North of England Cancer Network

Skin Cancer Clinical Guidelines

Document Information

<table>
<thead>
<tr>
<th>Title:</th>
<th>NECN Skin Cancer Clinical Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Skin NSSG Members</td>
</tr>
<tr>
<td>Circulation List:</td>
<td>See page 2</td>
</tr>
<tr>
<td>Contact Details:</td>
<td>Claire McNeill, Peer Review Co-ordinator</td>
</tr>
<tr>
<td>Telephone:</td>
<td>011382 52976</td>
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</tbody>
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Version History:

<table>
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<tr>
<th>Date</th>
<th>Version</th>
<th>Review Date</th>
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<tr>
<td>23.05.16</td>
<td>V2.2</td>
<td>May 2018</td>
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Document Control:

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<th>Version</th>
<th>Date</th>
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<tr>
<td>V2.2</td>
<td>23.05.16</td>
<td>Page 14 Mohs surgeons update Page 15 Darlington added Page 16 &amp; 18 Lead clinician update Page 13 – removal of virtual MDT on referral between teams Page 20- Haematology section 7.6 Page 6 Timed pathway updated</td>
<td>May 2016</td>
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<tr>
<td>V2.1</td>
<td>26.06.15</td>
<td>Named trainer/ assessor added to page 50</td>
<td>May 2016</td>
</tr>
<tr>
<td>V2.0</td>
<td>25.06.15</td>
<td>Document reviewed and updated</td>
<td>May 2016</td>
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<tr>
<td>V1.9</td>
<td>08.04.14</td>
<td>Population catchment changed to CCG</td>
<td>May 2014</td>
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### Guidelines agreed by:

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Organisation</th>
<th>Date Agreed</th>
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<tbody>
<tr>
<td>Skin NSSG Chair</td>
<td>Dr P Barrett</td>
<td>Newcastle upon Tyne Hospitals NHS FT</td>
<td>06.06.16</td>
</tr>
<tr>
<td>Skin NSSG Vice-Chair</td>
<td>Mr M Hussain</td>
<td>Northumbria Healthcare NHS FT</td>
<td>06.06.16</td>
</tr>
<tr>
<td>CYPCG Chair for: 14-1C-114j Patient Pathways Shared with Other MDTs</td>
<td>Roy McLachlan, Associate Director, NESCN</td>
<td>NHS England in Cumbria and the North East</td>
<td>06.06.16</td>
</tr>
<tr>
<td>Chemotherapy CCG Chair for: 14-1C-110j Chemotherapy Treatment Algorithms</td>
<td>Mr S Williamson</td>
<td>Northumbria Healthcare NHS FT</td>
<td>06.06.16</td>
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Skin NSSG members agreed the Guidelines on:  
**Date Agreed**: Emailed to group 06.06.16 for endorsement at the next meeting.  
**Review Date**: May 2017
11. Setting standards for Mohs Micrographic Surgery services. ........................................ 29

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Introduction

The Skin Network Site Specific Group has agreed to adopt the British Association of Dermatology (BAD) Guidelines, available at: [http://www.bad.org.uk/site/622/default.aspx](http://www.bad.org.uk/site/622/default.aspx)

1. **Network Configuration of Skin Services**

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<tr>
<th>Referring CCGs</th>
<th>Population</th>
<th>LSMDT</th>
<th>Named Lead/Contact</th>
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<tbody>
<tr>
<td>Northumberland</td>
<td>316</td>
<td>Royal Victoria Infirmary Newcastle</td>
<td>Dr J Langtry 0191 2336161</td>
</tr>
<tr>
<td>Newcastle West</td>
<td>144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newcastle North &amp; East</td>
<td>146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Tyneside</td>
<td>203</td>
<td></td>
<td></td>
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<tr>
<td>Gateshead (West)</td>
<td>120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durham Dales, Easington &amp; Sedgefield (excl Sedgefield)</td>
<td>186</td>
<td>University Hospital of North Durham Durham</td>
<td>Mr P Rubin 0191 3332333</td>
</tr>
<tr>
<td>North Durham</td>
<td>244</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darlington</td>
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</tr>
<tr>
<td>Hartlepool &amp; Stockton</td>
<td>287</td>
<td>The James Cook University Hospital (JCUH) Middlesbrough</td>
<td>Mr Siddiqui 01642 850850</td>
</tr>
<tr>
<td>South Tees</td>
<td>274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hambleton, Richmondshire &amp; Whitby</td>
<td>152</td>
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<tr>
<td>Sedgefield</td>
<td>87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumbria</td>
<td>328</td>
<td>Cumberland Infirmary Carlisle</td>
<td>Dr K Bazmi links to Newcastle SMDT 01228 523444</td>
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</table>

Source - Mid-2014 Population Estimates for Clinical Commissioning Groups (CCGs) in England - ONS.gov.uk

2. **Primary Care Referral Guidelines**

Please see Appendix 1 for comprehensive Skin Cancer Primary Care Referral Guidelines.
2.1 Pathway for Patients with Skin Cancer

Pathway for patients with suspected Skin Cancer

NB: Basal Cell Carcinoma is excluded from the 2 week cancer pathway

Provide information and psychological support
Holistic assessment and rehabilitation consideration
First treatment?

See TYA pathway
Inform patient’s GP
Allocate Skin CNS/Key Worker
Inter provider transfer point
Liaise & involve healthcare professionals as required
Decision to treat date

Maximum wait in days

2ww referral received in secondary care

First Specialist Assessment

Clinical History
Physical Examination

Yes

Malignant or Suspicious

Pathology results discussed with patient

No

Patient discharged with information on self assessment and prevention

If patient 16 to 24 years continue on skin cancer pathway and ALERT Teenage and Young Adult (TYA) MDT

Yes

Local MDT discussion

No

Patient discharged with information on self assessment and prevention

Yes

Further staging investigations as required

PNA
Sentinel Node Biopsy

Specialist MDT to discuss investigation, treatment & rehabilitation plan plus consideration for clinical trials

Treatment plan agreed with patient

Yes

Dermatology
Plastic Surgery
OMF Surgery
Radiotherapy
Chemotherapy

Specialist MDT discussion

Is further treatment required?

No

Appropriate after care

Earliest Clinically Appropriate Date for commencement of subsequent treatment

Yes
3. NSSG Guidelines for Teenage and Young Adults

Teenage and Young Adults Peer Review Measures Topic 11-1C (Functions of the Network Site Specific Groups for TYA)

1. Teenage and Young Adult Pathway for initial Management
The NSSG has received the document named ‘NECN Teenage and Young Adult Cancer Pathway Guidance Paper’ and agrees to follow the generic TYA Pathway with any site specific variations to be documented. Please see Appendix 1 for pathway.

2. Teenage and Young Adult Pathway for Follow up on completion of first line treatment
The NSSG has received the document named “NECN Teenage and Young Adults Follow up on completion of first line treated and agreed to follow this pathway. Please see Appendix 1 for pathway.

3. Pathways for cases involving Specialised NHS services (Only Gynae and Sarcoma)
The Gynae NSSG and SAG reviewed and agreed the Specialised NHS Service pathway for patient’s age 16-24 years. This is attached in Appendix 3
Appendix 1 – Teenage and Young Adult Pathway for initial Management

Teenage and Young Adult Cancer Pathway – 19 to 24 years old

- Urgent referral made by GP/ODD/Screening
- Emergency Admission
- Other source of referral (screening/genetics clinic)

Assess as per local Tumour Site Specific protocol:
> Sites specific diagnostic investigations
> May include diagnostic biopsies, but not definitive cancer surgery

- Cancer diagnosed or highly suspicious
- Patient informed of joint MDT review and place of care options
- NB MDT discussion should take place in tumour site specific MDT within PTC/TYA designated hospital and TYA MDT
- Review at TYAMDT
- Communicate & Liaise between MDTs
- Review at TYAMDT Specific haematological tumour MDT

Joint treatment planning decision agreed, including:
> Diagnosis and treatment modalities/regimen
> Place of treatment delivery, depending on patient age:
  > 16-18 years: PTC facility only (Paediatric & Adolescent Oncology, RVI, Newcastle)
  > 19-24 years: choice of PTC facility (Adult Oncology, FH, Newcastle) or TYA Designated Hospital
> Named consultant in charge of each treatment modality
> The arrangements/ refusals to provide age appropriate support if the treatment is delivered outside the PTC facility
> The results of the discussion of fertility issues
> Consider entry into clinical trials
> Consider palliative & supportive care needs
> Identify patient's key worker

PTC (RVI or Freeman) – treatment and ongoing care (with options for shared care or supportive care)
Designated TYA hospital treatment with option of TYAMDT outreach support 19-24 yr

- Haematological/Oncological Treatment (first definitive treatment)
  Surgery
  Chemotherapy
  Biological therapy
  Radiotherapy

Assess response at site specific haematological tumour MDT
Consider need for further/consolidation treatment

- Relapse or recurrent disease
  Yes
  
  No
  
  Long term follow up protocol

Further Treatment
- Palliative Care

Abbreviations
> TYA (Teenage and Young Adults)
> TYA DH (Teenage and Young Adult Designated Hospitals)
> PTC (Principal Treatment Centre Newcastle upon Tyne hospitals)
TYA follow up on completion of first line treatment pathway.

**Northern England Strategic Clinical Network CYPCG**

**Follow Up on Completion of First Line Treatment (19-24)**

**Principal Treatment Centre:** Newcastle-upon-Tyne Hospitals NHS Foundation Trust
Gateshead Health NHS Foundation Trust at Queen Elizabeth Hospital
City Hospitals Sunderland NHS Foundation Trust at Sunderland Royal Infirmary
North Tees and Hartlepool NHS Foundation Trust at University Hospital of North Tees
South Tees Hospitals NHS Foundation Trust at James Cook University Hospital

**TYA Designated Trusts:**

- Newcastle-upon-Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust at Queen Elizabeth Hospital
- City Hospitals Sunderland NHS Foundation Trust at Sunderland Royal Infirmary
- North Tees and Hartlepool NHS Foundation Trust at University Hospital of North Tees
- South Tees Hospitals NHS Foundation Trust at James Cook University Hospital

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**Completion of first line treatment**

Including surgery, radiotherapy, chemotherapy, biological or endocrine therapy) Patients aged 19-24 years should have been offered the choice between PTC NuTH and a TYA designated hospital

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**Responsibilities of TYA MDT**

- Review end of treatment summaries
- Continuing TYA team involvement according to identified needs
- Coordination of age appropriate clinical care and psychosocial support

**Responsibilities of Specialist Palliative Care MDT**

- Specialist Palliative Care representation as core member of TYA MDT.
- Work with patients across the Northern England Strategic Clinical Network, link with other trusts and community palliative care services.

