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Llywodraeth Cynulliad Cymru
Welsh Assembly Government

National Standards for Breast Cancer Services 2005



**Cancer Services
Co-ordinating Group**

**Grŵp Cydgysylltu
Gwasanaethau Canser**

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I. INTRODUCTION TO THE CANCER STANDARDS

I.1 These Cancer Standards replace the previous Minimum Standards issued in 2000 and continue the process of regularly reviewing and revising standards to maintain their relevance to the NHS in Wales.

I.2 Cancer Standards define the core aspects of the service that should be provided for cancer patients throughout Wales. The standards should be used in conjunction with other requirements for example from the Health and Safety Executive, NHS, National UK NHS Breast Screening Programme Standards, Royal Colleges and the National Institute for Clinical Excellence [NICE] recommendations and guidelines that cover patient care, facilities and staff. Trusts may provide or aim to provide additional services and work to more rigorous and/or wide-ranging standards. This should be encouraged.

I.3 Since 2000 there has been significant change in organisational structures within Wales. Further, both the NHS Quality Improvement Scotland and Department of Health have issued cancer standards and NICE is part way through a programme of issuing cancer service guidance for commissioners. There was therefore a pressing need to revise the existing Standards.

I.4 The Cancer Standards build on those published in 2000 and take account of the NICE cancer service guidance. The Minimum Standards of 2000 therefore form the basis of this set of Standards with a limited number of additional new standards. In some cases the new standards, supported by evidenced-based national guidance, are developmental and will be challenging for example those involving surgical re-organisation. It is recognised that such changes take time and resource to implement and it will therefore be important that the process of implementation is planned to start as soon as possible. Commissioners and providers, as Cancer Network stakeholders, will need to work with each Cancer Network core team of Lead Clinician and Manager to plan and deliver the service changes required.

I.5 Ongoing implementation of the Cancer Information Framework¹ will support the implementation of these new Standards as it focuses on the clinical information required for cancer teams and discussed at the team meeting.

¹ Cancer Information Framework WHC(2000)40 Apr 2000

2. METHODOLOGY

2.1 The Welsh Assembly Government tasked the Cancer Services Co-ordinating Group [CSCG] to oversee the development of cancer standards. For this latest revision the Cancer Standards Group of the CSCG has worked with the CSCG clinical cancer site steering groups and patient forum to develop the standards. Membership is at Annex I.

2.2 Work commenced in April 2003 with each steering group reviewing the Minimum Standards of 2000 in the light of subsequent national guidance and cancer standards. Cancer Networks were involved in the process via representation of Network clinical leads on the all Wales clinical steering groups. During this time, a number of draft and/or cancer service guidance documents were published by NICE which needed to be considered. Finally, a six-week consultation phase was run during February/April 2004 with completed Standards submitted to the Welsh Assembly Government in July 2004.

3. FORMAT

3.1 The standards are presented as a series of Topics. These address the organisational requirements that are key to effective delivery of care and then follow the main stages in the patient journey.

3.2 Within each Topic, a Rationale is presented that provides the context to the specific standards that follow.

3.3 Attached to each standard are monitoring criteria. The monitoring criteria are included in this document as indicative of the monitoring required. A separate and more detailed monitoring tool will be developed and piloted prior to release.

4. INTRODUCTION TO BREAST CANCER STANDARDS

4.1 The local breast cancer team will provide a rapid diagnostic and assessment service for all patients with breast cancer. The team will be the referral point for primary care clinicians [General Practitioners] and for patients found to have breast cancer within the secondary care environment. Where contracted to Breast Test Wales, the team will also manage patients with breast cancer found through the screening programme. Most breast cancer patients will require multi-modality treatment, with initial surgical management of the majority of breast cancer patients being carried out by the local team. Further oncological treatment such as radiotherapy and in many cases chemotherapy may, after discussion with the designated oncologist at the Multi-Disciplinary Team [MDT], need to be carried out at the cancer centre. Patients requiring specialist reconstructive techniques may need tertiary referral to other teams, including the regional plastic surgery centre, where appropriate.

