produce destructive competition or a sense of failure.

2.2 “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 a certain group.
2.3 “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.

2.4 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 undertaken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

2.5 “Quality” Aspects of Cancer Service Delivery

The peer review process recognises the qualitative as well as quantitative aspects of review and in addition to the objective recording of compliance against the measures there is a narrative part to the report that provides an overall summary of a team’s performance.

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
INTRODUCTION

Skin cancer differs fundamentally from other types of cancer in certain aspects which have determined the content of the 2006 Improving Outcomes Guidance (IOG).

These aspects include:

i. Its very high incidence overall, compared to other types of cancer.
ii. Its extremely wide range of seriousness, from extremely good prognosis to life-threatening.
iii. Its ready visibility and accessibility on the surface, giving opportunities for excision and diagnosis by practitioners in the community.

IOG Implementation

The specialist commissioning groups (SCGs) are responsible for agreeing the implementation proposals of the skin cancer 2006 IOG.

Shape of the Service

The IOG either explicitly or by implication, effectively specifies six levels of care, differing in the degree of specialisation and service consolidation needed. The personnel foreseen as offering these levels range from any general practitioner, through specifically authorised and trained community practitioners, local and specialist MDTs to supranetwork MDTs. All this is incorporated into the network referral guidelines and network infrastructure for skin cancer, set out in the measures. The types of case mix and the procedures which make up the different levels and the personnel practising at each level are given in Table 1.

This revised edition of the skin cancer measures takes into account the following:

- General revisions and reduction of the number of measures; a process common to a number of cancer sites.
- The revised and updated guidance on the management of skin cancer in the community, contained in the 2010 update to the NICE IOG on skin cancer, and the 2011 DH Revised guidance on GPwSI dermatology and skin surgery services Revised guidance on GPwSI dermatology and skin surgery services [GP and Practice Team Bulletin online]

Following discussions, subsequent to the production of the 2006 IOG, it was seen that in some networks there exist established groups or MDTs specializing only in the treatment of malignant melanoma. These were not specifically referred to in the IOG. It was not, however, the intention of the guidance development group that these should necessarily be incorporated into SS MDTs or, if remaining as ‘stand alone’ MDTs that they should be non compliant with peer review. Therefore, in order that they are constituted and function at least according to the quality of service expected of all MDTs, a set of measures for a melanoma MDT (MMDT) has been derived using the principles of the IOG.

A given skin cancer network may or may not choose to run a MMDT, but where it does, it should be put forward for review against the MMDT measures. In that case, the network’s overall practice in relation to such an MDT is specified at various points in the network group measures. (Topic 14-1C).
<table>
<thead>
<tr>
<th>Care Level</th>
<th>Person or Team</th>
<th>Case mix / Procedure</th>
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</table>
| 1         | Any general practitioner in the community | • Benign lesions  
• Actinic Keratoses  
• Precancerous – SCC in situ/Bowen’s |
| 2         | Community practitioners working to the 'DES/LES' model (Level 2a) or the 'model 1' service model (level 2b). See guidance below in the section on skin cancer in the community. (Page 10 of this document). | DES/LES list of BCCs. (Level 2a)  
Model 1 list of BCCs (level 2b). See guidance below in the section on skin cancer in the community. |
| 3         | LSMDT, hospital staff core team member (May be core member of SSMDT acting as ‘local’ LSMDT). Without mandatory individual case review by MDT. | • High risk BCC  
• SCC |
| 4         | LSMDT, hospital staff core team member(s), with mandatory individual case review by LSMDT (may be the SSMDT and its core members acting as ‘local’ LSMDT) | • High risk BCC  
• SCC  
• Malignant Melanoma (MM) – new, single primary, adult, non-metastatic, not for approved trial entry, up to and including stage II a (must fulfil all these criteria)  
• Radiotherapy if attendance by clinical oncologist at LSMDT  
• Lesion where diagnosis is uncertain but may be malignant  
• Incompatible clinical and histological findings |
| 5         | SSMDT hospital staff core team member(s) with mandatory individual case review by SSMDT. (May have been previously reviewed by LSMDT or rapidly referred without prior review). For some cases – only one agreed SSMDT, if more than one in the Network. | • Selected BCCs and SCCs needing plastic/reconstructive surgery by SSMDT core member (as per Network clinical guidelines)  
• Radiotherapy (as per Network clinical guidelines). If not discussed and treated by LSMDT clinical oncology core team member  
• Metastatic SCC on presentation or newly metastatic  
• MM – stage 1b or more, or <19 years or metastatic on presentation or newly metastatic or recurrent or for approved trial entry |
|   | Any cases for approved trial entry  
|   | Any cases for adjuvant therapy (as per Network clinical guidelines)  
|   | Histology opinion from SSMDT core pathology team member  
|   | Mohs surgery  
|   | Skin Cancer in immunocompromised patients including organ transplant recipients  
|   | Skin Cancer in genetically predisposed patients including Gorlin’s Syndrome  
|   | Cutaneous lymphoma  
|   | Kaposi’s sarcoma  
|   | Cutaneous sarcoma above superficial fascia. (Below fascia, refer to sarcoma MDT)in cancers  
|   | Other rare skin cancers (see appendix 1 in the Skin Cancer IOG pg 128/129.  
|   | Where a network chooses to have a M MDT all cases of MM for level 5 care from the M MDT’s catchment area should be referred to the M MDT.  
|   | There should be agreed working arrangements with site specialised MDT’s for SCC of Head and Neck and Sarcoma and mucosal malignant melanoma.  
| 6 | Supranetwork team. Selected Networks only. Agreed with SCGs.  
|   | Clinician responsible for named facilities for photopheresis (very small numbers of patients). Agreed with SCGs.  
|   | T-cell Cutaneous Lymphoma: Total Body Surface Electron Beam Therapy  
|   | T-cell cutaneous lymphoma. Photopheresis |
Notes:

- The IOG does not name 6 actual ‘levels’ of care but it does describe at least 6 mutually exclusive levels of specialisation which, for the purposes of service organisation and for peer review are best dealt with by the ‘levels’ model.

- Following along a row gives the person or team authorised to deliver a given level of care, this level being the highest level at which they should function, although they may deliver all lower levels; then it gives the case mix or procedures which may be delivered at that level of care, it being the lowest care level at which they should be delivered.

- Descriptions of the Directed Enhanced Service/Local Enhanced Service (DES/LES) and Model 1 lists of BCCs which make up Level 2 care can be found in the section on skin cancer in the community. The types of BCC which make up these lists, are classified from the point of view of peer review and referral for treatment as ‘low risk’ BCCs. Any BCCs outside these lists are considered for the purpose of referral for treatment and the purpose of peer review, as ‘high risk’ BCCs. These lists are specified in clinical terms, here since initial decisions in primary care, regarding referral for treatment need to be made before histology is available. There are additional types of BCC, to be added to the high risk category, defined later in this document, on histological criteria.

- Level 3 care requires any treatment to be mandatorily under the care of a hospital doctor who is a core member of the MDT, but without mandatory, formal discussion of the case by the MDT. The core member may however choose to present a given, particular case in this category for formal MDT discussion and level 3 cases should be included in the MDT’s audits. Level 4 care requires not only that any treatment should be mandatorily under the care of the MDT member but that this should also be discussed in the formal MDT meeting.

Community skin cancer clinicians are defined by the following criteria;
- Enrolment on a list of accredited clinicians
- Fulfil specific training requirement
- Working to specified quality assurance measures

These criteria are contained within a service specification for the Network Community Skin Cancer Service, agreed with the CCGs.

Local Skin Cancer MDTs (LSMDTs) should meet the following criteria:
- Agreed as part of a named locality in the network
- Being the only skin cancer MDT in their hospital

Specialist Skin Cancer MDTs (SSMDTs), in addition to fulfilling the criteria applying to LSMDTs, should meet the following criteria:
- Serving a catchment population for referral (their own local catchment plus the catchment of referring LSMDTs) of at least 750,000
- Serving as the LS MDT for their local (secondary) catchment population.
Supranetwork MDTs for TSEBT are defined by having their role and catchment population agreed by the relevant specialist commissioners. It is intended that in most cases, a supranetwork team will cover more than one Network.

The case numbers associated with photopheresis are extremely small, nationally, and the use of this treatment for malignancy (erythrodermic cutaneous T-cell lymphoma) is currently limited to 2 centres in England, with no apparent capacity problems. For this reason, it is not practical, to set mandatory measures for a full "supranetwork MDT" model to deliver this treatment. Networks are merely required to agree a referral guideline for this, with the SCGs, naming the facility which they will use.

Melanoma MDTs (MMDTs) should meet the following criteria:

- Listed as part of a named locality of the network
- Serving a catchment population for referral of a least 750,000
- Taking all referrals of malignant melanoma for level 5 care, from their catchment population.
- In addition, taking all referrals of malignant melanoma for level 4 care from their local (secondary) catchment population.

The above criteria constitute the minimum scope of a MMDT’s practice for compliance. The network may choose to agree, via its referral guidelines, a greater scope for the MMDT’s practice, e.g. taking malignant melanoma for level 4 care and above from the whole of its catchment population or taking direct referral of pigmented lesions from primary care. This is not subject to review.

It should be understood that in producing measures for the MMDT, it is not intended to encourage the initiation of large numbers of new MMDTs which add little to the service. The aim was to cater for teams which add value by consolidating expertise in the use of complex and potentially difficult treatments in the management of relatively uncommon clinical situations. It is hoped and expected that in practice, the MMDT would take Level 5 referrals for Malignant Melanoma from much more than the minimum, 750,000 catchment population.

The interrelationships and referral pathways between community practitioners and the different MDT types are given in Figure 1.
Management of Skin Cancer in the Community

Figure 2 Acceptable Models for the Management of Skin Cancer in the Community by Surgical excision or Curettage.

Under Community Based Provider Governance

DES/LES

Model 1

Under Acute Trust Governance

Model 2

Model 3

Brief Summary
The service provided under the ‘DES/LES’ contracting system and the Model 1 service are to allow doctors in the community to diagnose and surgically treat low risk BCCs at two levels of risk, under two different levels of training/other requirements. Service Model 2 is to allow trained medical or nursing practitioners to offer a technical surgical service in the community, for skin cancers diagnosed and given a treatment plan by other, legitimate referrers. Service Model 3 is to allow for hospital specialists from MDTs practicing in the community.