**Responsibilities of Tumour Site Specific MDT**

- Completion of End of Treatment Summary and Follow Up Care Plan produced by treating medical team within 6 months of completion of first line treatment, discussed with patient and copied to GP

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**TYA CNS**

**TYA PSYCHOLOGIST**

**TYA SOCIAL WORKER**

**TYA YOUTH SUPPORT CO-ORDINATOR**

**SPECIALIST PALLIATIVE CARE TEAM**

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Unhindered access into TYA MDT if any member of the clinical teams involved with the patients care have concerns about patient following completion of first line treatment (or if patient wishes a targeted discussion to take place).

TYA updates will be sent to TSS MDT treating medical team and copy sent to GP following any discussion.
<table>
<thead>
<tr>
<th>Contact Information</th>
<th>MDT RESPONSIBILITIES</th>
<th>Transition to TYA Transition to Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYA MDT</td>
<td>SPECIALIST PALLIATIVE CARE MDT</td>
<td>TUMOUR SITE SPECIFIC MDT</td>
</tr>
<tr>
<td>Location: NUTH</td>
<td>Location: NCCC Freeman Hospital</td>
<td>Completion of end of treatment summary and follow up care plan produced by treating medical team within 6 months of completion of first line treatment, discussed with patient and copy to GP</td>
</tr>
<tr>
<td>Time: Thursdays, 12:00-14:00</td>
<td>Time: Wednesdays, 09:30-11:30</td>
<td>Treatment Summaries should be assigned a level of care.</td>
</tr>
<tr>
<td>Lead Clinician: Dr Emma Lethbridge</td>
<td>Lead Clinician: Dr M. Comiskey</td>
<td>Level 1: Supported self-management with contact info about how to reconnect back into LTFU.</td>
</tr>
<tr>
<td>Lead Nurse: Mr David Short</td>
<td>Coordinator: Kerry Halliday</td>
<td>Level 2: Planned coordinated care with support from the primary treatment centre and local services. Low level care required such as monitoring with echocardiograms.</td>
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<tr>
<td>Coordinator: Sharon Buckley</td>
<td>Phone: 0191 233 6161</td>
<td>Level 3: Complex care requiring follow-up in the long-term follow up clinic usually requiring input from the multi-disciplinary team.</td>
</tr>
<tr>
<td>Email: <a href="mailto:tru.tr.tyamdt@nhs.net">tru.tr.tyamdt@nhs.net</a></td>
<td>Email: <a href="mailto:kerry.halliday@nuth.nhs.uk">kerry.halliday@nuth.nhs.uk</a></td>
<td>YEARS 1-5</td>
</tr>
<tr>
<td>TTYA MDT Review end of treatment summary</td>
<td>1. Specialist Palliative Care representation as core member of TYA MDT.</td>
<td>Clinical surveillance for disease recurrence and treatment toxicity monitoring (including history, clinical examination, laboratory investigations, imaging studies and invasive procedures where indicated according to tumour site specific follow up protocols)</td>
</tr>
<tr>
<td>TTYA CNS</td>
<td>2. All site specific MDT outcomes notified to palliative care lead clinician.</td>
<td>YEARS 6+</td>
</tr>
<tr>
<td>Co-ordination of clinical care.</td>
<td>3. Patients reviewed at any point along the pathway (diagnosis, relapse, long term follow up, end of life care).</td>
<td>Long term follow up for late effects of treatment, consider survivorship issues.</td>
</tr>
<tr>
<td>Acts as point of contact/reference</td>
<td>4. Holistic needs assessment to include family/carer.</td>
<td>Consider referral to long term follow up/late effects MDT if disease free after 5 years from completion of first line treatment.</td>
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<tr>
<td>TTYA Psychologist</td>
<td>5. Work with patients across the Northern England Strategic Clinical Network, link with other trusts and community palliative care services.</td>
<td>Consider extended clinical follow up to 10 years in selected patient groups as defined by the TSS MDT’s (e.g. brain/CNS, sarcoma, BMT, testis).</td>
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<tr>
<td>Continue to provide level 3+4 support according to need</td>
<td>6. MDT outcomes documented on Somerset.</td>
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<tr>
<td>Involvement in end of treatment clinic/event</td>
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<tr>
<td>TTYA Social Worker</td>
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<tr>
<td>Continue to provide support according to need</td>
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<tr>
<td>Introductory letter sent with information and offer of grant at time of diagnosis and relapse</td>
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<tr>
<td>More in depth service offered based on assessed need</td>
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<tr>
<td>TTYA Youth Support Co-ordinator</td>
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<tr>
<td>Continue to invite patients to support activities for up to 2 years post first line treatment</td>
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<tr>
<td>Involvement in end of treatment clinic/event</td>
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## Appendix 2 – Contact Details

### List of designated MDTs at Principal Treatment Centre and TYA Designated Hospitals (19 - 24 years)

<table>
<thead>
<tr>
<th>Name of NHS Trust and designated hospital site</th>
<th>Name of MDT</th>
<th>TYA Lead Clinician</th>
<th>TYA Lead Nurse</th>
<th>Contact Number</th>
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<tbody>
<tr>
<td><strong>Principal Treatment Centre</strong></td>
<td>All MDTs:</td>
<td>Dr Emma Lethbridge</td>
<td>David Short</td>
<td>0191 2448858 (Dect48858)</td>
</tr>
<tr>
<td></td>
<td>Breast</td>
<td></td>
<td><a href="mailto:david.short@nuth.nhs.uk">david.short@nuth.nhs.uk</a></td>
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<tr>
<td></td>
<td>Colorectal</td>
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<td></td>
<td>Head &amp; Neck</td>
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<tr>
<td></td>
<td>Lung</td>
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<tr>
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<td>Neurooncology (Brain/Spinal, Pituitary, Skull Base)</td>
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<tr>
<td></td>
<td>Sarcoma</td>
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<tr>
<td></td>
<td>Specialist Skin</td>
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<td></td>
<td>Specialist pancreatic</td>
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<td></td>
<td>Supra T-cell Lymphoma</td>
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<td>Teenage and Young Adult MDT</td>
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<tr>
<td></td>
<td>Specialist Upper GI</td>
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<tr>
<td></td>
<td>Specialist Urology</td>
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<td></td>
</tr>
<tr>
<td><strong>Gateshead Health NHS Foundation Trust - at Queen Elizabeth Hospital</strong></td>
<td>Specialist Gynaecology</td>
<td>Ms Christine Ang</td>
<td><a href="mailto:rachel.mugnai@ghnt.nhs.uk">rachel.mugnai@ghnt.nhs.uk</a></td>
<td>0191 4456148</td>
</tr>
<tr>
<td><strong>City Hospitals Sunderland NHS Foundation Trust - at Sunderland Royal Hospital</strong></td>
<td>Haematology</td>
<td>Dr Scott Marshall</td>
<td>Faye Laverick</td>
<td>0191 5656256</td>
</tr>
<tr>
<td></td>
<td>Specialist Urology (testicular only )</td>
<td></td>
<td><a href="mailto:faye.armstrong@chsft.nhs.uk">faye.armstrong@chsft.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td><strong>North Tees and Hartlepool NHS Foundation Trust - at University Hospital of North Tees</strong></td>
<td>All MDTs: Haematology</td>
<td>Dr Padmaja Lokireddy</td>
<td><a href="mailto:Katherine.Dawson@nth.nhs.uk">Katherine.Dawson@nth.nhs.uk</a></td>
<td>01642 617617 ext 24697</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>Local Upper GI</td>
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</tr>
<tr>
<td><strong>South Tees Hospital NHS Foundation Trust - at James Cook University Hospital</strong></td>
<td>All MDTs: Specialist Gynaecology</td>
<td>Dr Dianne Plews</td>
<td>Jill Linton</td>
<td>01642 854381</td>
</tr>
<tr>
<td></td>
<td>Breast</td>
<td></td>
<td><a href="mailto:jill.linton@stees.nhs.uk">jill.linton@stees.nhs.uk</a></td>
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<tr>
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Appendix 3 – NHS Specialised Services Pathway

NHS Specialised Services - Referral Pathway for Primary Malignant Bone Cancer for patients age 16-24 years within the North of England

Paediatrician → GP → Radiology/Incidental Finding

Referral to Sarcoma Service at Freeman Hospital Newcastle (FRH)
See Sarcoma pathway for contact details

If age 16-18 years refer to PTC paediatric & adolescent MDT at RVI and Bone & Soft Tissue MDT at FRH

All patients to be discussed at the TYA MDT (See TYA pathway for contact details)

If age 19-24 years refer to Bone & Soft Tissue MDT at FRH

Necessary to refer to National Ewing's Sarcoma MDT for discussion?

Yes

Submit electronic MDT proforma and link in via WebEx.

Please see Bone & Soft tissue site specific pathway and/or paediatric & adolescent pathway for detail

No

5 years post treatment for patients age 16-24 years

Age 16-18 at time of diagnosis refer to long term follow up clinic/MDT

Age 19-24 yrs at time of diagnosis follow up on adult protocol

Primary Bone Cancer Pathway DRAFT
Toni Hunt NECN Version 0.3 Aug 2012
NHS Specialised Services
Referral Pathway for Hydatidiform Mole / Gestational Trophoblastic Neoplasm / Choriocarcinoma
Weston Park Hospital, Sheffield

Gynaecologist / Antenatal dept perform U/S or histology from failed pregnancy confirms hydatidiform mole

Post Pregnancy, ectopic pregnancy or miscarriage confirms choriocarcinoma on histology or high clinical suspicion

Patient referred to Weston Park Hospital Sheffield. Histology reviewed and patient registered on national programme

Hydatidiform mole diagnosis confirmed on histology

Choriocarcinoma diagnosis confirmed on histology or further staging needed to confirm

hCG levels return to normal

hCG levels do not return to normal

Patient bloods & urine monitored by Sheffield copies to GP and referring gynaecologist

Complete follow up protocol

Outpatient visit at Sheffield for staging and treatment plan

Staging scan, blood tests, prognosis score, treatment plan at Sheffield

Discuss at Sheffield GTN MDT

Low risk methotrexate chemo can be given at local hospital under direction of Sheffield. If age 16-18 years this should be on teenage unit (RVI). If age 19-24 this should be on Young Adult unit at Newcastle (Freeman) or TYA Designated Unit at James Cook, Middlesbrough

Patients age 16-24 yrs having local low risk chemo to be alerted to Newcastle TYA MDT

All Treatment delivered at Sheffield

Patients age 16-24 yrs having local low risk chemo to be alerted to Newcastle TYA MDT

All follow up carried out by Sheffield (OPC, phone, email & text)

hCG monitoring will be for life via Sheffield. Copies sent to GP and referring gynaecologist

Choriocarcinoma Pathway
Toni Hunt NECN Version 0.4 Aug 2012
4. Appointments for immunosuppressed patients with suspected skin cancer

Immunocompromised patients have a higher risk of development of all types of skin cancers, which in addition tend to behave more aggressively and may be clinically atypical. Rapid access to specialist assessment and diagnosis by a core member of a skin cancer MDT is therefore paramount. There should be rapid access new and review appointments specifically set aside for immunocompromised patients with a suspected skin cancer.