Key References

- *Manual for Cancer Services. Department of Health [2004].*
- *Guidance on Screening and Symptomatic Breast Imaging. Royal College of Radiologists [2003].*
- *Guidance on Cancer Services. Improving Outcomes in Breast Cancer, Manual Update, National Institute of Clinical Excellence [2002].*
- *Clinical Standards, Breast Cancer. Clinical Standards Board for Scotland. [January 2001].*
- *Guidance for Purchasers. Improving Outcomes in Breast Cancer. Department of Health [1996].*
- *Cancer Services in Wales. A Report by the Cancer Services Expert Group chaired by Professor I Cameron [1996].*
- *Guidelines for Surgeons in the Management of Symptomatic Breast Disease in the United Kingdom. Eur. J. Surg. Oncol. 21, suppl A [1995].*
- *Provision of breast services in the UK: The advantages of specialist breast units. Report of working party of the British Breast Group [1994].*
- *Improving Quality in Cancer Care. Reducing Delays in Cancer Treatment. A Report of the Joint Council for Clinical Oncology [1994].*
- *Quality Control in Cancer Chemotherapy. Managerial and Procedural Aspects. A Report of the Joint Council for Clinical Oncology [1994].*
- *The Use of Computed Tomography in the Initial Investigation of Common Malignancies. Royal College of Radiologists [1994].*
- *Quality Assurance in Radiotherapy. Report of the Standing Sub-Committee on Cancer of the Standing Medical Advisory Committee [1991].*

TOPIC: ORGANISATION

OBJECTIVE 1: TO STRUCTURE CANCER NETWORKS SUCH THAT THEY BRING TOGETHER KEY STAKEHOLDERS IN BOTH COMMISSIONING AND PROVIDING CANCER CARE, WITH AN OPEN AND TRANSPARENT MANAGEMENT STRUCTURE.

Rationale: A Cancer Network is an organisational association between primary, secondary, tertiary and voluntary sector providers, social services and commissioners with care delivered by multidisciplinary clinical teams within a geographic area. Regular meetings between commissioners and providers, as stakeholder organisations, will facilitate review of service provision and ensure uniform standards of care are applied across the Network. The Network will need mechanisms in place to action reorganisation of services where appropriate.

Each Network should produce a Services Development Plan [SDP]² that will inform the commissioning process and involve Local Health Boards and Health Commission Wales as appropriate. It is recognised that service planning in relation to specialist cancer teams providing services for less common cancers may well need to involve collaboration between Networks. The development of the SDP will involve all stakeholder organisations and be advised by the Network Breast Cancer Group that is multidisciplinary and represents the breast cancer MDTs within the Network.

The Chief Executive of the organisation on whose premises care is being delivered remains the accountable officer for the quality of care. Where a clinical team provides care to more than one organisation, clear agreements will be required between organisations about how clinical governance responsibilities are to be carried out. In relation to team working, the recommendations made at the team meeting are advisory, and the responsibility for clinical decisions and actions always rests with the senior clinician under whose care the patient is at that point of their journey.

2 Service and Financial Framework target 2003-2004 - WHC(2003)001

STANDARD	MONITORING CRITERIA
1.1 Network management arrangements and accountability should be documented.	1.1 The establishment agreement detailing Network management accountability to be held by the Regional Office.
1.2 Agreements on clinical governance lines of accountability for clinical teams providing care in more than one organisation should be clearly documented.	1.2 Documentation detailing agreements on lines of accountability for clinical governance.
1.3 The Network should produce a SDP, which takes account of local and the all Wales priorities and policy and is updated annually.	1.3 <ul style="list-style-type: none"> a. The Network SDP, approved by the Network Board, is available for external peer review. b. The Network to report to the Regional Office on implementation of service plans.
1.4 Commissioners and providers as stakeholders of the Cancer Network should work with the Network team to identify priorities, taking account of all Wales Cancer Standards, NICE and other national guidance and agree an appropriate programme for implementation.	1.4 Regional Offices to monitor implementation of Network priorities.

OBJECTIVE 2: CARE PROVIDED BY TEAMS SHOULD BE WELL CO-ORDINATED TO PROVIDE AN EFFICIENT, EFFECTIVE SERVICE TO PATIENTS.

Rationale: Cancer care involves a number of different specialists working together as a team. To effectively work as a team, particularly across Departments within a Trust, co-ordination and clinical leadership is required.

The Trust Cancer Lead Clinician [TCLC] is accountable to the Trust Board via the Medical Director or Executive Lead for cancer and is responsible for identifying requirements to ensure cancer teams comply with the cancer standards. The TCLC needs to be supported by a senior management team.

The Breast Cancer Team Lead Clinician is accountable to TCLC of the Trust/s where services are provided and is responsible for identifying requirements to ensure the team complies with the Breast Cancer Standards.