1. The Service Provided Under the ‘DES/LES’ Contracting System

Practitioners.
GPs acting within the DES or LES NHS statutory framework under the ‘minor surgery’ section.

Governance
CCGs acting according to the DES/LES framework.

Scope of Practice
Excision (or according to clinical judgement, curettage), only of BCCs on the ‘DES/LES’ list, diagnosed by the practitioners themselves, either de novo or following referral for both diagnosis and management, from other practitioners. Practitioners acting according to the ‘DES/LES’ service model should not knowingly excise supposed neoplastic skin lesions of any higher risk than BCCs on the ‘DES/LES’ list.

Requirements of Practitioners

Competencies.
- Named techniques; local anaesthetics, punch biopsy, shave excision, elliptical excision with closure, and curettage. (Surgical procedures and related skills as in the 2011 DH guidance, Ref: Guidance and Competencies for the Provision of Services Using GPs with special interests [GPwSIs]; Dermatology and Skin Surgery, p13.)
Note: It is intended that this practice should essentially consist of the direct use of excision with closure, or curettage and cautery on lesions which have been confidently, clinically diagnosed as within the permitted scope of practice.

- Recognition and diagnosis of skin lesions on the ‘DES/LES’ list of BCCs.
- Assessment of competence should be by the direct observation of procedural skills (DOPS) assessment tool in the DH 2011 Guidance as above.

CPD

Annual attendance at a skin network group ‘educational’ meeting which should include:

- A presentation of network skin cancer audit results. The audit and the presentation should include a topic involving BCCs, of relevance to practitioners treating them in the community and a breakdown of individual practitioner performance.
- A four hour CPD session, with an emphasis on skin lesion recognition and the up to date management of skin cancer (including BCCs) for community practitioners.

Note: It is recognised that content should be appropriate to the practitioners present but it is strongly recommended that the diagnosis and management of skin cancer and, in particular, BCCs should be priority subjects for this session.

This CPD session is still a requirement for those practitioners who have been initially trained and assessed as competent for this level of practice.

Other Requirements.

Practitioners should:

- Send all skin samples for histological analysis.
- Keep records that capture the relevant parts of the national skin cancer minimum dataset.
- Follow a histology requesting and reporting protocol, including ‘fail-safe mechanisms, agreed with the relevant pathology laboratory.1
- Provide feedback to the CCGs.2
- Refer skin lesions outside the DES/LES list (and those classified as ‘high risk BCCs’ on histological grounds, following removal) according to the referral guidelines specified in the skin cancer measures. Lesions with incomplete margins, otherwise within the DES/LES remit, may be removed either by the practitioner or a member of the skin MDT, as agreed between them following discussion. These considerations regarding histologically incomplete excision do not apply to lesions treated by curettage.
- Be registered on a list of accredited community skin cancer practitioners.

Numbered notes on the requirements of practitioners:

1) The protocol should include the following specifications:
   - If a person has more than one lesion, samples should be sent in separate specimen pots with separate referral forms.
   - All samples should be accompanied by a checklist naming and enumerating the samples which have been sent.
   - By means of the list, any sample identified as not having been received by the laboratory should be immediately notified to the operating practitioner.
   - All results should be cross-checked against the list by the practitioners to ensure that they have been seen and actioned.
   - Reports should classify and report the following as ‘high risk BCCs’ on histological grounds:
     - Those with incomplete excision margins.
     - Morpheic, infiltrative, micronodular or basosquamous.
     - Perineural invasion below the dermis.

2) The feedback should include:
   - Numbers of cases excised and proportion completely excised.
   - Pre-excision clinical diagnosis versus post excision histological diagnosis.
2. Service Model 1

Practitioners.

Either ‘Group 3 GPwSIs’, trained and competent according to the DH Guidance Ref: Guidance and Competencies for the Provision of Services Using GPs with special interests [GPwSIs]: Dermatology and Skin Surgery. (2011)

Or a separate class of practitioners ‘GPwSIs in skin lesions’, trained and competent according to the above DH guidance.

Note on GPwSIs: The status of ‘Group3 GPwSI’, as trained and appointed prior to 2011, according to the previous DH guidance for GPwSIs is still valid for these measures.

Governance
CCGs acting according to the DH ‘GPwSI’, guidance.

Scope of Practice

Excision (or according to clinical judgement, curettage), only of BCCs on the ‘Model 1’ list, diagnosed by the practitioners themselves, either de novo or following referral for both diagnosis and management, from other practitioners. Practitioners acting according to the ‘Model 1’ service model should not knowingly excise supposed neoplastic skin lesions of any higher risk than BCCs on the ‘Model 1’ list.

Requirements of Practitioners.

Competencies.

Either all relevant competencies for the Group 3 GPwSIs (as given in the DH 2011 guidance as above),

or all relevant competencies for the ‘GPwSIs in skin lesions’, in the same DH guidance.

Note: Unlike the GPwSIs in skin lesions, the Group 3 GPwSIs are deemed competent for the management of additional, non-malignant skin conditions, outside the scope of the cancer peer review.

Clinic Attendance.

Group 3 GPwSI community skin cancer practitioners and GPwSIs in skin lesions should attend a monthly clinic with a consultant dermatologist.

Note: This should be in the general dermatological clinical practice of the consultant and the consultant need not be a core member of a skin cancer MDT but usually would be.

In addition they should annually attend a clinic which has a focus on skin cancer with a consultant dermatologist who is a core member of a skin cancer MDT.

CPD.

This is outlined in the DH 2011 guidance, Sections 5.1-5.3. The aspects of CPD for Model 1 practitioners which relate to the hospital skin cancer service are as follows:

- Annual attendance at the skin network group ‘educational’ meeting and submitting feedback results as part of the network audit, as for the DES/LES model.
- Attendance at four meetings per year of a named skin cancer MDT with which they are associated.

Note: There should be a total of 15 hours of CPD per year. The clinic attendances do not count towards this. The network group meeting would be expected to count for about 4 hours, and the four MDT meetings would also count. Any further time to make up 15 hours should be made up of other educational activities.
Other Requirements
Practitioners should:

• Send all skin samples for histological analysis.
• Keep records that capture the relevant parts of the national skin cancer minimum dataset.
• Follow a histology requesting and reporting protocol, including ‘fail-safe mechanisms, agreed with the relevant pathology laboratory’.¹
• Provide feedback to the commissioners or monitoring body delegated by the commissioners.²
• The practitioners should refer skin lesions outside the model 1 list (and those classified as ‘high risk BCCs’ on histological grounds, following removal) according to the referral guidelines specified in the skin cancer measures. Lesions with incomplete margins, otherwise within the model 1 remit, may be removed either by the practitioner or a member of the skin MDT, as agreed between them following discussion. These considerations regarding histologically incomplete excision do not apply to lesions treated by curettage.
• Be registered on a list of accredited community skin cancer practitioners.

Numbered notes on the requirements of practitioners:
1) The protocol should include the following specifications:
   o If a person has more than one lesion, samples should be sent in separate specimen pots with separate referral forms.
   o All samples should be accompanied by a checklist naming and enumerating the samples which have been sent.
   o By means of the list, any sample identified as not having been received by the laboratory should be immediately notified to the operating practitioner.
   o All results should be cross-checked against the list by the practitioners to ensure that they have been seen and actioned.
   o Reports should classify and report the following as ‘high risk BCCs’ on histological grounds;
     ▪ Those with incomplete excision margins.
     ▪ Morpheic, infiltrative, micronodular or basosquamous.
     ▪ Perineural invasion below the dermis.
2) The feedback should include:
   o Numbers of cases excised and proportion completely excised.
   o Pre-excision clinical diagnosis versus post excision histological diagnosis.

Note: The feedback information provides the information necessary for these community practitioners to be incorporated into the network skin cancer audit.


Practitioners.
Registered health care professionals, either medically qualified practitioners, registered nurses, or surgical care practitioners, all of whom are subject to the constraints given in the rest of this model.

Governance
Acute trust, associated with a named skin cancer MDT.

Scope of Practice
Excision or curettage (as directed by the referrers) of any skin cancers (other than procedures listed as ‘hospital only’—measure 14-2J-208) but with the provision that they
have been previously diagnosed by and have a treatment plan agreed by legitimate referrers.

*Note:* In order for the referrers to comply with the skin cancer measures, they would in most cases be a skin MDT. For referrers from the independent sector to comply, they would need to have voluntarily subjected themselves to peer review or agree to a contract which should stipulate adherence to the cancer measures. In either case, this would mean the case would need to have passed through the MDT process. This is what is meant by ‘legitimate referrers’. Another group of legitimate referrals would be cases confidently, clinically diagnosed by practitioners under DES/LES or Model 1 as being in their permitted area of practice, and referred for excision, or curettage and cautery.

**Requirements of Practitioners**

**Competencies**
The competencies agreed by a network assessor as being appropriate to their agreed area of practice, the latter agreed with the lead clinician of the MDT under whose governance they are working. Competence is assessed by a network trainer/assessor. (See measure 14-1C-108j.)

*Note:* GP Practitioners who are trained and competent in the Group 3 GPwSI and skin lesion GPwSI systems (2011 DH guidance) should be eligible, (other factors being suitable), without further assessment, for association with an MDT as Model 2 practitioners for the scope of surgical practice agreed as appropriate to their range of competencies.

**CPD and Outcome Monitoring.**
This will be determined by the arrangements applying to the MDT and trust under whose governance the practitioners are acting. It will be determined by national and professional body requirements and be ensured by such existing systems as the trust’s appraisal process and the relevant parts of the cancer peer review of the hospital services and cancer network.

**Other Requirements.**
The issues outlined under this heading for Model1 practitioners and those acting under the DES/LES system, will again be determined for Model 2 practitioners by the trust governance arrangements. However, it would be expected that these would be no less rigorous than for the other community practitioners, namely that they:

- Send all skin samples for histological analysis.
- Keep records that capture the relevant parts of the national skin cancer minimum dataset.
- Follow a histology requesting and reporting protocol, including ‘fail-safe mechanisms, agreed with the relevant pathology laboratory.