<table>
<thead>
<tr>
<th>Treatment centre</th>
<th>Named Lead/Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Dr C Blasdale 0191 2824548</td>
</tr>
<tr>
<td>Sunderland Royal Hospital</td>
<td>Dr J Niazi / Carol Heslehurst 0191 5699880</td>
</tr>
<tr>
<td>University Hospital North Durham</td>
<td>Dr M Vatve 0191 3332333</td>
</tr>
<tr>
<td>The James Cook University Hospital (JCUH)</td>
<td>Mr H Siddiqui 01642 850850</td>
</tr>
<tr>
<td>Carlisle Infirmary</td>
<td>Dr K Bazmi 01228 523444</td>
</tr>
</tbody>
</table>
5. Network Referral Guidelines Between Teams

- SSMDT pop. 776,000 Tees LSMDT level 5 will refer to Tees SSMDT & MMMDT
- SSMDT pop. 1,213,000 N Cumbria & Newcastle LSMDT level 5 will refer to Newcastle SSMDT & MMMDT
- SSMDT pop. 1,020,000 Sunderland & Durham LSMDT level 5 will refer to Durham SSMDT
- Immunocompromised clinics (Supra Network MDT for T Cell Lymphoma)

**Sunderland MDT is an Outreach Service provided by CDD**
6. Referral Arrangements for Photophoresis

The decision to refer for photophoresis is made in the joint oncology / mycosis fungoides clinic. There are two centres for photophoresis in the UK, Rotherham General Hospital and St Thomas’, London, and patients may be referred to either of these. 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.

<table>
<thead>
<tr>
<th>Designated Hospital for Photophoresis</th>
<th>Lead Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham Hospitals NHS Trust</td>
<td>Dr Peter Taylor 01709 280000.</td>
</tr>
<tr>
<td>Guys and St Thomas’ Hospital NHS Trust</td>
<td>Dr Sean Whitaker, Consultant Dermatologist Lead for ECP020 7188 6265, secretary 0207 7188 6263 ECP unit, <a href="mailto:skintumour@gstt.nhs.uk">skintumour@gstt.nhs.uk</a></td>
</tr>
</tbody>
</table>

7. Arrangements for skin cancers in Specific Anatomical Sites

7.1 Referral Arrangements for Mohs Micrographic Surgery

The Mohs Micrographic surgery unit in the Network is based at the Royal Victoria Infirmary, Newcastle. There are 3 Mohs surgeons with a current case load of 780 cases per annum (July 2013). Cases are referred by all specialities treating skin cancers from the Network. Further details of referral criteria (section 13)

<table>
<thead>
<tr>
<th>Designated Hospital for Mohs Micrographic Surgery</th>
<th>Lead Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr J Langtry</td>
</tr>
<tr>
<td></td>
<td>Dr C Lawrence</td>
</tr>
<tr>
<td></td>
<td>Dr T Oliphant</td>
</tr>
</tbody>
</table>

7.2 Head and Neck tumours and Skin Cancers

All types of skin cancer affect the head and neck region. These will vary from the more common to the rare tumour types and will range in degree of local invasive and metastatic potential. Advanced tumours in close proximity to the external auditory canal and nasal apertures may require complex multidisciplinary management.

All cutaneous malignant melanomas of the head and neck including periocular tumours but excluding nasal mucosal melanomas, should be managed by clinicians who are members of a skin cancer MDT. Nasal mucosal melanomas will be discussed in the head and neck MDT.

Some tumours may require a multidisciplinary approach, which may include oculoplastic surg eon, Mohs surgeon, plastic surgeon, head and neck surgeon, (ENT / maxillofacial), skull base surgeon and radio-oncologist.
### Designated Hospital for Head and Neck Cancers

<table>
<thead>
<tr>
<th>Designated Hospital for Head and Neck Cancers</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Road Hospital Nasal mucosal melanoma &amp; skull base</td>
<td>Mr A Welch</td>
<td>0191 2336161</td>
</tr>
<tr>
<td>Sunderland Royal Hospital Nasal mucosal melanoma</td>
<td>Mr A Burns</td>
<td>0191 5656256</td>
</tr>
<tr>
<td>Sunderland Eye Hospital Periocular</td>
<td>Miss F Chapman Mr R Boyce Mr S Osborne</td>
<td>0191 5656256</td>
</tr>
<tr>
<td>James Cook University Hospital Nasal mucosal melanoma &amp; skull base</td>
<td>Mr C Edge</td>
<td>01642 850850</td>
</tr>
<tr>
<td>North Cumbria Acute Hospitals Nasal mucosal melanomas</td>
<td>Mr A Robson</td>
<td>01228 523444</td>
</tr>
</tbody>
</table>

### Hospital for Oculoplastic Surgery

<table>
<thead>
<tr>
<th>Hospital for Oculoplastic Surgery</th>
<th>Clinicians</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Miss A Dickinson Mr E Barnes</td>
<td>0191 2336161</td>
</tr>
<tr>
<td>Sunderland Eye Infirmary</td>
<td>Miss F Chapman Mr R Boyce Mr S Osborne</td>
<td>0191 5656256</td>
</tr>
<tr>
<td>James Cook University Hospital</td>
<td>Mr A Gibson</td>
<td>01642 850850</td>
</tr>
<tr>
<td>Darlington Memorial Hospital</td>
<td>Mr P Chakroborthy</td>
<td>01325 380100</td>
</tr>
</tbody>
</table>
7.3 Anal and Skin Cancers

Skin cancers of the perianal and perineal regions will usually be diagnosed in dermatology clinics or in colorectal surgery clinics. All cases diagnosed should be discussed in the specialist colorectal MDT at the RVI or James Cook. This includes the following tumours of the perianal or perineal region;

- Basal cell carcinoma
- Squamous cell carcinoma
- Malignant melanoma
- Extra-mammary Paget’s disease (EMPD).

<table>
<thead>
<tr>
<th>Designated Hospital</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Mr S Plusa</td>
<td>0191 2336161</td>
</tr>
<tr>
<td>James Cook University Hospital</td>
<td>Mr T Gill</td>
<td>01642 850850</td>
</tr>
</tbody>
</table>
7.4 Gynaecology and Skin Cancers

Skin cancers of the vulval and genitocrural regions will usually be diagnosed in dermatology, plastic surgical, specialist genital or gynaecology clinics. All cases diagnosed should be discussed in the specialist gynaecological oncology MDT at Queen Elizabeth Hospital or James Cook University Hospital, as appropriate. This includes the following tumours:
- Vulval intraepithelial neoplasia grade 3
- Squamous cell carcinoma
- Malignant melanoma
- Extra mammary Paget’s disease (EMPD).

<table>
<thead>
<tr>
<th>Designated Hospital</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>Christine Ang</td>
<td>0191 4452872</td>
</tr>
<tr>
<td>James Cook University Hospital</td>
<td>Mr J Twigg</td>
<td>01642 850850</td>
</tr>
</tbody>
</table>

7.5 Urology and Skin Cancers

Skin cancers of the male genital region will usually be diagnosed in dermatology, plastic surgical, specialist genital or urology clinics. All cases diagnosed should be discussed in the male genital cancer MDT at Sunderland Royal Hospital. This includes the following tumours:
- In-situ squamous cell carcinoma
- Squamous cell carcinoma
- Extra mammary Paget’s disease (EMPD).

<table>
<thead>
<tr>
<th>Designated Hospital</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunderland Royal Hospital</td>
<td>Mr D Greene</td>
<td>0191 5656256</td>
</tr>
</tbody>
</table>
7.6 Haemato-oncology and Skin Cancers

See Operational Policy on Cutaneous Lymphoma (section 14).

Patients presenting with skin lesions associated with known or suspected systemic haemato-oncological malignancy should be reviewed by the haemato-oncology MDT before starting definitive treatments. Primary cutaneous B-cell lymphomas should be managed by the local haematooncology MDT.

Patients presenting in any speciality with known or suspected primary cutaneous T-Cell lymphoma should be reviewed by a Specialist Skin Cancer MDT (SSMDT)

Patients discussed at the Haematology MDT who transpire to have primary cutaneous lymphoma should be referred to a SSMDT.

<table>
<thead>
<tr>
<th>Designated Hospital</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Road Hospital</td>
<td>Dr J Frew</td>
<td>0191 2139220</td>
</tr>
<tr>
<td>Sunderland Royal Hospital</td>
<td>Dr V Hervey</td>
<td>0191 5656256</td>
</tr>
<tr>
<td>James Cook University Hospital</td>
<td>Dr A Wood</td>
<td>01642 850850</td>
</tr>
</tbody>
</table>

7.7 Sarcomas and Skin Cancers

Patients with cutaneous sarcomas that involve or penetrate the deep fascia or cutaneous sarcomas potentially requiring radiotherapy or chemotherapy should be referred to the sarcoma MDT based at Freeman Hospital. Kaposi's sarcoma and angiosarcoma all need to be approached using a multidisciplinary specialty. Angiosarcomas are generally managed by the sarcoma MDT with input from the skin MDT when appropriate. Patients with superficial cutaneous sarcomas including Kaposi sarcoma should be reviewed in the skin SSMDT and Mohs micrographic surgery considered where appropriate.

<table>
<thead>
<tr>
<th>Designated Hospital for Sarcoma SSMDT</th>
<th>Lead Clinician</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Hospital</td>
<td>Mr C Gerrand</td>
<td>0191 2336161</td>
</tr>
</tbody>
</table>
8. Guidelines for the Examination and Reporting of Skin Cancer Specimens

8.1 Introduction

These guidelines for the examination and reporting of skin cancer specimens are based upon the following guidance provided by the Royal College of Pathologists and available on the College website (www.rcpath.org).