STANDARD	MONITORING CRITERIA
<p>2.1 Each Trust should have an identified Cancer Management Team that reflects the manner in which cancer is treated across the management structures. Each team should include at a minimum</p> <ul style="list-style-type: none"> a. A Trust Cancer Lead Clinician. b. A designated Lead Manager. c. The lead Cancer Co-ordinator. d. A nominated Executive Lead. e. A designated Lead Cancer Nurse/Allied Health Professional. 	<p>2.1 Documentation detailing names and designation and a description of how the management team relate to internal management structures.</p>
<p>2.2 The TCLC should be appointed by the Trust Chief Executive and have recognised dedicated sessional time with administrative and senior management support.</p>	<p>2.2 Job plan to detail role, sessional time and management support for TCLC.</p>
<p>2.3 The TCLC should attend both Trust and Network cancer meetings as appropriate.</p>	<p>2.3 Detailed in Job Plan.</p>
<p>2.4 The breast cancer MDT lead clinician should be confirmed by the Cancer Network Board in consultation with their respective TCLC and Medical Director or Executive Lead.</p>	<p>2.4 Network documentation.</p>
<p>2.5 The breast cancer MDT lead clinician should</p> <ul style="list-style-type: none"> a. Have overall responsibility for team working, the team meeting, clinical audit. b. Provide clinical advice and co-ordinate any modernisation projects that are associated with working of the MDT. c. Have dedicated administrative and secretarial assistance to support the functioning of the MDT. d. Attend both Trust and Network cancer meetings as appropriate 	<p>2.5 Responsibility detailed in job plan with evidence provided of</p> <ul style="list-style-type: none"> a. Regular team meetings with attendance register. b. Clinical audit undertaken. c. Service modernisation e.g. process mapping and capacity/demand studies. d. Dedicated administrative and secretarial support. e. Attendance at Trust and Network meetings
<p>2.6 Each Trust should adopt a process, involving representatives from the Cancer Network³, by which the Trust Cancer Management Team report to the Trust at least annually on compliance with the cancer standards.</p>	<p>2.6</p> <ul style="list-style-type: none"> a. Outline of process for annual assessment b. Minutes of Trust Board meeting covering report on compliance to standards
<p>2.7 An analysis of the reasons for non-compliance with standards should be undertaken with action plans, agreed by the Cancer Network, drawn up as a result.</p>	<p>2.7 Trusts to provide documentation of agreed action plans.</p>

³ Network representatives may include members of the Network core team, local LHBs and User Groups.

TOPIC: PATIENT-CENTRED CARE

OBJECTIVE 3: TO ENSURE THAT PATIENTS AND OR THEIR CARERS HAVE SUPPORT AND ALL THE INFORMATION THEY REQUIRE REGARDING THE DIAGNOSIS, TREATMENT OPTIONS AND TREATMENT CARE PLAN.

Rationale: Appropriate information, whether provided in written form or via face-to-face communication, is required to support patients and their carers throughout the cancer journey. All healthcare professionals need to be sensitive to potential problems with communication with information being tailored to the needs of individual patients. Patients need appropriate information to make informed choices about their treatment. Special training can improve communication skills in general and will provide for effective communication of the diagnosis, treatment options and treatment care plan.

The psychological needs of patients are often not addressed⁴. People cope with distressing circumstances in a number of ways however for those facing the diagnosis of initial or recurrent cancer a number will experience significant levels of anxiety and depression and may benefit from specific psychological or psychiatric therapy.

⁴ National Service Framework No 1. NHS Cancer Care in England and Wales, Commission for Health Improvement, 2001

STANDARD	MONITORING CRITERIA
<p>3.1 The MDT should agree a communication policy regarding</p> <ol style="list-style-type: none"> Communication between members of the team. Communication between the team members and the patient and their carers. Communication skills training for team members with direct patient contact especially those involved in breaking bad news. Adequate time for patients to consider treatment options. 	<p>3.1 Detail of MDT communication policy to include</p> <ol style="list-style-type: none"> Evidence of communication skills assessment. Evidence that the MDT has considered the views of its patients or carers regarding the appropriateness of communication.
<p>3.2 Written information in a language and format appropriate to the patient should be offered to each new cancer patient. This should cover</p> <ol style="list-style-type: none"> General background information about the specific cancer. Detail of treatment options, specific local arrangements including information about the MDT and support services and whom the patient should contact if necessary. Details of local self-help/support groups and other appropriate organisations. 	<p>3.2 Copies of documentation provided to patients/carers.</p>
<p>3.3 The MDT should nominate a person to be responsible for ensuring written information is offered to all new patients.</p>	<p>3.3 Name of responsible person and detail of provision of written information within the communication policy.</p>
<p>3.4 A designated person/s should be responsible for ensuring that written information is generally available in appropriate wards/outpatient areas and is checked and replenished when necessary.</p>	<p>3.4 Name of responsible person/s.</p>
<p>3.5 Trusts should ensure all communication with patients with special needs in relation to language, culture and physical or learning disabilities is addressed.</p>	<p>3.5 Detail audit of Trust communication policy.</p>
<p>3.6 There should be access to a private room or area where patients and or their carers can discuss the diagnosis in conditions of adequate privacy with the appropriate member of the MDT.</p>	<p>3.6 Details should be provided of facilities available.</p>
<p>3.7 The MDT should ensure that patients are assessed for ongoing support following treatment for breast cancer.</p>	<p>3.7 Details to be provided by the appropriate MDT member.</p>