*Note:* The protocol should include the following specifications:

- If a person has more than one lesion, samples should be sent in separate specimen pots with separate referral forms.
- All samples should be accompanied by a checklist naming and enumerating the samples which have been sent.
- By means of the list, any sample identified as not having been received by the laboratory should be immediately notified to the operating practitioner.
- All results should be cross-checked against the list by the practitioners to ensure that they have been seen and actioned.
- Reports should classify and report the following as ‘high risk BCCs' on histological grounds;
  - Those with incomplete excision margins.
  - Morpheic, infiltrative, micronodular or basosquamous.
  - Perineural invasion below the dermis.
4. Service Model 3

Practitioners.
Hospital medical specialists, consultant core members of skin cancer MDTs practising in the community.

Note: This model would cover not only the above, but specialist trainees and NCCGs acting under the supervision of and in the name of consultant specialists. Although there is no specific mention of this aspect in the MDT cancer measures, it is accepted as a given aspect of an MDT’s hospital practice and should be no different for community practice.

If MDT core nurse members wish to treat skin cancer in the community, currently they should be trained as and practice as Model 2 practitioners.

Governance Framework.
The acute trust via the MDT arrangements.

Scope of Practice.
Whatever part of the MDT’s practice is deemed suitable for being carried out in the community, subject to the following:

The boundaries of an MDT’s clinical practice outside the hospital setting are not explicitly specified in the measures, but they would be constrained by:

- The need for formal case discussion by the MDT, for cases at level 4 and above
- The requirements for certain procedures to all be performed in the same hospital for the whole of an MDTs practice
- Apart from the above, the decision as to which other procedures should only be carried out in hospital and not in the community is currently a matter for clinical judgment. Any given network may choose to set its own protocols for this. This is not currently subject to the peer review measures.

Requirements of Practitioners
As for hospital specialist training and MDT core membership requirements.

The Lists of Low Risk BCCs, on Clinical Criteria.

1. The list of clinically defined BCCs suitable for excision (or according to clinical judgement, curettage) by practitioners under the DES/LES service model:

Patient.
Adult, 25 and over, with normal immunity and without any genetic predisposition to BCCs.

Lesion.
Newly presenting, nodular, definitely, clearly delineated BCC, up to 1 cm.

Site.
Below the clavicle but only in cosmetically and surgically straightforward areas.

2. The list of clinically defined BCCs suitable for excision (or according to clinical judgement, curettage) by practitioners under service model 1:

The DES/LES list as above with the addition of the following, only:

An increase in size up to 2cm but only when below the clavicle.
Lesions above the clavicle up to 1 cm but only in the permitted area—the chin, cheeks, forehead, temples, neck and sides of face.\textsuperscript{5}

**General note on the lists of BCCs.**
These lists convey the same information as set out in the similar lists in the NICE IOG Update, of May, 2010. In the latter, however it is expressed mainly \textit{negatively} as types of lesions which are to be \textit{excluded} from a given model of service delivery. It is expressed here mainly in the form of corresponding \textit{positive} information, to comply with the general safety advice to avoid negative recommendations.

**Notes to the reference numbers on the lists of BCCs.**
1. Refer on patients with immunosupression (including transplant patients) or Gorlin’s syndrome.
2. Refer on patients with BCCs recurrent after previous excision and BCCs persistent (i.e. having histologically positive resection margins) after excision.
3. Refer on BCCs of other morphological appearances, but see note on superficial BCCs, below.
4. Refer on patients with BCCs which are sited such that excision poses a potential risk to important underlying structures, areas where difficult excision may lead to a poor cosmetic result and areas where primary closure may be difficult.
5. Refer on patients with BCCs on the lips, nose, nasofacial sulci, nasofacial folds, periorbital areas and ears.

**Note on Superficial BCCs**
Adult patients with normal immunity and without genetic predisposition to BCCs, who have superficial BCCs, presenting to community practitioners, should be offered the choice of the full range of relevant non-surgical treatments as well as surgical. If the patient chooses surgical treatment, the BCC may fit into one or other of the above lists depending on its site and size characteristics, applied as above. If the patient chooses non-surgical treatment, this may involve referral to a core member of an MDT.

For MDT interaction to operate efficiently and for patient care to be delivered seamlessly, the following ground rules are necessary.

- Because of the very high incidence, excellent prognosis and straightforward treatment of many Skin Cancers, it is not necessary for all cases to be subject to a multidisciplinary treatment planning discussion, although they may still need to be treated only by an MDT core member (see the distinction between Care Levels 3 and 4). An MDT member may, however, bring any case for discussion, if they consider it necessary.
- Either category of practitioner and either type of MDT (LSMDT or SSMDT) may deliver levels of care below their highest level if required, e.g. LSMDTs may deal with AK’s or precancerous lesions.
- A MDT may choose to refer to a more specialised team in certain cases, than is required by the IOG.
- Any practitioner or MDT which identifies a case as obviously needing a certain level of care, may refer it straight to the appropriate group, e.g. a GP could refer an obvious case of melanoma, metastatic at presentation, to the contact point of an SSMDT (or M MDT if relevant), potentially by-passing the LSMDT if this saves time, and they know the correct referral contact point. Or, a core member of an LSMDT, on being referred in such a case, could refer the case straight to the SSMDT without a prior multi-disciplinary review by the LSMDT, the case being reviewed locally in retrospect after being passed on.
• It should be understood and expected that any case referred by an LSMDT to an SSMDT for discussion, may be taken on for treatment by the SSMDT without further permission from the referrers. Similar considerations apply to M MDTs.

• The detailed clinical indications for a given case to need input from specialist surgeons or oncologists may not be covered by any national consensus and may be subject to the prevailing local expertise and opinion. These are areas for agreement in the network clinical guidelines.

• Provided a given case is dealt with by the MDTs, according to the levels given above, and other relevant measures complied with, surgical excision of skin lesions may be performed by nursing or medical practitioners in the community, trained in skin surgical competencies as specified in the measures.

In addition to the system of authorised practitioners and MDTs outlined above, the networks are required to establish clinics for the management of skin cancer in immunocompromised patients, a large proportion of whom will be patients with transplanted organs.

Reviewing the Skin Cancer Network
Regarding the different aspects of the skin cancer network; the location of the relevant measures in the Manual for Cancer Services and who is responsible for each aspect for the purposes of peer review, is organised as follows:

• the structure and functions of the network group for skin cancer, deciding the location and distribution of MDTs, clinics for immunocompromised patients and supranetwork MDTs and facilities are the responsibility for review purposes of the chair of the network group and this is reviewed under topic 1C in the manual

• the responsibility for review purposes for providing a clinic for immunocompromised patients with skin cancer, lies with the relevant trust/provider and is reviewed under topic 1D of the manual;

• the structure and functions of the LSMDT are the responsibility for review purposes of the lead clinician of the MDT and this is reviewed under topic 14-2J-1 in the manual;

• the structure and functions of the SSMDT are the responsibility for review purposes of the lead clinician of the MDT and this is reviewed under topic 14-2J-2 in the manual;

• the structure and function of the MMDT are the responsibility for review purposes of the lead clinician of the MDT and this is reviewed under topic 14-2J-3 in the manual;

• the structure and functions of the supranetwork team dealing with TSEBT for selected T-cell cutaneous lymphoma cases are the responsibility for review purposes of the lead clinician for the MDT and this is reviewed under topic 14-2J-4 in the manual.
### Network Group Measures

#### Introduction
The responsibility for review purposes for measures dealing with the functions of the network group lies with the chair of the network group.

#### Key Theme
**Structure and Function**

#### Objective
*Patients have access to appropriate care.*

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| 14-1C-101j Network Configuration of MDTs | The local and specialist skin MDTs should be named with their host hospitals and trusts. Each MDT should comply with the relevant ground rules for networking (1) i.e:  
• It should be the only MDT in its host hospital;  
• It should be associated with only one Skin network group.  
A specialist skin MDT (SSMDT), should:  
• function as the LSMDT for its own local (secondary) referral population;  
• have a catchment population for specialist (level 5) referral of at least 750,000.  
Where relevant the melanoma MDT (MMDT) should be named with their host hospitals and trusts. (2)  
The MMDT should be:  
• taking all referrals of malignant melanoma for level 5 care from their catchment population;  
• taking all referrals of malignant melanoma for level 4 care from their local (secondary) catchment population;  
• have a catchment population for specialist (level 5) care for malignant melanoma, of at least 750,000.  
Where relevant the supranetwork T-cell lymphoma MDT should be named with its host trust.  
All the above arrangements, which constitute the configuration of the skin cancer clinical network, should be agreed by the director of the relevant area teams. | (1) A full version of the ground rules for networking, for all types of MDT, network groups and also cross cutting service groups can be found in Appendix 1. Only those relevant to the skin cancer MDTs and skin network group are quoted in this measure.  
(2) The network may choose not to have a MMDT. | Constitution. |
| 14-1C-102j Network Configuration of Skin Cancer Services in the Community | The network group should agree with the CCGs a policy for provision of skin cancer services in the community which includes that the provision of treatment for skin cancer over the network, if carried | Constitution. |

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**SKIN SPECIFIC MEASURES**

**GATEWAY No. 10790 - JAN 2014**

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out for NHS patients in the community setting, should be drawn only from the following 4 service models as specified in the introduction to these skin cancer measures:

i) The service provided under the DES/LES contracting system.

ii) Service model 1

iii) Service model 2

iv) Service model 3

The community skin cancer services should be named with their host organisations. For each service it should be specified:

- which of the 4 models of community service it will provide for which named parts of the network catchment area;
- the names of the relevant MDTs;
- the locations of any relevant community facilities.

Cancer Measures. These full specifications apply to this measure.

A given CCG may choose to commission using more than one of the 4 service models and CCGs are free not to commission any community skin cancer service, but to rely instead, entirely on MDTs working in the hospital setting.

CCGs may choose to commission some services from the independent sector. This sector is subject, via the contract, to the relevant parts of the IOG and Manual for Cancer Services.

14-1C-103j Agreed Network Distribution of Clinics for Immunocompromised Patients with Skin Cancer

The network group should agree in consultation with the cancer lead clinicians of each trust in the network, which trusts will staff and run a clinic for immunocompromised patients with skin cancer. The network should designate at least one such clinic, and (in addition, if necessary) any locality which contains a trust which hosts a centre for renal and/or liver and/or cardiac transplants should be required by the network to run such a clinic.

These trusts should be put forward for review against the relevant measure in topic 14-1D. Constitution.

Objective

There are clinical networking structures in place to support equity of patient care.