- Minimum dataset for skin cancer histopathology reports (May 2014)
- Key Performance Indicators – proposals for implementation (July 2013)
- The role of the lead pathologist and attending pathologists in the multidisciplinary team (March 2014)
- Double reporting in Histopathology (February 2013)

All skin cancer patients will be selected for review as per the national and local guidelines. There should be a nominated Lead skin pathologist for the service but all pathologists reporting skin cancer specimens should have the opportunity to contribute to the skin cancer MDT, participate in a relevant EQA scheme and in local audit (including an assessment of consistency where more than one pathologist participates in service provision).

If there is a significant discrepancy with the clinical findings the pathological material should be reviewed, if possible by a second pathologist with an interest in skin cancer.

Specimens should be reported to the standard required by COSD usually within seven to ten calendar days (80% within seven days and 90% within ten days). This will aid clinical decision making at the planned MDT meeting.

8.2 Specimen Types

Diagnostic
- Incisional biopsies
- Excisional biopsies
- Punch biopsies

Therapeutic
- Excision biopsies
- Lymph node dissections
- Sentinel lymph node biopsies

8.3 Specimen Examination

Each pathology service should establish a defined protocol for each type of diagnostic and therapeutic skin specimen type received by the laboratory, taking into account the above guidance. The protocols should be regularly reviewed and updated by the Lead skin pathologist, in consultation with other pathologists who participate in service delivery.
The protocols should include a mechanism for establishing the orientation of the specimen in agreement with the local skin surgical team.

Skin tissue should only be removed and stored for the purposes of research if it is surplus to the requirements of the diagnostic process. Appropriate patient consent and ethical approval should be obtained.

8.4 Pathology Guidelines

The NSSG has agreed network-wide pathology guidelines for the diagnosis and assessment of skin cancer. It is agreed that there should be equity of access so that all tissue samples are reviewed in high-quality histopathology services from primary and secondary care. Accurate diagnosis in dermatopathology depends on clinicopathological correlation, involving input from both clinician and pathologist. Although this can be achieved in difficult cases by inter-specialist discussion or seeing the patient records, in some instances (such as cutaneous lymphoma) it may be essential for the patient to be seen jointly.

Histopathology services for skin cancer may be part of a managed pathology network or equivalent model.

The Network agrees to implement the following:-

1. All skin cancers to be reported according to the RCPath minimum datasets.
2. Any histopathologist engaged in skin cancer reporting should show evidence of participation in EQA’s, MDT attendance and demonstrate CPD evidence relevant to skin cancer.
3. Malignant melanomas are to be double reported.
4. Specialist MDT to review skin cancer cases of greater risk or rarity. These cases usually represent advanced stages of a disease or those that are difficult or complex. Mandatory referral of such cases is indicated from the LSMDT to the SSMDT.
5. General EQA participation which includes skin for any pathologist involved in local MDT (LSMDT).
6. National Specialist Dermatopathology EQA participation for any pathologist involved in reviewing cases for the specialist MDT (SSMDT).
7. All newly diagnosed cutaneous lymphomas should be seen and managed by the SSMDT which should include a dermatopathologist with expertise in cutaneous lymphoma. There will be a named histopathologist for the Network who will act as the lead in cutaneous lymphoma. Cases of cutaneous lymphoma will be dealt with by specialist dermatopathologists/histopathologists working at the SSMDT level, with a low threshold for discussing cutaneous lymphoma cases with the named lead.
8.5 Minimum Dataset For Reporting

**Diagnostic Specimens**

**Punch and incisional biopsies:**
Tumour type plus those data items from the list below which can be reasonably and accurately adduced.

**Excision biopsies:**
These are often intended to be both diagnostic and therapeutic, so the complete dataset should be provided, as detailed below.

**Therapeutic excision specimens**

**For Basal Cell Carcinoma:**
Specimen type
Site
Greatest tumour dimension
High risk factors
  - Extension into subcutaneous tissue
  - “High risk” histological sub-type: Morphoeic/Infiltrative, Micronodular, Atypical (If predominant component, at invading edge or nearest to resection margin)
  - Atypical Squamous Component
  - Perineural spread
Completeness of excision, reported:
  - margins clear or excision complete (clearance greater than or equal to 1mm)
  - margins close to tumour (clearance less than 1mm)
  - margin involved or excision incomplete
Risk status

**Optional:**

For high risk tumours, margins may be measured to the nearest 0.5mm and the distance to the margin quoted.

Borderline completeness of excision (tumour to within one high power field) or excision borderline (tumour to within one high power field)

**For Squamous cell carcinoma:**
Specimen type
Site
Greatest tumour dimension
Tumour thickness
Presence or absence of lymphovascular invasion
Presence or absence of perineural invasion
Completeness of excision, reported:
  - margins clear or excision complete (clearance greater than or equal to 1mm)
  - margins close to tumour (clearance less than 1mm)
• margin involved or excision incomplete

Risk status

For Malignant Melanoma:
Specimen type
Site
Greatest tumour diameter
Histological Subtype
Breslow thickness
Clark level
Growth Phase
Ulceration
Regression
Angiolymphatic invasion
Perineural invasion
Microsatellite lesions
Distance to the nearest lateral margin (if specimen orientated specify margin)
Distance to deep margin
Mitotic Count per mm²
Tumour infiltrating lymphocytes

Optional:
• Presence of co-existing benign naevus.

The dataset items should ideally be reported in a proforma either within, or separate from or instead of the free text part of the pathology report. Departments and MDTs should work towards recording and storing the dataset items as individually categorised items in a relational database, so as to allow future electronic retrieval and to facilitate the use of pathology data in clinical audit, service planning and monitoring, research and quality assurance.

Laboratories should use an agreed diagnostic coding system (e.g. SNOMED).

All malignancies must be reported to the Northern and Yorkshire Cancer Registry, in accordance with the service level agreement with their host Trust.

8.6 Grading and Staging Conventions

Tumour grading:
• Basal cell carcinoma: No grading system.
• Squamous cell carcinoma: Broders grades I - IV (well, moderately, poorly or "not differentiated")
• Melanoma: Not applicable

Tumour staging:
• TNM classification of malignant tumours (AJCC 7th edition)
• For melanoma: Clark level, growth phase and Breslow thickness
8.7 Use Of Ancillary Laboratory Techniques

All laboratories providing a Pathology service in the network must have at least conditional laboratory accreditation and ensure participation in an appropriate external quality assurance programme which demonstrates satisfactory laboratory performance.

Immunohistochemical procedures which may be of value include the following:

<table>
<thead>
<tr>
<th>Diagnostic scenario</th>
<th>Immunohistochemical markers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamoid BCC v. Squamous cell carcinoma</td>
<td>EMA, BerEP4</td>
</tr>
<tr>
<td>BCC v. Skin Adnexal Carcinoma</td>
<td>EMA, CEA, CD117(adenoid cystica)</td>
</tr>
<tr>
<td>Morpheeic BCC v. Desmoplastic trichoepithelioma</td>
<td>Bcl-2, Ki67 and CD34</td>
</tr>
<tr>
<td>Sarcomatoid SCC or BCC from mesenchymal neoplasms, spindle cell melanoma and AFX</td>
<td>Cytokeratin, p63, EMA, S100, Vimentin</td>
</tr>
<tr>
<td>Pseudovascular SCC v. epithelioid angiosarcoma</td>
<td>CD31, CD34, Ulex eu., EMA</td>
</tr>
<tr>
<td>DFSP v. deep dermatofibroma</td>
<td>CD34, Factor XIIIa</td>
</tr>
<tr>
<td>Melanocytic lesions</td>
<td>S100, MelanA, HMB45, Ki67</td>
</tr>
<tr>
<td>Merkel cell tumour v. small cell carcinoma</td>
<td>CD56, Synaptophysin, CK20, TTF1</td>
</tr>
</tbody>
</table>

8.8 Governance

All pathologists reporting skin cancer specimens should participate in a relevant general histopathology EQA scheme and in local audit (including an assessment of consistency where more than one pathologist participates in service provision). Audit may take the form of:

- review of compliance with specimen examination and reporting procedures
- completeness of datasets
- systematic logging of diagnostic agreement/disagreement during review of cases for MDTMs
- review of diagnostic consistency between pathologists using data from cases in EQA circulations or blind circulations.

The results of the audit process should be discussed with all pathologists who participate in service delivery and used to inform the development of reporting protocols.
8.9 Referral for Review or Specialist Opinion

All patients referred for treatment at a hospital within the North of England Cancer Network following diagnosis elsewhere must be reviewed and discussed at the treating hospital’s multidisciplinary team meeting (MDTM).

The complete diagnostic pathology report must be available at the MDTM, and where appropriate, the histological/cytological material should be reviewed prior to the meeting. This is particularly important if there is a significant discrepancy with the clinical findings. Pathological material should be requested at least 5 working days before and received at least 3 days before the relevant MDTM to allow sufficient time for review.

A formal report should be issued by the reviewing pathologist to the responsible clinician at the treating hospital. The results of the review should be sent to the original pathologist, either by copy of the review report or by letter.

Where patients have been referred for oncology treatment, requests for specialist biomarker studies will be co-ordinated between the treating oncology service, their local pathology service and the referring hospital’s pathology service, as appropriate.

The oncology service must agree a mechanism for requesting tests and the relevant pathological material with their local pathology service. Requests for pathological material should be made in good time to ensure that results are available at the MDTM where the patient is to be discussed.

All suspected skin lymphoproliferative lesions or lymphomas should be referred to the Haematological Malignancy Diagnostic Service for phenotypic analysis and confirmation of diagnosis.

Other cases do not need systematic central review nor referral out with the Network,
  - unless the patient is being referred for treatment externally or by the Cancer Centre,
  - when cases should be referred to the Lead Pathologist of the appropriate MDT and
  - dealt with according to their specialist MDT guidelines.

Cases referred for individual specialist or second opinion will be dealt with by the individual pathologist and a report issued by them. Where relevant, tissue blocks should be made available to allow any further investigations that are deemed appropriate. The result of the review should be communicated to the referring pathologist by letter and also by fax/telephone as appropriate.

8.10 References

1. Minimum dataset for Skin cancer histopathology reports.
   The Royal College of Pathologists (May 2014)
   a. Basal cell carcinoma
   b. Malignant melanoma
   c. Squamous cell carcinoma
9. Imaging Guidelines

9.1 Introduction

The majority of skin cancers do not require imaging. There are no national guidelines available, and in their absence, this document aims to optimise imaging of skin cancer in the North of England Cancer Network. Skin cancer imaging is usually used to determine either the possible extent of local invasion and/or detect distant metastases.