STANDARD	MONITORING CRITERIA
<p>3.8 Patients found to have significant levels of anxiety and or depression⁵ should be offered prompt access to specialist psychological or psychiatric care capable of providing level 3 and level 4 psychological interventions as defined in the NICE Supportive and Palliative Care Guidance.</p>	<p>3.8 Detail access arrangements.</p>
<p>3.9 Cancer Networks should facilitate a Network wide approach to psychological support services as recommended in the NICE Supportive and Palliative Care Guidance.</p>	<p>3.9 Networks to detail access arrangements.</p>

⁵ Supportive and Palliative Care Guidance for Adults with Cancer, NICE 2004

TOPIC: THE MULTIDISCIPLINARY TEAM

OBJECTIVE 4: TO ENSURE THAT BREAST CANCER CARE IS PROVIDED BY A SPECIALIST MULTIDISCIPLINARY TEAM.

Rationale: Patient care needs to be provided by a team of specialists to ensure provision of high quality care taking account of a range of expertise within different specialties. Team working and collaboration between teams will support cover for annual leave, sick leave and holidays. Adequate cover will enable the MDT to function at all times. Smaller Trusts may want to co-operate to achieve sufficient activity to maintain a specialist team with appropriate resources.

Team membership will need to be reviewed following publication of national guidance to ensure appropriate input into the management of patients and to reflect new roles such as advanced practitioners as they become established.

A programme of audit, defining performance against the cancer standards, will provide the Cancer Networks, MDTs, health commissioners, the public, and the Welsh Assembly Government with the information needed to maintain and improve cancer services.

Identifying and rewarding areas of strength are important for morale and motivation. By developing an effective audit programme, Networks and MDTs can also define whether any weaknesses are due to organisational factors or to resource issues, a distinction that is of the utmost importance in seeking the appropriate remedy.

STANDARD	MONITORING CRITERIA
<p>4.1 All clinicians treating breast cancer should be part of the multidisciplinary team and have designated time to attend the MDT meeting.</p>	<p>See 4.2</p>
<p>4.2 The MDT should include the following breast cancer specialists⁶ who should have time allocated to prepare for and attend the MDT meeting</p> <ul style="list-style-type: none"> a. Surgeons with each seeing at least 50 new primary breast cancer cases per year⁷. b. Breast imaging specialist. c. Pathologist with designated time for breast work. d. Oncologists with designated time for breast work. e. Clinical nurse specialists in breast cancer. f. MDT co-ordinator/data clerk. 	<p>4.2</p> <ul style="list-style-type: none"> a. Detail names and designated time of MDT members including documentation confirming sessional commitment by clinicians and cancer specific post-registration qualifications of team members. b. Evidence that the breast imaging specialist has attended an approved Royal College of Radiologists [RCR] course and audits performance. c. Arrangements for cover when core MDT members are absent. d. Detail arrangements for dedicated co-ordination and secretarial support.
<p>4.3 The MDT should have a named contact and appropriate access to the following support staff/services</p> <ul style="list-style-type: none"> a. Plastic surgery. b. Orthopaedic surgery. c. Neurosurgery. d. Cancer genetics. e. Palliative care physician/nurse – members of a specialist palliative care team. f. Clinical Psychologist/psychiatry. g. Lymphoedema services. h. Physiotherapy. i. Allied Health Professionals. j. Primary care team. k. Social work. 	<p>4.3 Detail access arrangements to the support staff/services and provide names of specialists designated to work with/advise the MDT.</p>

6 In addition, breast care teams may choose to include in the core team selected individuals from the extended team e.g. therapy radiographer, palliative care specialist.