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| 14-1C-104j Network Group Membership | (1) There may be additional agreed members and attendance at an individual meeting need not be limited to the agreed members.

Any one individual may fulfill more than one of the roles on the list, compatible with their discipline and status.

(2) If there are no user representatives, there should be an agreed mechanism for obtaining user advice.

(3) There may be additional points in the agreed terms of reference. | Constitution.

Annual Report including meeting attendance spread sheet.

The spread sheet should include names, roles and MDT represented.
• one of the NHS employed members of the network group should be nominated as having specific responsibility for users’ issues and information for patients and carers;
• a member of the network group nominated as responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the network group;
• named secretarial/administrative support.

There should be terms of reference agreed for the network group which include: (3)
• the provision of clinical opinion on issues relating to skin cancer for the network;
• the development of patient pathways and clinical guidelines;
• the co-ordination and consistency across the network for cancer policy, practice guidelines, clinical and patient experience outcomes, research and service development;
• consulting with the relevant 'cross cutting' network groups where applicable and with CCGs on issues involving the community skin cancer service.

14-1C-105j  Network Group Meetings

The network group should meet regularly and record attendance. The attendance of MDT representatives is reviewed as part of the MDT measures. Constitution. Annual Report including meeting attendance spread sheet.

14-1C-106j  Work Programme and Annual Report

The network group should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the director of the relevant area team. Work Programme. Annual Report.

It should include details of any planned service developments and should specify the personnel responsible and the timescales for implementation.

The network group should have produced an annual report for the SCN and relevant area team.

Objective
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

Measure  Notes  Evidence

14-1C-107j  Designated Hospital Practitioners for Mohs Surgery

The network group should name those hospital practitioners which the network authorises as the only practitioners to carry out the procedure known as Mohs surgery. (1)

This includes the procedure known as 'Slow Mohs surgery'.

(1) The named practitioners may be in another network and cases are referred to them, but their compliance regarding minimum case numbers still counts towards.

Constitution.
Each named practitioner should have carried out a total of at least 50 complete Mohs surgical procedures per year averaged over the last two complete calendar years prior to the networks peer review visit or self-assessment.

### Training Policy for Model 2 Community Practitioners with Named Trainers / Assessors

The network group should, in consultation with the MDTs, agree a training policy for the network for "Model 2" community practitioners which includes that unless they fulfil the exemption conditions (1), practitioners should be trained and assessed in an agreed selection of the skin surgery curriculum and competencies as set out in 'Guidance for the accreditation of General Practitioners with a special interest in dermatology [GPwSIs] and General Practitioners performing skin surgery 2011'.

The network group should, in consultation with the MDTs, agree named trainers / assessors of competence for the network for the Model 2 practitioners' training. They should be core dermatologist or surgical members of skin cancer MDTs. (2)

(1) Exemption may be conferred by the practitioner having had 2 years of practice in skin cancer surgery, verified by the lead clinician of the MDT, or they have been trained in skin surgical competencies according to the SS1 and SS2 specifications of the 2007 DH Guidelines. The 2 years period will be measured up to October 2008. Following that date, practitioners with less than 2 years experience will not be exempt from training, for compliance with the measures.

(2) The trainer and assessor roles should be interchangeable, and such personnel may act for more than one MDT.

### Key Theme

**Co-ordination of Care / Patient Pathways**

**Objective**

*All patients receive agreed treatment that is consistent and equitable.*

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<td>14-1C-109j</td>
<td>Clinical Guidelines</td>
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The network group should produce clinical guidelines; i.e. how a given patient should be clinically managed, at the level of which modalities of imaging and pathology investigation and which modalities of treatment and their specific indications. The guidelines should include:

- the pathology requesting and reporting protocol with failsafe mechanisms, applicable to community and hospital practice. (See the 'Management of Skin Cancer in the Community' section in the introduction to these skin cancer measures);
- that there should be a named histopathologist for the network, to whom all new presumed cases of cutaneous lymphoma, should be referred for a
second histology opinion; (1) that cases referred to an SSMDT (or MMDT if relevant) from another MDT should be subject to a review of their histology by a core histopathologist member of the SSMDT.

agreed requirements for clinical guidelines it is recommended that these are adopted.

### 14-1C-110j  
**Chemotherapy Treatment Algorithms**

The network group, in consultation with the relevant chemotherapy cross cutting groups should agree a list of acceptable chemotherapy treatment algorithms. It should be updated bi-annually.

Please see further details in appendix 3.

Annual Report. Work Programme. Examples of treatment algorithms should be seen at Internal Validation (IV) and Peer Review Visit (PR).

**Objective**

*All patients receive co-ordinated care.*

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| 14-1C-111j  
**Patient Pathways for Primary Care/ Community Services and MDTs** | (1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.  
(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.  
(3) This includes SSMDTs acting in their capacity as local teams for their own local (secondary) catchment population. The principle of a given primary care practice stating that patients will be referred to a given MDT is not intended to restrict patients or GP choice. A rational network of local and specialist MDTs can only be developed if;  
i) there is an agreement on which MDT the patients will normally be referred to and;  
ii) the resulting referral catchment populations are counted once for planning purposes.  
It is accepted that individual patients will, on occasion, be referred to different teams, | |
depending on specific circumstances. For instance, there is special provision in the skin cancer IOG for doctors working in the community to refer patients meeting the necessary criteria, directly to the SSMDT for specialist review.

### 14-1C-112j Patient Pathways Between MDTs

The network group should produce patient pathways between MDTs (i.e. the named services, hospitals and MDTs which a patient should be referred to according to named indications, during their investigation, treatment, psychological and social support, rehabilitation and follow up). The pathways should include the relevant contact points for the hospitals and MDTs (1,2) and cover the following:

- that LSMDTs should refer cases of the types of skin cancer needing care level 5 as in the introduction to the skin cancer measures, to a named SSMDT for discussion and management, stating which named LSMDTs will refer to which named SSMDTs. If there is more than one SSMDT in the network, the single named SSMDT to which each of the following types of case should be referred: (3,4)
  - cutaneous lymphoma;
  - kaposi’s sarcoma;
  - cutaneous sarcoma above superficial fascia;
  - other rare skin cancers.
- besides the specific case mix and procedures which make up each level, the network group should agree any other parameters which should determine whether a case should be referred for the opinion of:
  - a surgical core member of the SSMDT and for associated MDT review;
  - an oncological core member of the SSMDTand for associated MDT review.

1. This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.
2. Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.
3. Where there is a MMDT the guidelines should state which LSMDTs and SSMDTs should refer level 5 cases to the MMDT.
4. LSMDTs may make referrals to SSMDTs in another network and SSMDTs may receive referrals from a LSMDT in another network. These inter-network arrangements should be agreed and stated, naming teams and their host hospitals. The responsibility for these inter-network arrangements lies for review purposes, with the referring CCG and the referring MDT. Regarding referral of specified skin cancer types to a single SSMDT, although each type in the list should be referred to a single SSMDT, they do not all need to be referred to the same SSMDT.

### 14-1C-113j Patient Pathways for Supranetwork MDTs/Services

The network group should produce patient pathways for supranetwork MDTs/services. The pathways should include the relevant contact points for the hospitals and MDTs and cover the following:

- that cases of nodular mycosis fungoides (stage 2B or over) should be referred for discussion and consideration of TSEB to a named

New Measure Evidence

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New Measure Evidence

SKIN SPECIFIC MEASURES GATEWAY No. 10790 - JAN 2014
supranetwork T-cell lymphoma MDT; that cases of erythrodermic cutaneous T-cell lymphoma, stages 3 and 4, having both skin involvement and circulating T-cell clonal cells, should be discussed with the clinician in charge of a named photopheresis facility for potential referral and treatment by photopheresis.

14-1C-114j  | Patient Pathways Shared with Other MDTs

The network group should agree patient pathways with the relevant network groups specifying which out of the site specific MDT or skin cancer MDT should deal with which cases in which clinical situations and which parts of the patient pathway for the following:

- head and neck skin cancer;
- anal and perianal skin cancer;
- skin cancer of external female genitalia;
- skin cancer of external male genitalia;
- lymphoma involving skin;
- sarcoma involving skin; (1)

The network group should agree with the chair of the relevant teenage and young adult cancer network co-ordinating group (TYACNCG), the teenage and young adult (TYA), skin cancer patient pathways for initial management, follow up on completion of first line treatment and cases involving NHS specialised services.

The network group should agree a pathway to the effect that any patient with metastatic carcinoma of unknown origin should be referred on for discussion by the carcinoma of unknown primary MDT.

(1) The skin / sarcoma pathway should be compatible with the IOG recommendations that sarcomas which are large or involve or penetrate the superficial fascia and those of histological types potentially requiring chemotherapy should be referred to the sarcoma MDT.

Key Theme
Patient Experience

Objective
All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Measure | Notes | Evidence
---|---|---
14-1C-115j  | Patient Experience | Annual Report.

In the course of their regular meetings, the network group should annually review patient feedback of their associated MDTs and any actions implemented, and should agree an improvement programme with them.
**Key Theme**

**Clinical Outcomes / Indicators**

**Objective**

*All patients receive treatments intended to provide the best possible outcomes, consistent across the MDTs.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14-1C-116j</strong></td>
<td>Clinical Outcomes Indicators and Audits</td>
<td>Information from the cancer outcomes and service dataset (COSD) should be used where relevant. The compliance for this measure relates to the discussion of the data.</td>
</tr>
</tbody>
</table>

In the course of their regular meetings, the network group should annually review the progress (or discuss the completed results, as relevant), of their associated MDTs' outcome indicators and audits, which should have been carried out, or the data examined across all its associated MDTs:

- Any skin cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);
- Clinical indicators identified in section 2 of the measures.

| **14-1C-117j** | Clinical Governance Arrangements for Community Practitioners | (1) Monitoring the adherence of any individual community practitioner to requirements is not carried out by the Peer Review. It is the responsibility of the trusts or CCGs depending on the practice model in question. (2) It is recognised that content should be appropriate to the practitioners present but it is strongly recommended that the diagnosis and management of skin cancer and, in particular, BCCs should be priority subjects for this session. | Constitution. |

The network group should, in consultation with MDTs, agree a policy for arrangements for community practitioners which includes the following:

- that Group 3 and skin lesion GPwSIs and 'Model 2' practitioners (see the introduction to the skin cancer measures), practising in the network, should each be associated with a named LSMDT or SSMDT;
- that community skin cancer practitioners should have their practice included in the network audit;
- that MDT lead clinicians should monitor the attendance of any GPwSIs associated with their MDT, at four MDT meetings a year and an annual community practitioners educational network group meeting. (1)

The network group should hold at least one educational meeting per year to which community skin cancer practitioners are invited (2), and which includes:

- A presentation of network skin cancer audit results. The audit and the presentation should include a topic involving BCCs, of relevance to practitioners treating them in the community and a breakdown of individual practitioner performance;
- A four hour CPD session, with an emphasis on skin lesion recognition and the up to date management of skin cancer (including BCCs) for community practitioners.
**Objective**  
*All patients have equitable access to treatments that could potentially improve outcome.*

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<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>14-1C-118j Discussion of Clinical Trials</td>
<td></td>
<td>Annual Report. Work Programme.</td>
</tr>
</tbody>
</table>

The network group should discuss the MDT's report on clinical trials, annually with each of its associated MDTs and agree an improvement programme with them.
**Skin Measures for Immunocompromised Patients**

**Introduction**
This measure should be applied to each trust in the network which according to the network agreement outlined in [14-1C-103j](#) should establish clinics for immunocompromised patients with skin cancer. The responsibility for review purposes for these measures lies with the cancer lead clinician of the host trust.