9.2 Local disease

When there is clinical concern with regards to the possible extent of local invasion, the choice of imaging will depend on the site of the lesion. This aspect of imaging may vary depending on local radiological expertise.

9.3 MRI for local extent of skin cancer

When local disease is extensive or when it is close to vital structures, MRI scanning can be very useful. It has superior soft tissue contrast especially in the head and neck region. In the head and neck region, a neck node screen should be part of this examination.

9.4 CT for local extent of skin cancer

MDCT can be used as an alternative to MRI scans in some patients who have difficulty with MRI. CT is better at detecting cortical bone destruction. For patients who are being considered for a nodal block dissection, a CT scan of the chest, pelvis and abdomen should be considered before the procedure.

9.5 Ultrasound for local extent of skin cancer

Ultrasound can provide useful imaging information with regards to the local extent of disease. The information obtained often saves the need for performing further complex imaging. A high-resolution ultrasound scanner with a linear 7 – 12 MHz probe is often used for this examination.

9.6 Metastatic skin cancer

This group of skin cancers includes high-grade squamous cell carcinoma and melanoma.
9.7 MDCT (Multi-Detector CT)

MDCT scan is commonly used in most centres for the evaluation of metastatic skin cancer. The areas scanned will depend on the site of the primary lesion and local lymph nodes.

9.8 PET / PETCT

PET / PETCT can be used to exclude metastatic melanoma in cases where there is equivocal diagnostic imaging and in cases where surgical options are affected by the possible presence of metastatic disease.

9.9 Ultrasound

High-resolution ultrasound has very good soft tissue contrast and when combined with FNAC can have high accuracy in detecting metastatic lymphadenopathy.

9.10 Cutaneous Lymphoma

All patients newly diagnosed with cutaneous lymphoma except cases of stage I mycosis fungoides should undergo staging CT scans of thorax, abdomen and pelvis (Whittaker et al, 2003).

References

- S.J.WHITTAKER, J.R.MARSDEN,* M.SPITTLE AND R.RUSSELL JONES
- Joint British Association of Dermatologists and U.K. Cutaneous Lymphoma Group

10. Audit

All pathologists reporting skin cancer specimens should participate in a relevant general histopathology EQA scheme and in local audit (including an assessment of consistency where more than one pathologist participates in service provision). Audit may take the form of:

- review of compliance with specimen examination and reporting procedures
- completeness of datasets
- systematic logging of diagnostic agreement/disagreement during review of cases for MDTMs
- review of diagnostic consistency between pathologists using data from cases in EQA circulations or blind circulations.

The results of the audit process should be discussed with all pathologists who participate in service delivery and used to inform the development of reporting protocols.
The Skin NSSG to discuss in advance; an audit programme on a yearly circle at the NSSG meeting.
The audit needs to be agreed and the audit lead for the network to liaise with the teams involved in the audit.
Completion and presentation of the audit should be documented in the minutes and presentation upload to the NESCN website.


<table>
<thead>
<tr>
<th>Designated Hospital for Mohs Surgery</th>
<th>Lead Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital, Newcastle Upon Tyne</td>
<td>Dr J Langtry 0191 2336161</td>
</tr>
</tbody>
</table>

The Network follow the national standard for Mohs Micrographic Surgery and details can be found at the British Society of Dermatological Surgery

12. Operational Policy for the Cutaneous T cell Lymphoma

12.1 Introduction:

All newly diagnosed patients with cutaneous T cell lymphomas from Newcastle upon Tyne, Northumberland, Cumbria and North Durham and all patients with cutaneous T cell lymphomas (CTCL) referred to the CTCL team from outside this area, are discussed in the monthly CTCL MDT. The procedures and policies of the skin MDT described above apply equally to the CTCL team. In addition to the general skin cancer procedures and policies, the following apply specifically to the CTCL Sub-group.

12.2 Purpose of the MDT in relation to Cutaneous T cell Lymphomas;

The CTCL MDT, within the Newcastle Skin Cancer MDT, ensures a co-ordinated multidisciplinary approach to the diagnosis, treatment and care of patients with CTCL by:

- Ensuring prompt multidisciplinary review of all patients referred with CTCL both from within and from outside the catchment area of the CTCL MDT.
- To discuss the histology of all patients referred with CTCL within the MDT to ensure accurate diagnosis.
- To organise appropriate staging and produce a management plan for each patient.
- To enter patients into research studies where available and appropriate.
• To regularly review and audit treatment policies and outcomes including patient satisfaction and to apply to results to continually improve the service.

• To share patient care with Dermatologists / Oncologists / Haematologists close to the patient’s home where appropriate and to ensure prompt transmission of information to their Primary Care physicians and shared-care physicians to achieve optimal patient care.

• To ensure that treatment protocols are regularly reviewed and updated

12.3 Leadership arrangements and responsibilities;

The Lead Clinicians for the CTCL service are Sophie Weatherhead (Dermatology) and Dr John Frew (Oncology).

12.4 Responsibilities of the Cutaneous T cell Lymphoma Lead Clinicians:

• To lead the clinical activity of the CTCL Multidisciplinary Team, working to agreed guidelines to ensure that the service meets local, regional and national standards.

• To produce and revise clinical guidelines for the management of CTCL. These are currently included within the NECN Haematology NSSG clinical guidelines.

• To arrange periodic management meetings of the CTCL team.

• To contribute items relevant to the CTCL service to the Annual Report of the Skin MDT, with the support of the Cancer Management Team.

12.5 Core Nurse Member:

The CTCL service has a specialist nurse who is a core member of the MDT, and she provides support and advice to all patients who use the service, including advice related to systemic treatment including Interferon and chemotherapy. Patients treated primarily with skin directed treatments will receive expert nursing advice from the Phototherapy Nursing team in Dermatology. Patients receiving skin directed treatment and/or systemic treatment in their hospital under a shared care arrangement, will receive expert nursing advice and support from the Specialist dermatology and/or haematology/ oncology nurses within their local hospital.

12.6 Membership Arrangements:

The Cutaneous Lymphoma MDT, within the Lymphoma MDT, includes:

• Dr John Frew – Core Member, Consultant Clinical Oncologist
• Professor Peter Farr – Core Member for Cutaneous Lymphomas only, Consultant Dermatologist
• Dr Sophie Weatherhead – Core Member for Cutaneous Lymphomas only, Consultant Dermatologist
• Dr Muzlifah Haniffa – Core Member for Cutaneous Lymphomas only, Consultant Dermatologist
• Dr Chris Bacon – Core Member, Consultant Histopathologist
• Dr Akhtar Husain – Core Member, Consultant Histopathologist
• Dr Fraser Charlton – Core Member, Consultant Histopathologist
• Sophie Alexander – Nurse Specialist
• Anneka Kershaw – MDT Coordinator

Dr Sophie Weatherhead will be responsible for leading CTCL research and recruitment to clinical trials.

When a patient or patients with CTCL are listed for discussion at the MDT, the above Core Members should be present at a minimum of two thirds of the meetings and should arrange appropriate cover when absent.

12.7 Referral Arrangements:

Patients with CTCL are notified to the MDT Co-ordinator by telephone or e-mail for discussion at the next MDT.

Patient Pathways – see attached

CTCL MDT – the monthly meeting takes place during the CTCL clinic on the first Thursday of each month at 11.00-11.30.

A list of patients to be discussed at the meeting is circulated by e-mail to all members of the MDT prior to the meeting. The MDT will discuss:

• All newly diagnosed cutaneous lymphomas from the MDT catchment population that have been referred to the service
• All cutaneous lymphomas referred to the Cutaneous Lymphoma Team from outside the catchment
• Patients with relapse requiring discussion

MDT outcomes of CTCL patients are minuted as for other patients and the minutes are circulated and a record of the decision is kept in the MDT file and a hard copy placed in the patient’s notes. The MDT minutes will be a source of information for audits.

Matters relating to operation of the CTCL MDT will be discussed at the Newcastle CTCL MDT Annual General Meeting.
12.8 Key Workers:

All patients will be assigned a keyworker who is also a core member of the MDT, but as patients with CTCL are drawn from a wide area, they may also have an appropriate key worker at their local hospital.

12.9 Patient Information:

Written information is available for patients including information about their specific diagnosis, systemic treatments and total skin electron beam therapy. Feedback from patients will be obtained on a regular basis via patient surveys (see Patient Information Pathway).

12.10 Relationship with NSSG:

The CTCL MDT relates primarily to the NECN Haematology NSSG via Dr Sophie Weatherhead.

The CTCL MDT agreed to:

- Participate in audits and case presentations at local/regional network meetings.
- Revise clinical guidelines regularly.

13. Clinical Trials

The Cancer Reform Strategy states that “in order to ensure that we build for the future of cancer services there is a need for increased support for research”. This statement underpins the need for promoting research to fill the gaps in the evidence and spreading good practice.

The Clinical Research Network: North East and North Cumbria Division 1 (Cancer) (CRN:NECN) will be meeting the performance based working proposals for the National Cancer Research Network (NCRN). This includes maintaining overall accrual and improving accrual into randomised controlled studies, (RCT’s) with the aim being to provide as wide reaching a portfolio as possible across the NECN.

There is a need to ensure that the Networks portfolios are inclusive of trials for all disease groups and that there is an expansion of pre-malignancy and non-cancer screening trials. CRN:NECN believe it is important that patients within the NECN have equity of access to trials open.

- New initiatives to strengthen research into prevention of cancer are underway. The Research Networks will work with key stake holders and the Primary Care Research Networks to ensure that patients in the North East and Cumbria have access to these trials.
- The CRS states that there is funding for screening trials and the Research Networks will support the setting up and coordination of screening trials.
• The NCRN has an important role in identifying potential new therapies and making sure that clinical trials are undertaken in a timely manner. NCRN engages with Industry and NICE with the aim of maximising the impact of NCRN trials on subsequent NHS Practice. There will be further investment over the next 10 years into researching cures and treatments of the future. The Research Networks will ensure they maintain a wide reaching balanced portfolio and promote industry trials.

• Access to high quality information is a prerequisite for patients to be able to participate in decision making about their care and this includes research trials. All staff need to be aware of research portfolios so they can ensure they provide patients with relevant information. Details of research portfolios are circulating by newsletters and via SSMDTs.