7 Guidance on Cancer Services. Improving Outcomes in Breast Cancer, Manual Update, NICE, 2002

STANDARD	MONITORING CRITERIA
4.4 A regular team meeting should form the basis of clinical management and inter-team communication.	4.4 Detail team meetings held and % attendance of individual team members.
4.5 All new breast cancer cases from whatever source should be discussed at the MDT meeting.	4.5 Clinical audit.
4.6 The MDT should ensure that all relevant sections of the all Wales Cancer Data Set are completed for each new patient diagnosed with breast cancer.	<p>4.6 Detail</p> <ul style="list-style-type: none"> a. Number of new breast cancer cases referred to the team [or members of the team] per year and recorded on the all Wales Cancer Data Set. b. Number of new primary breast cancer cases referred per MDT surgeon per year. c. Number of symptomatic breast mammograms reported per year per breast imaging specialist⁸. d. % completion of the core all Wales Cancer Data Set. e. % completion of the extended all Wales Cancer Data Set.
4.7 The MDT should participate in all Wales clinical audits as specified by the CSCG All Wales Breast Cancer Steering Group.	4.7 Reports of the All Wales Breast Cancer Steering Group.
4.8 The MDT should participate in Network-wide clinical audit as specified by the Network Breast Cancer Advisory Group.	4.8 Network annual report to detail Network-wide audit programmes and resulting action plans.
4.9 Trusts should ensure that the expected registration of incidence, using the Patient Episode Database for Wales [PEDW] data, is submitted to the Welsh Cancer Intelligence and Surveillance Unit [WCISU] within 3 months of calendar year end.	4.9 WCISU to monitor registrations received against expected registrations [based on an average of the last 3 years registration per Trust].

⁸ RCR guidance recommends a minimum of 500 symptomatic mammograms to be reported per year

TOPIC: INITIAL REFERRAL AND TIMES TO TREATMENT

OBJECTIVE 5: PATIENTS WITH BREAST CANCER SHOULD BE REFERRED, DIAGNOSED AND TREATED PROMPTLY.

Rationale: There is evidence that higher survival rates are associated with detection and treatment of early stage, less advanced disease. Therefore it is important to support public awareness of symptoms that may indicate cancer and ensure GPs refer promptly to appropriate cancer teams for assessment and treatment if necessary. There is also evidence that patient anxiety contributes to worse clinical outcomes.⁹ Prompt access to see a specialist will lessen this anxiety. Patients and/or their carers may want to discuss the diagnosis & treatment with their GPs. The GP needs basic information transferred rapidly in order to support such patients at a time of great distress.

Initially efforts have been directed to ensure that patients referred urgently with suspected cancer are offered an appointment with a member of the MDT within 10 working days. This now needs to be built upon and extended to ensure that patients are not only seen promptly but also, should they be found to have cancer, should complete diagnostic investigations and start treatment within an accepted time frame that applies generally to all cancers. Shorter waiting times are required for specific cancers where clinically indicated. For certain types of cancer the definitive treatment policy is initial surveillance with specific anticancer therapy deferred until such time as is clinically indicated.

The focus in setting waiting times targets is to work towards continual improvement. It is recognised that an MDT may already meet the new targets and such performance needs to be maintained and further improved. Where waiting times are longer than now specified the MDT should work to reduce them to the target.

⁹ Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer. The Manual. The National Institute for Clinical Excellence, 2004

STANDARD	MONITORING CRITERIA
5.1 The Cancer Network breast cancer advisory group should agree referral guidelines for use by breast cancer MDTs and GPs, which should be revised on publication of the NICE referral guidelines.	5.1 Confirmation that the Network Manager and all local GPs in the area have a copy of referral guidelines.
5.2 Written referral pathways should be drawn up by the breast cancer MDTs in collaboration with primary care which detail the patient journey from whichever point patients access the system.	5.2 Confirmation that the Network Manager has a copy of the agreed referral pathways.
5.3 The Network should ensure that referral pathways are adhered to particularly where pathways cross Trust or Network boundaries.	5.3 Networks to provide evidence of review of agreed referral pathways.
5.4 Patients presenting to their GP with symptoms within the criteria for suspected breast cancer should be referred as 'urgent suspected cancer' to the breast cancer MDT. ¹⁰	5.4 Audit of referral process.
5.5 Patients referred as urgent suspected cancer by the GP and confirmed as urgent by a member of the MDT or their representative should, if diagnosed with breast cancer, start definitive treatment within 2 months of the receipt of the referral at the hospital.	5.5 Waiting times from receipt of confirmed 'urgent suspected cancer' referrals to start of definitive treatment.
5.6 The GP should be informed if the specialist downgrades an urgent suspected cancer referral to non-urgent.	5.6 Audit of downgraded referrals.
5.7 Results of diagnostic tests should be communicated to patients within 1 week of the last diagnostic procedure.	5.7 Waiting time from last diagnostic procedure to communication of results e.g. by telephone or clinic visit.
5.8 Confirmation of the diagnosis of breast cancer should reach the GP within 24 hours of the patient being informed.	5.8 Audit of proportion of patients diagnosed with cancer where information was sent to the GP within the required time scale.
5.9 Patients should be seen by the breast cancer Clinical Nurse Specialist [CNS] when informed of a diagnosis of cancer.	5.9 CNS to provide details.
5.10 When diagnosed with breast cancer, patients not already included as an urgent suspected cancer referral should start definitive treatment within 1 month from diagnosis regardless of referral route.	5.10 Waiting times from diagnosis to start of definitive treatment.
5.11 Patients undergoing radiotherapy should be treated within the maximum waiting times as recommended by The Joint Council for Clinical Oncology [JCCO] ¹¹ .	5.11 Waiting times from receipt of the request form by the radiotherapy department, or verbal request, to the date of the first radiotherapy fraction.