**Key Theme**
**Structure and Function**

**Objective**
*Immunocompromised patients with skin cancer have access to a specialised service.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-1D-101j</td>
<td>Provision of Clinics for Immunocompromised Patients with Skin Cancer</td>
<td>(1) The clinic may be part of an existing clinic provided conditions above are fulfilled. (2) There may be other clinic medical and nursing staff in addition to those specified.</td>
</tr>
</tbody>
</table>

There should be a regular clinic in one of the hospitals of the locality (1,2) which should:
- be identified on the hospital outpatient department clinic list or timetable as a clinic for immunocompromised patients with skin cancer;
- have bookable numbered clinic slots identified for the immunocompromised patients;
- have a dermatologist core member of a named MDT with direct patient care sessions for the clinic in their job plans;
- have a nurse specialist member of a MDT with the clinic specified as part of their workplan or job description.
Skin Local MDT Measures

Introduction

The MDT is the group of people from 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. 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.

Key Theme

Structure and Function

Objective

All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-101</td>
<td>Core Membership</td>
<td>(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</td>
</tr>
<tr>
<td></td>
<td>There should be a single named lead clinician with agreed list of responsibilities for the skin MDT who should then be a core team member. (1)</td>
<td>(2) 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. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</td>
</tr>
<tr>
<td></td>
<td>The MDT should provide the names of core team members and their cover for named roles in the team. (2)</td>
<td>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</td>
</tr>
<tr>
<td></td>
<td>Each clinical core member should have sessions specified in the job plan for the care of patients with skin cancer and attendance at MDT meetings.</td>
<td>(3) They may be taking part in the national specialist dermatopathology EQA - this confers compliance.</td>
</tr>
<tr>
<td></td>
<td>The core team specific to the skin cancer MDT should include:</td>
<td>(4) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</td>
</tr>
<tr>
<td></td>
<td>- two dermatologists;</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>- a histopathologist who should be taking part in a general EQA that includes skin pathology; (3,4)</td>
<td>Including confirmation of any specific requirements of the roles.</td>
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<tr>
<td></td>
<td>- a skin nurse specialist;</td>
<td>Annual Report including meeting attendance spread sheet.</td>
</tr>
<tr>
<td></td>
<td>- a clinical oncologist, where radiotherapy is provided by the local MDT;</td>
<td>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</td>
</tr>
<tr>
<td></td>
<td>- MDT co-ordinator/secretary; (5)</td>
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<td></td>
<td>- at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (6)</td>
<td></td>
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<tr>
<td></td>
<td>- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users’ issues and information for patients and carers;</td>
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<tr>
<td></td>
<td>- a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies</td>
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</tbody>
</table>
is integrated into the function of the MDT.

| 5 | (5) The co-ordinator/secretary role needs different amounts of time depending on team workload. |
| 6 | (6) For level 2 psychological support, the relevant disciplines 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 4. |

<table>
<thead>
<tr>
<th>14-2J-102</th>
<th>MDT Quorum</th>
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<tbody>
<tr>
<td>The MDT should have treatment planning meetings scheduled fortnightly unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the skin cancer MDT is made up of the following core members, or their cover (2) • one dermatologist; • one histopathologist; • one clinical oncologist, where radiotherapy is provided by the local MDT; • one skin nurse specialist; • one MDT co-ordinator</td>
<td></td>
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<tr>
<td>(1) The % should be calculated over the 12 months prior to the assessment. (2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover. This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members’ discretion.</td>
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<table>
<thead>
<tr>
<th>14-2J-103</th>
<th>MDT Review</th>
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<tbody>
<tr>
<td>There should be an operational policy whereby all new patients specified as level 4, 5 and 6 care should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. (1,2) The policy should specify that the results of patients’ holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting (3).</td>
<td></td>
</tr>
<tr>
<td>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician’s discretion. (2) Those at levels 5 and 6 may be referred on straight after diagnosis to SSMDTs or a supranetwork team as relevant with retrospective</td>
<td></td>
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</table>
**Objective**

*Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.*

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<thead>
<tr>
<th>Measure</th>
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<th>Evidence</th>
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<tbody>
<tr>
<td><strong>14-2J-104</strong> Core Members Attendance</td>
<td></td>
<td></td>
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<tr>
<td>All core members of the MDT should attend at least two thirds of the number of meetings.</td>
<td>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</td>
<td>Annual Report including meeting attendance spread sheet. The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</td>
</tr>
</tbody>
</table>

| **14-2J-105** Extended Membership of MDT | | |
| The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: | | Operational Policy. |
| • a person agreed as able to provide advice on cosmetic camouflage; | | |
| • a person agreed as contact point for prosthetic service; | | |
| • a person agreed as contact point for orthotics service; | | |
| • a person agreed as contact point for the lymphoedema service; | | |
| • a clinical geneticist/person agreed as able to provide genetic counselling. | | |

| **14-2J-106** MDT Agreement to Clinical Governance Arrangements for Community Practitioners | | |
| The MDT should agree the policy for arrangements for community practitioners, with the network group and it should declare all of its associated community practitioners both Model 1 (GPWSIs) and Model 2 practitioners. The lead clinician of the MDT should monitor the attendance of the team’s associated model 1 practitioners at four MDT meetings and an network group educational meeting per year and make an | If the MDT is agreed as having no associated community practitioners, according to the network configuration for the community skin cancer service, this part of the measure is not applicable. Lack of compliance with this | Operational Policy. Annual Report. |
annual report of the results of this to the relevant community skin cancer clinician accreditation group.

not only means lack of compliance with this measure, but also implies lack of compliance with measure 14-2J-107 which reviews the training of declared Model 2 community practitioners. Whether or not all GPWSIs in a CCG's catchment are associated with one MDT or another, is the responsibility of the CCG.

<table>
<thead>
<tr>
<th>Measure</th>
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<tbody>
<tr>
<td></td>
<td>The MDT should agree the network training policy for Model 2 community practitioners with named trainers/assessors.</td>
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<td></td>
<td>The model 2 community practitioners associated with the MDT should:</td>
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<td></td>
<td>• <strong>EITHER</strong> have been trained and assessed as competent in skin surgery, according to the network training policy;</td>
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<td></td>
<td>• <strong>OR</strong> be exempt from training according to the network training policy.</td>
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<td></td>
<td>For compliance with this measure all of the MDTs associated Model 2 practitioners should be compliant.</td>
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<td></td>
<td>If the MDT is agreed as having no Model 2 practitioners according to the network configuration for the community skin cancer service, this measure is not applicable.</td>
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<td></td>
<td>The agreed trainers / assessors need not be from the membership of the MDT under review.</td>
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</table>

**Key Theme**

**Co-ordination of Care / Patient Pathways**

**Objective**

*All patients receive agreed treatment that is consistent and equitable.*

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<thead>
<tr>
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<tbody>
<tr>
<td>14-2J-108</td>
<td><strong>Clinical Guidelines</strong></td>
<td>Operational Policy.</td>
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<tr>
<td></td>
<td>The MDT should agree the clinical guidelines specified in measure 14-1C-109j.</td>
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<td></td>
<td>Where available, these should reflect national guidelines and policy.</td>
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<td></td>
<td>Operational Policy. Clinical Guidelines should be available for IV and PR visit.</td>
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</table>

**Objective**

*All patients receive co-ordinated care.*

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<thead>
<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>14-2J-109</td>
<td><strong>Patient Pathways</strong></td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>The MDT should agree the network-wide patient pathways specified in measure 14-1C-111j to 14-1C-114j.</td>
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</table>
### Treatment Planning

The MDT should agree and record individual patient's treatment plans. The record should include:

- the identity of patients discussed;
- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration);
- confirmation that the holistic needs have been taken into account.

### Attendance at the Network Group

The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.

### Key Theme

**Patient Experience**

**Objective**

*All patients receive patient centred care with respect and dignity which takes account of their holistic needs.*

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<tbody>
<tr>
<td><strong>14-2J-112</strong></td>
<td>Key Worker</td>
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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 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 policy should have been implemented.

### Patient Information

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

*Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription. It is recommended that the information 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*
emotional effects.

self-assessment the team should confirm the written information which is offered to patients.

<table>
<thead>
<tr>
<th>14-2J-114</th>
<th>Permanent Record of Consultation</th>
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<tbody>
<tr>
<td>The MDT should be offering 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:</td>
<td></td>
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<tr>
<td>• diagnosis;</td>
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<tr>
<td>• treatment options and plan;</td>
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<tr>
<td>• relevant follow up (discharge) arrangements.</td>
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</table>

| Operational Policy. |

<table>
<thead>
<tr>
<th>14-2J-115</th>
<th>Patient Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 were offered:</td>
<td></td>
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<tr>
<td>• a key worker;</td>
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<tr>
<td>• assessment of their physical, emotional, practical, psychological and spiritual needs (holistic needs assessment);</td>
<td></td>
</tr>
<tr>
<td>• the MDTs information for patients and carers (written or otherwise);</td>
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<tr>
<td>• the opportunity of a permanent record or summary of a consultation at which their treatment options were discussed.</td>
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</table>

The exercise 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.