• Reducing inequalities in equity of access to cancer trials.

• Promoting research proposals on cancer in under-represented groups – encouraging more trials which include older people and ensuring that children and young adults are treated at centres where a complete portfolio of relevant trials is supported.

• NCRI will help fund research on data collected by the National Cancer Intelligence network (NCIN), facilitating a more informed analysis of cancer services.

• To ensure research is incorporated in World Class Commissioning for cancer.

• To work more closely with our Patient and Carer Group, particularly in relation to equity of access for patients to clinical trials. We hope they will be able to help us provide a patient's perspective and help support us raise awareness.

The Cancer Reform Strategy supports the need for promoting integration of research into routine practice and the CRN:NECN are keen to advance this concept.
14. Cutaneous Lymphoma Pathway

Cutaneous Lymphoma Pathway
Tcell(CTCL) and Bcell (CBCL)

Referral to local dermatologist by GP

Patient seen in local Dermatology outpatient clinic

CTCL/CBCL suspected?

Biopsy taken and sent to pathology. Patient given appointment for two weeks

Patient attends clinic for Pathology Results (provisional).

CTCL/CBCL confirmed?

Appropriate staging arranged. Consider referral to Newcastle cutaneous lymphoma team

Discussed at local +/- for Newcastle MDT meeting. Management agreed

Local Dermatology service for skin directed treatment

Newcastle Mycosis Fungoides clinic for specialist treatment eg PUVATSEI

Newcastle or local Lymphoma clinic for systemic treatment

Patient reassured and discharged

Patient reassured and discharged or follow up arranged

Incidental finding from other source

Radiotherapy
15. Guidelines for skin cancer follow-up.

The frequency of follow-up is probably best judged by the managing consultant and patient. As a guide the following recommendations have been made.

Patient follow-up is based on an agreement between patient and specialist. Patients may be followed up by the specialist, cancer nurse specialist, GP or self monitor after appropriate instruction.

**Basal cell carcinoma (BCC)**

No recommendations on follow-up are made in the BAD guidelines on the management of BCC.

Patients with non-aggressive BCC where treatment is satisfactorily completed may be discharged.

Patients with high risk BCC or where complex reconstruction has been undertaken should be followed up appropriately.

(High risk BCC includes recurrence, greater than 2cm diameter, H region of face, aggressive histological growth pattern, less than 40 years of age).

**Squamous cell carcinoma (SCC)**

There are no universally recognised guidelines for the follow-up of SCC. Based on rates of recurrence and metastases from previous studies it is recommended that SCCs be split into three categories for follow-up based on the algorithm below:

1. SCC excised with adequate margins (≥1mm)?
   - No □ Consider re-excision and refer to MDT for discussion

2. SCC diameter ≥2cm or occurred in site of chronic ulceration or radiation/thermal scarring?
   - Yes □ High risk

3. If diameter < 2cm - number of risk factors:
   - ≥2mm Breslow depth
   - Clarks level ≥ IV
   - Perineural invasion
   - Site = lip or ear
   - Poorly or undifferentiated
   - ≥ 2 □ High risk
   - 1 □ Moderate risk
   - 0 □ Low risk

4. If Low risk, is the patient immunosuppressed?
   - Yes – consider long term 6 monthly follow-up.
Follow up regimes

Low risk
Discharge back to GP.
Ensure adequate education regarding self examination.

Moderate risk
Review patient at 3, 6 and 12 months then discharge.

High risk
Review patient 3 monthly for 1 year, 4 monthly for 1 year then 6 monthly for 1-3 years.

Cutaneous malignant melanoma (CMM)
The BAD guidelines on CMM management recommend that in situ CMM do not need follow-up.

CMM with stage I A should be followed up every 3 months for 1 year and may then be discharged.

CMM with stage I B to III A should be followed up every 3 months for 3 year and then every 6 months for to 5 years, with stage III B and III C every 6 months for a further 5 years.
16. **Palliative Care**

Network wide guidelines exist for the management of certain core symptoms and situations in palliative care. These have been incorporated into a small A5 sized booklet and are distributed across the network. They are also available on the North of England cancer network website where other guidelines and links will be available at: [http://www.nescn.nhs.uk/](http://www.nescn.nhs.uk/)

We also feel it can be helpful to give an explanation of some of the different terms often encountered when ‘palliative care’ is discussed.

**Supportive Care**

“Umbrella” term for all services which help patient and family to cope with the condition and its treatment – from pre-diagnosis, through diagnosis and treatment, to cure, continuing illness or death and into bereavement

Aims to help patient maximise benefits of treatment and to live as well as possible with the effects of the disease

Should be given equal priority alongside diagnosis and treatment.

Supportive care includes:
- Self help and support
- User involvement
- Information giving
- Psychological support
- Symptom control
- Social support
- Rehabilitation
- Complementary therapies
- Spiritual support
- End of life and bereavement care

**Palliative Care**

Part of, and embraces many elements of, supportive care.

Defined (NICE 2004) thus: “the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments”.

Key features of palliative care
- Affirm life and regard dying as a normal process.
- Provide relief from pain and other distressing symptoms.
- Integrate the psychological and spiritual aspects of patient care.
- Offer a support system to help patients live as actively as possible until death.
- Offer a support system to help the family cope during the patient’s illness and in their own bereavement.
General Palliative Care is that care delivered by health professionals whose main role is not working with palliative care patients but who necessarily come across these patients in their work. This care is therefore delivered by a majority of healthcare professionals.

Specialist Palliative Care is delivered by professionals for whom the majority of their working role is in managing patients with palliative care needs. These professionals would therefore manage, or be advising in the care of, patients and their families whose needs are more complex, challenging, time consuming and refractory to usual input, and where this demand exceeds which can reasonably be expected to be delivered by a professional whose main role is in another discipline.

**End of Life Care**
An approach that enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement.

Key features of end of life care

- Anticipation and management of deterioration in the patient’s condition
- Advance care planning in accordance with patient preferences
- Patient choice about place of care and death
- Effective co-ordination of care across all teams and providers of care (in statutory, voluntary and independent sectors) who are involved in the care of patient and family

**Care of the Dying**

- Care of the patient and family in the last hours and days of life.
- Incorporates four key domains of care, physical, psychological, social and spiritual
- Supports the family through this phase and into bereavement.

**References**

- *National Council for Palliative Care Palliative Care Explained* [http://www.ncpc.org.uk](http://www.ncpc.org.uk)
North of England Cancer Network

Skin Cancer Primary Care Referral Guidelines

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<td>Skin NSSG members</td>
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</table>
1. General recommendations

All suspected Squamous Cell Carcinoma and Malignant Melanoma must be referred to secondary care on the "2 week rule" pathway. All Basal Cell Carcinomas should be referred to secondary care except for low risk Basal Cell Carcinomas which may be referred to secondary care or in intermediate care, or treated by specifically commissioned community cancer clinicians, where the local PCT has deemed appropriate, see Appendix 1 for levels of care.

A patient presenting with skin lesions suggestive of skin cancer or in whom a biopsy has been confirmed should be referred to a team specialising in skin cancer (see Appendix 2 for clinical pathways).

All primary healthcare professionals should be aware of the 7-point weighted checklist for assessment of pigmented skin lesions.

All primary healthcare professionals who perform minor surgery should have received appropriate accredited training in relevant aspects of skin surgery including cryotherapy, curettage, and incisional and excisional biopsy techniques, and should undertake appropriate continuing professional development. (Please see appendix 3 for Community Skin Cancer Training Policy). Skin cancer surgery by a primary care physician will be confined to pre-cancers except for those primary physicians specifically commissioned by their CCG to operate on low risk BCCs. Such commissioning requires agreed audit and appraisal by the CCG.

All excised skin specimens should be sent for pathological examination.

On making a referral of a patient in whom an excised lesion has been diagnosed as malignant, a copy of the pathology report should be sent with the referral correspondence, as there may be details (such as tumour thickness, excision margin) that will specifically influence future management.

7 point checklist

All primary healthcare professionals should use the weighted 7-point checklist in the assessment of pigmented lesions to determine referral:

Major features of the lesions: (scoring 2 points each)
- change in size
- irregular shape
- irregular colour

Minor features of the lesions: (scoring 1 point each)
- largest diameter 7 mm or more
- inflammation
- oozing
- change in sensation
Suspicion is greater for lesions scoring 3 points or more. However, if there are strong concerns about cancer, any one feature is adequate to prompt urgent referral.

**Two Week Wait Fax Numbers – GP Referral Guidelines**

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<th>Fax/Tel</th>
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</tr>
</tbody>
</table>
2. Skin Cancer Community Pathway

Community Skin Cancer Pathway - August 2009

Group A – General Practitioner

Group B – GPwSI Community Skin Cancer Services

Group C – Secondary Care

Notes on arrows

- Red arrows are suspected cases of melanoma & SCC (both of which must be referred under the two-week rule) and high-risk BCC. Occasionally unexpected cases of melanoma & SCC are found after a lesion has been removed in the community and sent for histology, all such cases must also be referred under the two-week rule.

- Black arrows refer to cases of low-risk BCC (see Appendix 1) and other skin lesions not suspicious of melanoma & SCC but still in need of diagnostics.

Notes on groups

Group A

- Suitable for managing actinic keratoses and Bowens disease.

Group B

Clinicians manage patients as in group A but differ in the following ways:

- Any general practitioner knowingly managing cases of low-risk BCC (Appendix 1) in patients from their own practice must register with the community skin cancer lead and submit annual audit data that demonstrates:
  - Good levels of complete excision rates (95% or above)
  - Good cosmetic outcomes – clinicians should be able to use
subcutaneous suturing techniques where appropriate

- That clinicians have the knowledge of how and when to use non-surgical treatment options

- They have been accredited as GPwSi in dermatology / skin surgery as per the department of Health Guidelines:-

  'Implementing care closer to home - convenient quality care for patients Parts 1-3’ at [www.pcc.nhs.uk/173.php](http://www.pcc.nhs.uk/173.php) and


- They can be referred patients from GPs for the diagnosis and management of AK, Bowens, low-risk BCC and other skin lesions not suspicious of SCC / melanoma.

- In exceptional circumstances they can manage other lesions.

- They are part of the local MDT and need to attend meetings when appropriate.

**Group C (Secondary Care)**

- Management of low risk BCC. Patients may be referred into Dermatology or Plastic Surgery.

- Management of high-risk BCC, SCC, melanoma and rare skin tumours. Patients must be referred to Plastic Surgery or Dermatology.