10 a) Referral Guidelines for Suspected Cancer. Department of Health. 2000. b) Referral Guidelines for Suspected Cancer. NICE. Expected Publication date 2005.

11 Good Practice Guide for Clinical Oncologists. Second Edition. Royal College of Radiologists. London. 2003.

TOPIC: DIAGNOSIS, STAGING AND TREATMENT

OBJECTIVE 6: PATIENTS WITH BREAST CANCER SHOULD BE DIAGNOSED, STAGED AND TREATED PROMPTLY AND IN-LINE WITH BEST PRACTICE GUIDELINES.

Rationale: There is good evidence from clinical trials that patients treated within a trial setting fare better than those treated outside of a trial setting, and this is thought to be due in large measure to the benefits of treatment according to documented protocols, with details of action to be taken in case of adverse effects, dose escalation, etc. Standardisation of protocols across the Cancer Network will enable outcome assessment to be performed in a uniform manner, and staff gain greater expertise by concentrating on a lesser number of well-defined protocols.

STANDARD	MONITORING CRITERIA
<p>6.1 Clinical management of patients including follow-up should follow written locally agreed, clinical policies, in-line with the NICE service guidance and clinical guidelines when published. These clinical policies should be developed by the Network cancer site advisory group for use by breast cancer MDTs within the Network.</p>	<p>6.1 Documentation detailing</p> <ul style="list-style-type: none"> a. The agreed clinical policies b. Evidence from clinical audit that policies are being followed
<p>6.2 Each MDT should provide a written programme of audit to assess adherence to clinical policies.</p>	<p>6.2 Annual cancer report to detail MDT audit programmes and resulting action plans.</p>
<p>6.3 New breast cancer patients should be offered pre-, peri- and post-operative nursing care by the breast cancer CNS.</p>	<p>6.3 Detail arrangements for new breast cancer patients to access the breast cancer CNS including</p> <ul style="list-style-type: none"> a. Number of new breast cancer patients seen by the breast cancer CNS. b. Number of new breast cancer patients seen pre-, peri- and post-operatively by the breast cancer CNS. c. Number of new patients visited at home by the breast cancer CNS.
<p>6.4 Patients should be given the opportunity to enter approved clinical trials for which they fulfil the entry criteria.</p>	<p>6.4 The team to provide documentation of all open trials and numbers of patients entered per trial per year.</p>

OBJECTIVE 7: THE MDT SHOULD HAVE ACCESS TO HIGH QUALITY IMAGING SERVICES.

Rationale: Imaging is important in the diagnosis and staging of many patients with cancer. Waits for imaging investigations may introduce significant delays before clinical diagnosis is confirmed and appropriate treatment can be instituted. This is particularly true for complex investigations.

Imaging departments need to work to high standards of service delivery that encompass management systems, waiting list management, procedural work, examination reporting, provision of clinical advice and quality assurance.

In order to achieve this initial work is required to unify imaging protocols and staging reports between different hospitals. This will avoid additional unnecessary studies and make clinically meaningful comparison and review of services and outcomes possible.

STANDARD	MONITORING CRITERIA
7.1 Imaging departments should provide clear, written information to MDTs on the range of investigations provided, and their availability. Where availability is limited or intermittent, particularly for complex investigations, there should be written alternative referral pathways agreed with the Cancer Network.	7.1 Copy of documentation to be provided by the appropriate clinical head of imaging services.
7.2 All Departments of Clinical Radiology should have written policies on the referral and imaging investigations of patients with cancer or suspected cancer by cancer site. These should reflect the latest advice from the Royal College of Radiologists [RCR] ¹² .	7.2 Detail of written policies to be provided by the appropriate clinical head of imaging services.
7.3 Standardised imaging protocols for staging should be agreed within each Cancer Network.	7.3 Network Manager to have copies of standardised protocols. Local copies of documentation to be provided by the appropriate clinical lead of imaging services.
7.4 Staging should be reported in a standardised format agreed within each Cancer Network.	7.4 Copies of documentation to be held by Network Manager. MDT to provide evidence of adherence to the standardised format.
7.5 Each MDT should have access to specialist opinion for radiological diagnosis and staging where appropriate.	7.5 Detail access to specialist radiological opinion.
7.6 Specialist radiologists should have regular sessions in their area of expertise identified in their job plan.	7.6 Detailed in job plan.