The exercise may consist of a survey, questionnaire, focus group or other method. There may be additional items in the exercise. It is recommended that other aspects of patient experience are covered. As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.

| Annual Report / Service Profile. |

| Key Theme |
| Clinical Outcomes / Indicators |

| Objective |
| All patients receive treatment intended to provide the best possible outcomes that is consistent across the network. |

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Evidence</th>
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<tbody>
<tr>
<td>14-2J-116</td>
<td>Clinical Indicators Review / Audit</td>
<td></td>
</tr>
<tr>
<td>The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings:</td>
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<td></td>
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<tr>
<td>• any skin cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);</td>
<td></td>
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</table>

Information from the cancer outcomes and service dataset (COSD) should be used where relevant. The compliance for this measure relates to the discussion of the data.

**Objective**

*All patients have equitable access to treatments that could potentially improve outcomes.*

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<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>14-2J-117</td>
<td>Discussion of Clinical Trials</td>
<td>(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting. (2) The TYA CNCG’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. (3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</td>
</tr>
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</table>

The MDT should produce a report at least annually on clinical trials, for discussion with the network group. 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 network group.

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

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

- Leukaemia;
- Lymphoma;
- Germ cell malignancy;
- 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 at the teenage and young adults’ cancer network co-ordinating group (TYA CNCG) (2,3).

14-2J-118 | Bi-annual Educational / Audit Meetings | There may be more than two such meetings per year. The MDT may combine with other skin cancer MDTs for this purpose, e.g. a network-wide meeting. The meeting may be used for other purposes, additional to those specified in this measure. | Annual Report. |

The MDT should take part in at least two meetings per year which fulfil the following:

- the authorised clinicians practising in the community and associated with the MDT are invited to attend;
- the progress and/or results of the network skin cancer audit (as specified in measure 14-1C-115j) are discussed;
- teaching is given on aspects of skin cancer management.
Skin Specialist MDT Measures

Introduction
The MDT is the group of people from 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. 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.

Key Theme
Structure and Function

Objective
All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

<table>
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<tr>
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<th>Evidence</th>
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<tbody>
<tr>
<td>14-2J-201</td>
<td>Core Membership</td>
<td>(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability. (2) 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. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member. All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT. (3) For a SSMDT sharing its catchment population with that of a MMDT: The level 5 care for malignant melanoma should be referred to the MMDT and the SSMDT need not have a medical oncologist as a core member (although they may choose to), but if there is no medical oncology</td>
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</tbody>
</table>

There should be a single named lead clinician with agreed list of responsibilities for the skin SMDT who should then be a core team member. (1)
The MDT should provide the names of core team members and their cover for named roles in the team. (2)
Each clinical core member should have sessions specified in the job plan for the care of patients with skin cancer and attendance at MDT meetings.
The core team specific to the skin cancer SMDT should include:
- two dermatologists;
- two surgeons, at least one of whom should be a consultant surgeon trained in plastic and reconstructive surgery;
- clinical oncologist;
- medical oncologist; (3)
- two histopathologists who should be taking part in the national specialist dermatopathology EQA; (4)
- imaging specialist; (5)
- skin nurse specialist;
- MDT co-ordinator/secretary; (6)
- at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7)
- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users’ issues and
information for patients and carers;
• a member of the core team 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.

| core member, there should be 
one as a member of the 
extended team (see measure 
on the extended MDT). |
|---|---|
| (4) The role of the 
histopathologist can be met 
by a group of named 
histopathologists provided 
each meets the workload and 
EQA requirements. |
| (5) The role of the imaging 
specialist can be met by a 
group of named specialists 
provided each meets the 
required workload. |
| (6) The co-ordinator/secretary 
role needs different amounts 
of time depending on team 
workload. |
| (7) For level 2 psychological 
support, the relevant 
disciplines 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 4. |

<table>
<thead>
<tr>
<th>14-2J-202</th>
<th>MDT Quorum</th>
</tr>
</thead>
</table>
| The MDT should have treatment planning meetings 
scheduled fortnightly unless the meeting falls on a 
public holiday. The attendance at each individual 
scheduled treatment planning meeting should constitute 
a quorum, for 95% or more, of the meetings. (1) |
| The quorum for the skin cancer SMDT is made up of 
the following core members, or their cover (2) |
| • one dermatologist; |
| • one surgeon; |
| • one clinical oncologist; |
| • one medical oncologist; (3) |
| • one histopathologist; |
| • one imaging specialist; |
| • one skin nurse specialist; |
| • one MDT co-ordinator. |

| (1) The % should be calculated over the 12 months 
prior to the assessment. |
| (2) The members counting towards the quorum should 
be drawn from the list of named core members or their 
named cover as specified in the core membership 
measures and are therefore subject to the definition of 
acceptable core members or their cover. |
| (3) For a SSMDT sharing its 
catchment population with 
that of a MMDT: The level 5 
care for malignant melanoma 
should be referred to the 
MMDT and the SSMDT need 
not have a medical oncologist 
as a quorum member. |

| Annual Report 
including meeting 
attendance spread 
sheet. |
| The spread sheet should include the 
dates of all scheduled 
meetings and the 
names and roles of core members. |
This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members’ discretion.

<table>
<thead>
<tr>
<th>14-2J-203</th>
<th>MDT Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan (1). The policy should specify that the cases for individual MDT review should include those cases specified as ‘level 4’ care (where the SSMDT is acting as its own local MDT) and ‘level 5 and 6’ care. For an SSMDT acting as the cutaneous lymphoma for the network the policy should include that a consultant responsible for photopheresis should discuss all cutaneous lymphoma cases referred for potential photopheresis at an MDT meeting prior to treatment. The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting (3).</td>
<td></td>
</tr>
<tr>
<td>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician’s discretion. (2) Those at level 6 may be referred on straight after diagnosis to a supranetwork team with retrospective review by the SSMDT. (3) e.g. Letters emails or phone calls between certain specified members, retrospective discussion at the next scheduled meeting.</td>
<td></td>
</tr>
<tr>
<td>Operational Policy.</td>
<td></td>
</tr>
</tbody>
</table>

**Objective**

*Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-204</td>
<td><strong>Core Members Attendance</strong></td>
<td>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Report including meeting attendance spread sheet. The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</td>
</tr>
</tbody>
</table>

| 14-2J-205 | **Extended Membership of MDT** | The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: |
| | | • a person agreed as able to provide advice on |
| | | Operational Policy. |
- cosmetic camouflage;
- a person agreed as contact point for prosthetic service;
- a person agreed as contact point for orthotics service;
- a person agreed as contact point for the lymphoedema service;
- a clinical geneticist/person agreed as able to provide genetic counselling;
- for a SSMDT sharing its catchment population with that of a MMDT: it should have a medical oncologist as a member of the extended team if not already offered as a core team member.

### MDT Agreement to Clinical Governance Arrangements for Community Practitioners

The MDT should agree the policy for arrangements for community practitioners, with the network group and it should declare all of its associated community practitioners both Model 1 (GPWSIs) and Model 2 practitioners.

The lead clinician of the MDT should monitor the attendance of the team's associated model 1 practitioners at four MDT meetings and an network group educational meeting per year and make an annual report of the results of this to the relevant community skin cancer clinician accreditation group.

If the MDT is agreed as having no associated community practitioners, according to the network configuration for the community skin cancer service, this part of the measure is not applicable.

Lack of compliance with this not only means lack of compliance with this measure, but also implies lack of compliance with measure 14-2J-207 which reviews the training of declared Model 2 community practitioners. Whether or not all GPWSIs in a CCG's catchment are associated with one MDT or another, is the responsibility of the CCG.

### Training for Model 2 Community Practitioners

The MDT should agree the network training policy for Model 2 community practitioners with named trainers/assessors.

The model 2 community practitioners associated with the MDT should:

- **EITHER** have been trained and assessed as competent in skin surgery, according to the network training policy;
- **OR** be exempt from training according to the network training policy.

For compliance with this measure all of the MDTs associated Model 2 practitioners should be compliant.

If the MDT is agreed as having no Model 2 practitioners according to the network configuration for the community skin cancer service, this measure is not applicable.

The agreed trainers / assessors need not be from the membership of the MDT under review.
### Specific Procedures Carried Out in Same Named Hospital

The following procedures carried out by the members of the SSMDT, together with their acute post operative care, should each take place in the same named hospital, e.g. all block lymph node dissections should be carried out in the same hospital, and all limb perfusion in same hospital, but the hospital for block lymph node dissections need not be the hospital for limb perfusions.

- block lymph node dissections;
- sentinel node biopsy;
- metastatectomy/debulking for recurrent melanoma;
- isolated limb perfusion;
- isolated limb infusion;
- reconstruction procedures involving microvascular surgical techniques.

For the purpose of self-assessment a list of the procedures and which hospital should be included in the annual report. There may be different hospitals for different procedures but all cases of each individual procedure of the MDT on the list should be carried out in one hospital.

### Individual Surgical Member Inguinal or Axillary Dissections Workload

Each individual core surgical member of the SSMDT who performs inguinal or axillary lymph node dissections on the MDT’s patients should fulfil the following with regards to those patients:

- The summed total number of groin plus axillary dissections per year should be 15 or more.

Only dissections performed for skin cancer count towards the total. The total of 15 may consist of entirely inguinal or entirely axillary or a combination of both types of procedure. The total should be averaged over the two most recent complete calendar years prior to the peer review visit or completed self-assessment. For a lymph node dissection to count towards the total the surgeon should have been present and scrubbed at the procedure as evidenced by their being named as a participating surgeon in the operation notes. This measure does not apply to neck node dissections.