- As with previous guidelines (Cancer Care Alliance GP and South Tees Hospitals referral guidelines). Refer to Plastic Surgery if:
  
  - Lesion >1 cm in diameter
  - Where primary wound closure after full excision is difficult
  - Location of lesion affects functionality or is aesthetically significant

**Low Risk BCC**

For the purpose of this document ‘low risk BCC’ is considered to be any BCC, other than those given below:

Clinical features of BCCs at high risk of recurrence (any one of these):

- Site Face, scalp, ears.
- or, Size 2cms or more
- or, Circumstances
- immunocompromised patient
- genetically predisposed patients (e.g. Gorlins Syndrome)
- previously treated lesion
flat lesion, hard thickened skin (appearance of morphoeic BCC)

Exceptions to the Normal Patient Pathway

All patients with suspected / confirmed cases of life-threatening skin cancer must be referred to secondary care without exception. This includes all cases of melanoma and the vast majority of SCC.

Occasionally patients in the community skin cancer service (group B) are found to have higher-risk BCC and low-risk SCC. There exist a very small group of such patients who can continue to be managed in this setting. Examples of such exceptions include patients refusing further treatment and those refusing to go to secondary care. All such cases need to be discussed with consultant colleagues at the local MDT meetings.

NB: Pathway adapted August 2009 from Teesside Community Skin Cancer Pathway

3. Specific Recommendations

MELANOMA

Change is a key element in diagnosing malignant melanoma. For low-suspicion lesions, careful monitoring for change should be undertaken using the 7-point checklist for 8 weeks. Measurement and photographs with a marker scale and/or ruler may be done.

In patients with a lesion suspected to be melanoma, an urgent referral to a dermatologist or other appropriate specialist (Plastic Surgeon) with experience of melanoma diagnosis should be made, and excision in primary care should be avoided.

Weblink: U.K. guidelines for the management of cutaneous melanoma

SQUAMOUS CELL CARCINOMAS

Squamous cell carcinomas present as keratinizing or crusted tumours that may ulcerate. Non-healing lesions larger than 1 cm with significant induration on palpation, commonly on face, scalp or back of hand with a documented expansion over weeks to months, may be squamous cell carcinomas and an urgent referral should be made.

Squamous cell carcinomas are common in patients on immunosuppressive treatment, but may be atypical and aggressive. In patients who have had an organ transplant who develop new or growing cutaneous lesions, an urgent referral should be made.
In any patient with histological diagnosis of a squamous cell carcinoma made in primary care, an urgent referral should be made.

**Weblink:** Multiprofessional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma

**BASAL CELL CARCINOMAS**

Basal cell carcinomas are slow growing, usually without significant expansion over 2 months, and commonly occur on the head and neck. Where there is a suspicion that the patient has a basal cell carcinoma, a non-urgent referral should be made. For the purpose of GP referral, “low risk BCC” are those on torso or limbs which are less than 20 mm diameter.

**Weblink:** Guidelines for the management of basal cell carcinoma
## Appendix 1 – Models for Level of Care

<table>
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<th>Level</th>
<th>Person or Team</th>
<th>Case Mix/Procedure</th>
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| 1     | Any general practitioner in the community | - Benign lesions  
- Actinic Keratoses  
- Precancerous – SCC in situ/Bowens |
| 2     | Listed community skin cancer clinicians associated with a named MDT (LSMDT or SSMDT acting as 'local' SMDT) (Community Model 1) | - Low risk BCC |
| 3     | LSMDT, hospital staff core team member (may be core member of SSMDT acting as 'local' LSMDT). Community Model 2-under Acute Trust Governance Without mandatory individual case review by MDT. | - High risk BCC  
Other than categories below  
- 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' MDT) | - High risk BCC  
- SCC  
- Malignant Melanoma (MM) – new, single primary, adult, non-metastatic, not for approved trial entry, up to and including stage IIc (must fulfil all these criteria, stage IIb and onwards must be discussed with a core member of SSMDT)  
- 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 | - Selected BCCs and SCCs, rare skin cancers, cutaneous sarcomas above superficial fascia needing plastic/reconstructive surgery by SSMDT core member (except where such service is available at LSMDT level, following discussion with a core member of SSMDT, 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 |
| Supranetwork team. Selected Networks only. Agreed with Specialist Commissioning Groups. | MM – stage IIIa or more, or <19 years or metastatic on presentation or newly metastatic or recurrent or for approved trial entry (except where those patients could be managed locally by a core member of LSMDT, following discussion with SSMDT)
- 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

Cases to be dealt with by only one agreed SSMDT per Network, if more than one in the Network
- Cutaneous lymphoma
- Kaposi’s sarcoma
  - Cutaneous sarcoma above superficial fascia
    (Below fascia, refer to sarcoma MDT)

Other rare skin cancers (see appendix 1 in the Skin Cancer IOG pg 128/129)

Notes:
- Where a network chooses to have a MMDT all cases of MM for level 5 care from the MMDTs catchment area should be referred to the MMDT.
- There should be agreed working arrangements with certain site specialised MDTs
- All possible primary cutaneous lymphomas with a lack of diagnostic consensus at SSMDT should be reviewed by the Supra-Network.

| T-cell cutaneous lymphoma: total body surface electron beam therapy | Notes:
- All patients with Stage IIB-IVB MF?SS and rare CTCL variants to be reviewed by the supra-network for diagnostic confirmation/management plan to be implemented by SSMDT unless specific therapies/trials are only available in the supranetwork centre.
- Patients with early stage MF (IB-IIA) who are resistant to skin directed therapies should be reviewed by the supra-network centre as at risk of disease progression
| Clinician responsible for named facilities | T-cell cutaneous lymphoma: photopheresis |
for photopheresis (very small number of patients) Agreed with SCGs. Cases discussed in SSMDT for cutaneous lymphoma in host network.
Appendix 2 - Model Pathways

Suspected Malignant Melanoma Pathway

Non-urgent referral route

Out-patient appointment in Dermatology / Plastic Surgery at appropriate site

Has patient already had biopsy

Yes

Urgent 2WW referral to Dermatology

Urgent 2WW referral to Plastic Surgery

Out-patient appointment with Plastic Surgery at appropriate site

Has patient already had biopsy

Yes

Is Biopsy Indicated

No

Clinically MM / Proven from Biopsy

Patient has biopsy

Patient diagnosis confirmed

Excision required

Patient referred to Plastic Surgery

Patient referred to Plastic Surgery

Patient has biopsy

Patient diagnosis confirmed

Clinically Highly Suspicious

Excision required

Patient referred to waiting list for excision

Patient has excision

Patient diagnosis confirmed

Oncology Referral

Referral to Dermatology

Referral to Head and Neck Team

Referral to Plastic Surgery

Other MDT Referral

Radiotherapy

Excision +/– Other surgical treatment
Appendix 2 - Community Skin Cancer Training Policy

North of England Cancer Network

Community Skin Cancer Training Policy

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<td><strong>Date:</strong> Reviewed 09.05.16</td>
</tr>
<tr>
<td><strong>Version:</strong> v.04</td>
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<tr>
<td><strong>Review Date:</strong> May 2017</td>
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COMMUNITY SKIN CANCER TRAINING POLICY

This guide describes the training requirements for GPwSIs providing skin cancer services. This policy outlines interim minimum standards to be adhered to before this strategy is in place.

1. Principles:

1.1. The training for all GPs commissioned to deliver skin cancer services in the community must adhere to the standards described in the Manual for Cancer Services 2008: Skin Measures, and specifically Measures 08-6A-104j and 08-6A-105j.

1.2. All GPs wishing to act as GPwSIs for skin cancer will be registered with their relevant primary care organisation.

1.3. Where GPs are commissioned to provide services above Care Level 2, separate arrangements will be made for their training and governance in accordance with the Manual for Cancer Services 2008: Skin Measures.

1.4. Audit of activity should be undertaken.

Names Trainers/Assessors

The Network group in consultation with the MDTs, agreed named trainers/assessors, who must be core dermatologist or surgical members of skin cancer MDTS.

The Network named trainer/assessor of competence for the network for the Model 2 practitioners training are;

Mr Mumtaz Hussain.
Training

1.1 Training responsibilities

The CCG Clinical Lead is responsible for ensuring that the training requirements for GPwSIs are complied with in accordance with network arrangements.

The specific training in skin cancer undertaken by the GPwSI must be given under the supervision of a consultant dermatologist or other specialist members of the skin cancer MDT.

1.2 Training requirements

The requirements for designation as a GPwSI treating skin cancer will include:

- group 3 training requirements (guidance and competencies for the provision of services using GPs with special interests - GPwSIs. DH April 2007. Gateway ref 7954. Dermatology specialty) -Clinical assessments (modified mini-CEX) x 4, DOPS 1 and DOPS 2, Meet NICE IOG guidance requirements
- undergo 15 hours CPD in skin cancer per year;
- have one session per year with a consultant dermatologist or other specialist core member of a skin cancer MDT;

1.3 Records of training relevant to skin cancer undertaken

Records must be kept by each GPwSI of training and CPD undertaken with date of the training, institution and the named supervisor, and the dates approved by the CCG Clinical Lead.
Proposal for Training Workshops for Community Skin Cancer Clinicians

To host a Bi-annual half-day skin cancer workshop for primary care physicians involved in providing a skin cancer service model in their locality.

Justification
There is a need for a regular programme of training, maintaining skills and developing knowledge.

What
A half day programme to include interactive lectures, forums for discussion and problem solving case presentations.

Who
Led by secondary care surgical dermatology.

Inclusion
All primary care physicians aspiring to provide or providing a skin cancer service model in their locality.

Exclusion
All other primary care physicians.