12 a) RCR Guidelines for Doctors 'Making the Best Use of A Department of Clinical Radiology 2003'
b) The Use of CT in the Initial Investigation of Common Malignancies 1994 c) A guide to the practical use of MRI in oncology 1999

OBJECTIVE 8: THE MDT SHOULD HAVE ACCESS TO HIGH QUALITY BREAST PATHOLOGY SERVICES.

Rationale: Pathology laboratories should work to high standards of service delivery that encompass management systems, diagnosis, specimen reporting, provision of clinical advice and quality assurance.

Adequate and appropriate information in pathology reports is essential to inform prognosis, plan individual patient treatment, support epidemiology and research and to evaluate clinical services and support clinical governance.

STANDARD	MONITORING CRITERIA
8.1 All pathology laboratories should participate in Technical External Quality Assessment [EQA] and Clinical Pathology Accreditation [CPA].	8.1 Certificate of participation in EQA/CPA.
8.2 Reports on resection specimens should comply with all items of the pathology component of the all Wales Cancer Data Set.	8.2 Audit of completeness of pathological reporting.
8.3 Pathologists reporting breast cancer specimens should participate in an appropriate Breast Histological EQA Scheme.	8.3 Confirmation of participation in EQA scheme.
8.4 Each MDT has a mechanism for access to specialist opinion for histopathological diagnosis and classification of difficult lesions where appropriate.	8.4 Detail Network arrangements to access specialist histopathological opinion.

OBJECTIVE 9 : TO ENSURE PATIENTS RECEIVE RADIOTHERAPY WHICH IS PLANNED, PRESCRIBED, DELIVERED AND SUPERVISED IN A SAFE AND EFFECTIVE MANNER.

Rationale: As with all other forms of treatment, the results of radiotherapy are likely to be optimum when it is delivered according to a formal written policy specifying dose, fractionation, overall treatment time, planning technique and means of verification plus other appropriate QA measures. This is especially true of radical [curative] therapy, where a uniform approach is necessary to be able to evaluate outcomes. It is also important that policies are in line with those in use elsewhere in the UK and worldwide. Where there is substantial deviation, this should be in the context of a formal clinical trial. Palliative treatments will need to be individualised on a more frequent basis, but the overall approach should conform as closely as possible to a written policy.

There are circumstances where evidence exists for the superiority of one form of technology over another. An example is of the use of conformal radiotherapy in some pelvic malignancies, as a means of reducing treatment-related side effects.¹³ Networks need to have a strategy to ensure that patients for whom such technology is optimum are able to access it, even if this means crossing Trust or Network boundaries. The general quality of procedures in the radiotherapy department will be reflected in externally modulated quality schemes as originally specified by Quality Assurance in Radiotherapy [QART].

13 Guidance on Cancer Services Improving Outcomes in Urological Cancers - The Manual, 2002

STANDARD	MONITORING CRITERIA
9.1 Patients receiving radiotherapy should be treated according to an agreed, documented policy or in a formal clinical trial.	9.1 a. Radiotherapy centres to have written clinical policies available. b. Clinical audit of compliance to policies to be undertaken. c. Deviations from the policy to be documented.
9.2 Radiotherapy centres should jointly agree definitions to monitor major long-term morbidity following radical radiotherapy.	9.2 Documentation of definitions of radiotherapy-related morbidity agreed by radiotherapy centres and provided to Network Managers.
9.3 Major long-term morbidity rates following radical radiotherapy should be monitored.	9.3 Audits of radiotherapy-related major morbidity by cancer. Results of audit to be sent to the Network Manager.
9.4 All radiotherapy centres should have a recognised quality system accredited by an authorised standards institution to a recognised standard.	9.4 Documentation of accreditation certification.
9.5 Equipment capable of delivering conformal radiotherapy should be available to each Network.	9.5 a. Detail type and location of planning equipment. b. Detail type and location of multi-leaf collimator-equipped linear accelerator. c. Detail availability of treatment verification facilities. d. Accreditation certification.
9.6 Equipment capable of delivering Intensity Modulated Radiotherapy [IMRT] should be available to each Network.	9.6 Documentation of implementation of/or plans to implement IMRT.

OBJECTIVE 10: TO ENSURE PATIENTS RECEIVE CHEMOTHERAPY WHICH IS PLANNED, PRESCRIBED, DELIVERED AND SUPERVISED IN A SAFE AND EFFECTIVE MANNER.

Rationale: As with all other forms of treatment, the results of chemotherapy are likely to be optimum when it is delivered according to a formal written policy. It is also important that policies are in-line with those in use elsewhere in the UK and worldwide. Where there is substantial deviation, this should be in the context of a formal clinical trial.