### Key Theme

**Co-ordination of Care / Patient Pathways**

**Objective**

All patients receive agreed treatment that is consistent and equitable.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-210</td>
<td>Clinical Guidelines</td>
<td>Where available, these should reflect national</td>
</tr>
</tbody>
</table>

The MDT should agree the clinical guidelines specified in measure 14-1C-109.
### Objective
*All patients receive co-ordinated care.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-211</td>
<td>Patient Pathways</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>The MDT should agree the network-wide patient pathways specified in measure 14-1C-111j to 14-1C-114j.</td>
<td></td>
</tr>
<tr>
<td>14-2J-212</td>
<td>Treatment Planning</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>The MDT should agree and record individual patient's treatment plans. The record should include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• the identity of patients discussed;</td>
<td></td>
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<tr>
<td></td>
<td>• the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration);</td>
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<tr>
<td></td>
<td>• confirmation that the holistic needs have been taken into account.</td>
<td></td>
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<tr>
<td>14-2J-213</td>
<td>Attendance at the Network Group</td>
<td></td>
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<tr>
<td></td>
<td>The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.</td>
<td>Annual Report including meeting attendance spread sheet.</td>
</tr>
</tbody>
</table>

### Key Theme
*Patient Experience*

### Objective
*All patients receive patient centred care with respect and dignity which takes account of their holistic needs.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>14-2J-214</td>
<td>Key Worker</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>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 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 policy should have been implemented.</td>
<td></td>
</tr>
</tbody>
</table>

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**SKIN SPECIFIC MEASURES**

GATEWAY No. 10790 - JAN 2014

45
### 14-2J-215 Patient Information

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.

Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.

It is recommended that the information 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 offered to patients.

Operational Policy. Examples should be available for IV and PR visit.

### 14-2J-216 Permanent Record of Consultation

The MDT should be offering 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.

Operational Policy.

### 14-2J-217 Patient Feedback

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 were offered:

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

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

As an alternative to the measure the relevant local results of the national patient survey may be offered as compliance with this measure.

Annual Report / Service Profile.
**Key Theme**

**Clinical Outcomes / Indicators**

**Objective**

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-218</td>
<td>Clinical Indicators Review / Audit</td>
<td>Information from the cancer outcomes and service dataset (COSD) should be used where relevant. The compliance for this measure relates to the discussion of the data.</td>
</tr>
</tbody>
</table>

The MDT should annually review their data, discuss the progress of their audit or discuss the completed results, as relevant, of the following outcome indicators and/or audits, with the network group, at one of the regular network group meetings:

- any skin cancer outcome indicators for hospital practice, required by the Clinical Commissioning Group Outcomes Indicator Set (CCGOIS);
- clinical indicators identified in section 2 of the measures;
- the skin cancer audit identified in measure 14-1C-116.

**Objective**

All patients have equitable access to treatments that could potentially improve outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-219</td>
<td>Discussion of Clinical Trials</td>
<td>(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting. (2) The TYA CNCG’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. (3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</td>
</tr>
</tbody>
</table>

The MDT should produce a report at least annually on clinical trials, for discussion with the network group. 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 network group.

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

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

- Leukaemia;
- Lymphoma;
- Germ cell malignancy;
- 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 at the teenage and young adults’ cancer network co-ordinating group (TYA CNCG) (2,3).
<table>
<thead>
<tr>
<th><strong>14-2J-220</strong></th>
<th>Bi-annual Educational / Audit Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MDT should take part in at least two meetings per year which fulfil the following:</td>
<td>There may be more than two such meetings per year.</td>
</tr>
<tr>
<td>• the authorised clinicians practising in the community and associated with the MDT are invited to attend;</td>
<td>The MDT may combine with other skin cancer MDTs for this purpose, e.g. a network-wide meeting.</td>
</tr>
<tr>
<td>• the progress and/or results of the network skin cancer audit (as specified in measure <a href="#">14-1C-116</a>) are discussed;</td>
<td>The meeting may be used for other purposes, additional to those specified in this measure.</td>
</tr>
<tr>
<td>• teaching is given on aspects of skin cancer management.</td>
<td>Annual Report.</td>
</tr>
</tbody>
</table>

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**SKIN SPECIFIC MEASURES**

GATEWAY No. 10790 - JAN 2014 48
## Melanoma MDT (MMDT) Measures

### Introduction
The MDT is the group of people from 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. 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.

### Key Theme
#### Structure and Function

#### Objective
All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-301</td>
<td>Core Membership</td>
<td>(1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) 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. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) For clinical oncologist see measure on the extended MDT (14-2J-305).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5) The role of the imaging operational Policy. Operational Policy. Including confirmation of any specific requirements of the roles.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Report including meeting attendance spread sheet.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</td>
</tr>
</tbody>
</table>

There should be a single named lead clinician with agreed list of responsibilities for the melanoma MDT who should then be a core team member. (1)

The MDT should provide the names of core team members and their cover for named roles in the team. (2)

Each clinical core member should have sessions specified in the job plan for the care of patients with melanoma and attendance at MDT meetings.

The core team specific to the melanoma MDT should include:

- two dermatologists;
- two surgeons, at least one of whom should be a consultant surgeon trained in plastic and reconstructive surgery;
- medical oncologist; (3)
- two histopathologists who should be taking part in the national specialist dermatopathology EQA; (4)
- imaging specialist; (5)
- skin nurse specialist;
- MDT co-ordinator/secretary; (6)
- at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month; (7)
- an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users’ issues and information for patients and carers;
• a member of the core team 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.

specialist can be met by a group of named specialists provided each meets the required workload.

(6) The co-ordinator/secretary role needs different amounts of time depending on team workload.

(7) For level 2 psychological support, the relevant disciplines 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 4.

<table>
<thead>
<tr>
<th>14-2J-302</th>
<th>MDT Quorum</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MDT should have treatment planning meetings scheduled fortnightly unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for the skin MMDT is made up of the following core members, or their cover: (2) • one dermatologist; • one surgeon; • one medical oncologist; • one histopathologist; • one imaging specialist; • one skin nurse specialist; • one MDT co-ordinator.</td>
<td>(1) The % should be calculated over the 12 months prior to the assessment. (2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover. This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members’ discretion.</td>
</tr>
<tr>
<td>14-2J-303</td>
<td>MDT Review</td>
</tr>
<tr>
<td>There should be an operational policy whereby all new patients should be reviewed by the multidisciplinary team for discussion of their initial treatment plan (1). The policy should specify that the results of patients' holistic needs should be taken into account in the decision making. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting (2).</td>
<td>(1) Other occasions when a patient should require MDT discussion should be covered in the agreed patient pathways. It should be understood that any patient may be referred outside the policy, at any stage, at an individual clinician's discretion. (2) e.g. Letters emails or Operational Policy.</td>
</tr>
</tbody>
</table>

Annual Report including meeting attendance spread sheet. The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.
Objective
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-304 Core Members Attendance</td>
<td>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</td>
<td>Annual Report including meeting attendance spread sheet. The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</td>
</tr>
<tr>
<td>14-2J-305 Extended Membership of MDT</td>
<td>The MDT should provide the names of members of the extended team for named roles in the team if they are not already offered as core team members. The named extended team for the MDT should include: • clinical oncologist; • a person agreed as able to provide advice on cosmetic camouflage; • a person agreed as contact point for prosthetic service; • a person agreed as contact point for orthotics service; • a person agreed as contact point for the lymphoedema service.</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td>14-2J-306 Specific Procedures Carried Out in Same Named Hospital</td>
<td>Specific Procedures Carried Out in Same Named Hospital</td>
<td>For the purpose of self-assessment a list of the procedures and which hospital should be included in the annual report. There may be different hospitals for different procedures but all cases of each individual procedure of the MDT on the list should be carried out in one hospital.</td>
</tr>
</tbody>
</table>
- isolated limb infusion;
- reconstruction procedures involving microvascular surgical techniques.

<table>
<thead>
<tr>
<th>14-2J-307</th>
<th>Individual Surgical Member Inguinal or Axillary Dissections Workload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each individual core surgical member of the MMDT who performs inguinal or axillary lymph node dissections on the MDT’s patients should fulfil the following with regards to those patients:</td>
<td></td>
</tr>
<tr>
<td>- The summed total number of groin plus axillary dissections per year should be 15 or more.</td>
<td></td>
</tr>
<tr>
<td>Only dissections performed for skin cancer count towards the total.</td>
<td></td>
</tr>
<tr>
<td>The total of 15 may consist of entirely inguinal or entirely axillary or a combination of both types of procedure.</td>
<td></td>
</tr>
<tr>
<td>The total should be averaged over the two most recent complete calendar years prior to the peer review visit or completed self-assessment.</td>
<td></td>
</tr>
<tr>
<td>For a lymph node dissection to count towards the total the surgeon should have been present and scrubbed at the procedure as evidenced by their being named as a participating surgeon in the operation notes.</td>
<td></td>
</tr>
<tr>
<td>This measure does not apply to neck node dissections.</td>
<td></td>
</tr>
<tr>
<td>Annual Report.</td>
<td></td>
</tr>
</tbody>
</table>

**Key Theme**

**Co-ordination of Care / Patient Pathways**

**Objective**
All patients receive agreed treatment that is consistent and equitable.

<table>
<thead>
<tr>
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<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-308</td>
<td>Clinical Guidelines</td>
<td>Where available, these should reflect national guidelines and policy.</td>
</tr>
<tr>
<td>The MDT should agree the network clinical guidelines for malignant melanoma.</td>
<td>Operational Policy. Clinical Guidelines should be available for IV and PR visit.</td>
<td></td>
</tr>
</tbody>
</table>

**Objective**
All patients receive co-ordinated care.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-309</td>
<td>Patient Pathways</td>
<td></td>
</tr>
</tbody>
</table>
### 14-2J-310  
**Treatment Planning**

The MDT should agree and record individual patient's treatment plans. The record should include:

- the identity of patients discussed;
- the multidisciplinary treatment planning decision (i.e. to which modality(s) of treatment - surgery, radiotherapy, chemotherapy, hormone therapy or supportive care or combinations of the same, that are to be referred for consideration);
- confirmation that the holistic needs have been taken into account.

### 14-2J-311  
**Attendance at the Network Group**

The lead clinician of the MDT or representative should attend at least two thirds of the network group meetings.

### Key Theme

**Patient Experience**

**Objective**

*All patients receive patient centred care with respect and dignity which takes account of their holistic needs.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| **14-2J-312**  
**Key Worker** |       |          |

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 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 policy should have been implemented.

| **14-2J-313**  
**Patient Information** |       |          |

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

*Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.*

It is recommended that the information 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*
emotional effects.

### 14-2J-314 Permanent Record of Consultation

The MDT should be offering 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.

### 14-2J-315 Patient Feedback

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 were offered:

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

The exercise 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.