Chemotherapeutic agents include other complex, systemic therapies such as biological agents and cytokines. Chemotherapeutic agents are potentially dangerous and fatalities have occurred due to the inappropriate administration of some chemotherapeutic agents via the intrathecal route. It is therefore essential that chemotherapy is provided by trained specialist staff in a safe environment with appropriate facilities. Standardisation of protocols across the Cancer Network will enable outcome assessment to be performed in a uniform manner, and staff gain greater expertise by concentrating on a lesser number of well-defined protocols.

STANDARD	MONITORING CRITERIA
<p>10.1 There should be an overarching Trust chemotherapy policy, compatible with any guidance from NICE or The Joint Council for Clinical Oncology [JCCO], covering generic issues pertinent to chemotherapy</p> <ol style="list-style-type: none"> a. Staff grading, training and competencies. b. Prescribing. c. Preparation and dispensing. d. Administration. e. Disposal of waste and spillage. 	<p>10.1 Documentation of the Trust chemotherapy policy detailing the following</p> <ol style="list-style-type: none"> a. Staff authorised to initiate chemotherapy. b. Documentation of the on-site facilities for the preparation of chemotherapy and of compliance with NHS standards for aseptic preparation. c. Job description of designated pharmacist responsible for overseeing pharmacy services to the ward/out-patient area where chemotherapy is administered. d. Facilities for the administration of chemotherapy plus any dedicated areas for administration of intrathecal chemotherapy if this is undertaken. To include details of policies and equipment for the administration of chemotherapy plus the management of emergencies such as anaphylaxis, extravasation, spillage of cytotoxics and cardiac arrest. e. Training and post-registration qualifications of chemotherapy nurses. f. Confirmation that the Trust chemotherapy policy is available in all areas where chemotherapy is administered.

STANDARD	MONITORING CRITERIA
<p>10.2 Detailed written chemotherapy protocols should be used for the management of all cancer sites treated by Trust personnel. These protocols should include,</p> <ul style="list-style-type: none"> a. Regimen/s and their indication. b. Drug doses and scheduling. c. Pre- and post-treatment investigations. d. Dose modifications. 	<p>10.2 Detail of Trust chemotherapy protocols by cancer site.</p>
<p>10.3 Intrathecal chemotherapy should be controlled by a process which ensures that it is only prepared, handled and administered by suitably trained personnel who appear on the intrathecal chemotherapy register for that site.</p>	<p>10.3 Annual monitoring by All Wales Principal Pharmacist Quality Control.</p>
<p>10.4 Major morbidity following chemotherapy in patients treated with curative intent should be monitored.</p>	<p>10.4 Audits of chemotherapy-related major morbidity for patients treated with curative intent by cancer.</p>

OBJECTIVE 11: TO ENSURE THAT ALL PATIENTS RECEIVE ADEQUATE ASSESSMENT OF, AND PROVISION FOR, THEIR PALLIATIVE CARE NEEDS AT ALL TIMES AND IN EVERY SETTING. THIS INCLUDES CARE OF DYING PATIENTS, THEIR FAMILIES AND CARERS.

Rationale: The palliative approach may be applicable at any stage of a patient's illness and incorporates the particular needs of the dying patient. It is the responsibility of all health professionals caring for those with progressive life-threatening disease, informed by a knowledge of palliative care principles and practice and supported by a specialist palliative care team.

STANDARD	MONITORING CRITERIA
11.1 All health professionals engaged in care should receive training to allow adequate assessment and delivery of general palliative care.	11.1 Details of Trust and Cancer Network arrangements for staff education and training in palliative care principles and practice.
11.2 There should be clear arrangements to access specialist palliative care services.	11.2 Details in MDT guidelines of access arrangements to specialist palliative care as defined in the CSCG Standards for Specialist Palliative Care.
11.3 Palliative care needs should be rapidly addressed, and specialist palliative care advice available, in all settings 24 hours a day.	11.3 Community documentation in patient records of <ul style="list-style-type: none"> a. Responsibility for out-of-hours medical care. b. Details of access to nursing care if no 24 hour district nursing service available. c. Trust and Cancer Network documentation on accessing out-of-hours specialist palliative care advice.
11.4 An integrated system should be in place in all care settings to ensure best practice in the multiprofessional care of dying patients. The All Wales Care Pathway for the Last Days of Life represents an appropriate model.	11.4 Detail in MDT guidelines on use of end of life care pathway.
11.5 All profession-specific teams engaged in palliative care provision such as nursing, physiotherapy, occupational therapy, should have at least one member who has undergone post-registration education and training in palliative care.	11.5 Details of <ul style="list-style-type: none"> a. Availability of post registration education and training programmes. b. Trust identification of staff training priorities in palliative care.

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