### Key Theme

**Clinical Outcomes / Indicators**

**Objective**

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14-2J-316 Clinical Indicators Review / Audit</strong></td>
<td>Information from the cancer outcomes and service dataset (COSD) should be used where relevant. The compliance for this measure relates to the discussion of the data.</td>
<td>Annual Report / Service Profile. Work Programme.</td>
</tr>
</tbody>
</table>
Objective
All patients have equitable access to treatments that could potentially improve outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-317</td>
<td>Discussion of Clinical Trials</td>
<td>(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting. (2) The TYA CNCG’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. (3) For compliance with this measure, the MDT should agree a final programme for improvement for TYA clinical trials with the TYA CNCG.</td>
</tr>
</tbody>
</table>

The MDT should produce a report at least annually on clinical trials, for discussion with the network group. 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 network group.

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

In addition, applicable only to MDTs dealing with the following cancer sites:
- Leukaemia;
- Lymphoma;
- Germ cell malignancy;
- 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 at the teenage and young adults’ cancer network co-ordinating group (TYA CNCG) (2,3).
### Introduction
This section contains measures for the supranetwork T-cell cutaneous lymphoma team. This is a team which has been selected by specialist commissioners to deal with a particular group of cutaneous T-cell lymphoma (CTCL) patients for the whole of their host network and also other named networks. The team is built around the special expertise and facilities required to offer Total Surface Electron Beam Therapy (TSEBT). The measures concentrate on delivering this therapy. The many other measures relevant to the general functions of an MDT and the quality of care of these patients, are considered for the purpose of peer review to have been covered by the review of their referring SSMDTs.

The team may choose to have additional core and/or extended team members besides those specified here. Possible working models for such a team may involve it being part of an existing SSMDT or video-conferencing with any referring clinician. These or other models are not precluded provided the team fulfils the measures in this section.

Whether the supranetwork team undertakes other aspects of management of CTCL besides TSEBT is subject to arrangements between networks.

At which stage in the patient pathway the patient needs to be seen by a member of the supranetwork team, and whether a given patient needs to be seen, is again subject to arrangements between networks.

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.

### Key Theme
**Structure and Function**

**Objective**
*All patients benefit from expert multidisciplinary discussion of their diagnosis and treatment without delay.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| 14-2J-401   | Core Membership | (1) The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability.  
(2) Where a medical speciality is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member.  
(3) The co-ordinator/secretary role needs different amounts of time depending on team workload.  
The team may choose to have additional core and/or |

Operational Policy.  
Including confirmation of any specific requirements of the roles.  
Annual Report including meeting attendance spread sheet.  
The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.
performing TSEBT should be a core member of the supranetwork MDT.

<table>
<thead>
<tr>
<th>14-2J-402</th>
<th>MDT Quorum</th>
</tr>
</thead>
<tbody>
<tr>
<td>The attendance at each individual treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1) The quorum for this MDT is made up of the following core members, or their cover: (2) • clinical oncologist with a total surface electron beam therapy practice; • histopathologist who is the named histopathologist for cutaneous lymphoma; • dermatologist who is a core member of an SSMDT; • one MDT co-ordinator.</td>
<td></td>
</tr>
<tr>
<td>(1) The % should be calculated over the 12 months prior to the assessment. (2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover. This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members’ discretion.</td>
<td>Annual Report including meeting attendance spread sheet. <em>The spread sheet should include the dates of all scheduled meetings and the names and roles of core members.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14-2J-403</th>
<th>MDT Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be an operational policy whereby all patients referred for TSEBT should be reviewed by the multidisciplinary team for discussion of their case.</td>
<td>Operational Policy.</td>
</tr>
</tbody>
</table>

**Objective**

*Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.*

<table>
<thead>
<tr>
<th>14-2J-404</th>
<th>Core Members Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All core members of the MDT should attend at least two thirds of the number of meetings.</td>
<td>The intention is that core members of the team should be personally committed to the MDT which is reflected in their personal attendance at a substantial proportion of meetings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14-2J-405</th>
<th>All Treatments with TSEBT Should be Delivered in the Same Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>All treatments with TSEBT for patients from the supranetwork catchment area of the team should be delivered in the same department.</td>
<td>Operational Policy.</td>
</tr>
</tbody>
</table>

Annual Report. |
### Key Theme
#### Co-ordination of Care / Patient Pathways

**Objective**

*All patients receive co-ordinated care.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-406</td>
<td></td>
<td>Operational Policy.</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td></td>
<td>Example of treatment plan to be available for IV and PR visit.</td>
</tr>
</tbody>
</table>

The MDT should agree and record individual patient's treatment plans. The record should include:

- the identity of patients discussed;
- the multidisciplinary treatment planning decision; in particular whether or not:
  - TSEBT is to be used;
  - They are to be otherwise managed by the supranetwork team or the referring MDT.

### Key Theme
#### Patient Experience

**Objective**

*All patients receive patient centred care with respect and dignity which takes account of their holistic needs.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-407</td>
<td></td>
<td>Operational Policy.</td>
</tr>
<tr>
<td>Patient Information</td>
<td></td>
<td>Examples should be available for IV and PR visit.</td>
</tr>
</tbody>
</table>

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

- information specific to TSEBT 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.

Where available, it is recommended that the information and its delivery to patients and carers should be in the format of the NHS Information Prescription.

It is recommended that the information 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.
### Key Theme
**Clinical Outcomes / Indicators**

### Objective
All patients have equitable access to treatments that could potentially improve outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-2J-408</td>
<td>Clinical Indicators Review / Audit</td>
<td>(1) For compliance with this measure the MDT should produce a proposed programme for improvement and at the discussion with the network group, settle on a mutually agreed programme between the participants of the meeting.</td>
</tr>
</tbody>
</table>

The MDT should produce a report at least annually on clinical trials, for discussion with the network group. 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 network group.

The MDT should agree a final programme for improvement at the network group discussion meeting.
**Section 2 Clinical Indicators/Lines of Enquiry**

**Introduction**

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self assessment report and any plans for improvement should be included in their work programme.

**Clinical Indicators**

- TBA
Appendix 1 Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarized as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between network groups for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Network Groups

- The network group should be the only such network group for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the network group should be associated with more than one MDT.
- For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.
  - Notes: The network group need only be associated with one specialist/supranetwork type MDT but may be associated with more than one.

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with:

- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.
  - Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
  - Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and/or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances. This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.
• The MDT should be the only such MDT for its cancer site on or covering a given hospital site.
  • Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.

• The MDT should be associated with a single named network group for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
  • Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one network group, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate network group for each of its specialty sites.

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the ‘local’ type MDTs.

• The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.
• The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.
• The specialist MDT should act as the ‘local’ type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.
  • Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site.
• The specialist MDT should be associated with a single named network group, (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
Appendix 2 Roles and Responsibilities

Roles and Responsibilities

Introduction

Role of the network group

The network group 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 MDT leads from the relevant associated organisations.

The network group should:

- agree a set of clinical guidelines and patient pathways to support the delivery of high quality equitable services across the network;
- 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;
- review and discuss identified risks/untoward incidents to ensure learning is spread;
- agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

Responsibilities of the MDT lead clinician

The MDT lead clinician should:

- 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;
- 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;
- 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 the MDT meetings and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- provide the link to the network group either by attendance at meetings or by nominating another MDT member to attend;
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded, clinically validated and that appropriate data collection is supported.
Appendix 3 Chemotherapy Treatment Algorithms

Introduction

Introduction; (Definitions). Regimens, Protocols and Algorithms

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 their definition of a regimen narrower, but not wider. This is relevant to measures in the chemotherapy section (Topic 3S).

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 range of regimens for each relevant step 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 of the chemotherapy measures. There may be other formats which would be acceptable to the reviewers.

In practice, a change of regimen or order of regimens may no longer comply with a previously agreed treatment algorithm, but a change of one of the minor aspects of a treatment protocol would still comply. The measure for network groups is concerned only with chemotherapy algorithms.

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 network group should produce the algorithms for its compliance with this measure and the relevant chemotherapy multi-professional teams should produce a compatible list of algorithms for the network group's cancer site for their own service (measure 11-3S-122). The relevant chemotherapy multi-professional teams should each agree lists with all the network groups 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 network group agreed list.

This exercise should include oral chemotherapy.

This measure is assessed as part of the responsibility of each network group, but from the chemotherapy cross cutting group'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. Updates require changes only when judged clinically necessary by the network group.
Appendix 4 Psychological Support Levels

Introduction

This appendix gives the definitions, for the purpose of the measures and peer review, of the service levels. The term 'Health Professional' as used in the definitions of levels 1 and 2, implies a professional in a discipline other than the psychiatry/psychology/counselling disciplines themselves, since it is assumed that basic qualification in these disciplines would exempt a practitioner from level 2 training.

Level 1

Is defined as a degree of psychological screening, intervention and support which is deliverable by any qualified health or social care professional, without any further psychological training other than that provided by the basic training in their own discipline.

Note: Level 1 does not feature directly in the measures but it is specified here to set a baseline for comparison with the higher levels and to put them in perspective.

Level 2

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is a health or social care professional who has received further psychological training, as specified below, in addition to that provided by the basic training in their own discipline.

The additional training is as follows:

I. Attendance on the National Advanced Communications Skills Training course from one of the nationally approved programmes.

PLUS

II. Participation in a network based training programme, relevant to cancer patients and their carers which covers basic psychological screening, psychological assessment and basic psychological intervention skills.

The detailed content of the training programme will be agreed by the network and is not subject to peer review, but for illustration purposes examples of the training in screening are: Jenkins, K. & North, N. (2008) 'Psychological Assessment Skills: A training course for all health and social care staff working in cancer services'. Salisbury NHS Foundation Trust; or, training in the use of a Holistic Needs Assessment tool such as the Distress Thermometer.

For illustration purposes, examples of the training in psychological intervention skills are: Training in Solution Focussed Techniques, or Anxiety Management, or Problem Solving, or Cognitive Behavioural Therapy.

Level 3

Is defined as a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a counsellor, accredited by the one of the national voluntary regulatory bodies for counselling;
- an NHS psychotherapist accredited by one of the national voluntary regulatory bodies for psychotherapy.

Level 4

Is a degree of psychological screening, intervention and support which requires a practitioner who is one of the following:

- a consultant psychiatrist;
- a consultant liaison psychiatrist;
- a clinical or counselling psychologist.

Note:

All of the above should have completed an induction at level 3. that meets the British Psychosocial Oncology Society (BPOS) and SIGOPAC requirements.