Timetable (indicative)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.30 – 13.50</td>
<td>Coffee</td>
</tr>
<tr>
<td>13.50 – 14.00</td>
<td>Introduction &amp; learning needs</td>
</tr>
<tr>
<td>14.00 – 14.20</td>
<td>SCC precursors: Actinic Keratosis &amp; Bowen’s</td>
</tr>
<tr>
<td>14.20 – 14.30</td>
<td>Discussion</td>
</tr>
<tr>
<td>14.30 – 14.50</td>
<td>Keratoacanthoma &amp; cutaneous horn</td>
</tr>
<tr>
<td>14.50 – 15.00</td>
<td>Discussion</td>
</tr>
<tr>
<td>15.00 – 15.20</td>
<td>SCC</td>
</tr>
<tr>
<td>15.20 – 15.30</td>
<td>Discussion</td>
</tr>
<tr>
<td>15.30 – 15.50</td>
<td>Coffee</td>
</tr>
<tr>
<td>15.50 – 16.30</td>
<td>Problem solving case presentations</td>
</tr>
<tr>
<td>16.30 – 16.50</td>
<td>Back to basics; sending specimens to pathology, checking pathology reports etc</td>
</tr>
</tbody>
</table>
Operational Policy for the Cutaneous T cell Lymphoma (CTCL) MDT

This Operational Policy was agreed by the Cutaneous T Cell Lymphoma (CTCL) MDT on 14th May 2015

This Operational Policy was agreed by Mr R Bliss, Trust Lead Cancer Physician on

Date for Review May 2016
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<td>3. Leadership Arrangements &amp; Responsibilities</td>
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Introduction:

All patients with a new diagnosis of CTCL presenting within the NECN (North of England Cancer Network) catchment area should be discussed by the CTCL MDT. The CTCL MDT functions as an integral part of the monthly CTCL clinic which permits combined clinical and pathological assessment of patients. CTCL membership is listed below. Patients with more advanced disease are frequently discussed at the systemic lymphoma MDT when systemic therapies are indicated.

Purpose of the CTCL MDT;

The CTCL MDT ensures a co-ordinated multidisciplinary approach to the diagnosis, treatment and care of patients with CTCL diagnosed within the NECN catchment by:

- Ensuring prompt multidisciplinary review of all patients referred with CTCL from Lymphoma and Skin MDTs within the NECN catchment, including histology review to ensure accurate diagnosis
- Organising appropriate staging and producing a management plan for each patient.
- Entering patients into research studies where available and appropriate
- Regularly reviewing, updating and auditing treatment policies, protocols and outcomes including patient satisfaction and applying the results to continually improve the service
- Sharing patient care with Dermatologists/Oncologists/Haematologists close to the patient’s home where appropriate and ensuring prompt transmission of information to their Primary Care physicians and shared-care physicians to achieve optimal patient care.

Leadership arrangements and responsibilities: (11-2J-401)

The Lead Clinician for the CTCL MDT is Dr Sophie Weatherhead as agreed by the Trust Lead Cancer Clinician.

The CTCL Lead clinician’s responsibilities include:

- Leading the clinical activity of the CTCL MDT, working to agreed guidelines, to ensure that the service meets local, regional and national standards.
- Participating, with other MDT members, in audits and case presentations at local/regional network meetings.
- Working within the Lymphoma MDT and liaising, as necessary, with the Specialist Skin MDT to ensure a prompt and high quality integrated service
- Producing and revising clinical guidelines for the management of CTCL. These are currently included within the NECN Skin NSSG clinical guidelines and will be submitted to the Haematology NSSG for simultaneous inclusion in the Haematology Guidelines.
- Arranging periodic management meetings of the CTCL MDT, including an Annual General Meeting.
- Preparing a CTCL MDT Annual Report, with the support of the Cancer Management Team, and preparing documents for Peer Review.
Core Nurse Member:

Patients treated primarily with skin directed treatments in Newcastle receive expert nursing advice from the Phototherapy Nursing team in Dermatology. Patients receiving skin directed treatment and/or systemic treatment in their local hospital under a shared care arrangement, will receive expert nursing advice and support from the Specialist dermatology and/or haematology nurses within their local hospital. The Skin Lymphoma Specialist Nurse also fulfils this role providing invaluable support to patients in the clinic and acting as a first point of contact to the service.

CTCL MDT Core Membership: (11-2J-402/406)

<table>
<thead>
<tr>
<th>Core Member</th>
<th>Designation</th>
<th>Arranged Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr John Frew</td>
<td>Consultant Clinical Oncologist</td>
<td>Dr Joanne Lewis</td>
</tr>
<tr>
<td>Prof Peter Farr</td>
<td>Consultant Dermatologist (for Cutaneous Lymphoma only)</td>
<td>Dr Sophie Weatherhead</td>
</tr>
<tr>
<td>Dr Sophie Weatherhead</td>
<td>Consultant Dermatologist (for Cutaneous Lymphoma only)</td>
<td>Prof Peter Farr</td>
</tr>
<tr>
<td>Dr Muzlifah Haniffa</td>
<td>Consultant Dermatologist (for Cutaneous Lymphoma only)</td>
<td>Dr Sophie Weatherhead</td>
</tr>
<tr>
<td>Dr Chris Bacon</td>
<td>Consultant Histopathologist (Network agreed specialist for cutaneous lymphoma)</td>
<td>Dr Katrina Wood</td>
</tr>
<tr>
<td>Dr Akhtar Husain</td>
<td>Consultant Histopathologist</td>
<td>Dr Fraser Charlton</td>
</tr>
<tr>
<td>Dr Fraser Charlton</td>
<td>Consultant Histopathologist</td>
<td>Dr Akhtar Husain</td>
</tr>
<tr>
<td>Sophie Alexander</td>
<td>Nurse Specialist</td>
<td>TBA</td>
</tr>
<tr>
<td>Anneka Kershaw</td>
<td>MDT Coordinator</td>
<td>Other MDT Coordinator</td>
</tr>
</tbody>
</table>

Any Consultant Oncologist in the catchment area of the MDT who is responsible for performing TSEBT (known as Total Skin Electron Irradiation – TSEI – in Newcastle) should be a core member of the Supranetwork Team. This is currently Dr John Frew (11-2J-403) (Appendix 1 for Dr J Frew work schedule).

All treatments with TSEBT for patients from the Supranetwork catchment area of the MDT are delivered in the Northern Centre for Cancer Care (NCCC) under the care of Dr J Frew. (11-2J-404)

Dr Sophie Weatherhead will be responsible for leading CTCL research and recruitment to clinical trials.
The Core Members should be present at a minimum of two thirds of the CTCL MDT meetings and should arrange appropriate cover when absent. A copy of the MDT attendance record can be found within the Annual Report and arranged cover detailed above.

**Referral Arrangements:**

Patients with CTCL are referred from Lymphoma and Skin MDTs within the NECN catchment to Dr Weatherhead and/or Dr Frew. A proforma is completed and emailed to the MDT Co-ordinator for discussion at the next CTCL MDT. An outpatient appointment is given for the same date (when necessary) to permit joint clinical and pathological review of the patient often essential for accurate diagnosis of CTCL. Patients who need an immediate treatment decision are not delayed until the next available MDT. These patients are discussed outside the meeting with necessary actions taken and then discussed at the next MDT retrospectively.

**Patient Pathways**

Details of the Cutaneous T-Cell Lymphoma pathway can be found at Appendix 2.

**Operation of the CTCL MDT: (11-2J-405)**

Time and Place – the CTCL MDT is incorporated into the monthly CTCL clinic between 11-11.30. Patients are reviewed prior to the MDT for clinical assessment and then immediately following the MDT for feedback, confirmation of the diagnosis and the agreement of a management plan.

MDT Co-ordinator – circulates a list of patients to be discussed at the meeting by e-mail to all members of the MDT prior to the meeting. CTCL patients for discussion are notified to the MDT co-ordinator by completion of an electronic proforma and include all newly diagnosed patients with CTCL from the NECN catchment population.

CTCL MDT outcomes are electronically recorded and circulated. A record of the MDT decision is kept in the MDT file and a hard copy is placed in the patient’s notes. A copy of the MDT outcome form is at Appendix 3. *(11-2J-408)* The MDT minutes are a source of information for audits.

Matters relating to operation of the CTCL MDT are discussed at the combined CTCL MDT Annual General Meeting.

**Key Workers:**

As patients with CTCL are drawn from a wide area, the key worker will often be the Specialist Nurse from the Haematology or Dermatology Team at their local hospital. Patients from the Newcastle catchment area will have a key worker appointed as for other lymphoma patients. The Key Worker Policy can be found at Appendix 4.
Patient Information: (11-2J-409)

Written information is available for patients including information on TSEI (total skin electron beam therapy), Interferon alpha, Lymphomatoid papulosis, Mycosis Fungoidies and CTCL in general. Patients can also access further information via the websites listed below:

- The British Association of Dermatologists website have a variety of leaflets and info for patients [http://www.bad.org.uk/site/578/default.aspx](http://www.bad.org.uk/site/578/default.aspx)

Feedback from patients is obtained by regular patient surveys.

Relationship with NSSG:

The CTCL MDT relates primarily to the NECN Haematology NSSG via Dr John Frew. There are no formal links at present with the NECN Skin NSSG but the increased involvement of the skin cancer nurse specialist is expected to improve communication when necessary.

Cancer Research Network:

There are no current clinical trials approved by the NSSG for Mycosis Fungoides (11-2J-410).
## Appendix 1  Job Plan – Dr J Frew

<table>
<thead>
<tr>
<th>Day</th>
<th>morning</th>
<th>afternoon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>08-09 Admin</td>
<td>14-17 OPD Clinic</td>
</tr>
<tr>
<td></td>
<td>09-13 Radiotherapy Planning</td>
<td>17 - 18.30 Admin</td>
</tr>
<tr>
<td>Tuesday</td>
<td>08-09 Admin</td>
<td>13.30 - 17.00 Brachy/SPA alternate</td>
</tr>
<tr>
<td></td>
<td>09-13 Floor clinic</td>
<td>weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17-17.30 Admin</td>
</tr>
<tr>
<td>Wednesday</td>
<td>08-08.30 Admin</td>
<td>14-15 Trials clinic</td>
</tr>
<tr>
<td></td>
<td>08.30-10 Ward Round</td>
<td>15-16.30 Lymphoma MDT</td>
</tr>
<tr>
<td></td>
<td>10-13 Lymphoma clinic</td>
<td>16.30-17 Admin</td>
</tr>
<tr>
<td></td>
<td>(MYCOSIS FUNGOIDES CLINIC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(first Thurs every month)</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>08-09 Admin</td>
<td>14.30-17 urology MDT</td>
</tr>
<tr>
<td></td>
<td>09-13 OPD urology clinic/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MYCOSIS FUNGOIDES CLINIC (first Thurs every month)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17-18 Admin</td>
</tr>
<tr>
<td>Friday</td>
<td>08-09 Admin</td>
<td>SPA 5.30pm</td>
</tr>
<tr>
<td></td>
<td>09-10 Trials meeting every 4 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-11 Lymphoma aiplanning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11-13.30 Lymphoma MDT</td>
<td></td>
</tr>
</tbody>
</table>
Referral to local dermatologist by GP

Most skin lymphomas are not suspected by the GP and hence not subject to the 2 week rule

Patient seen in local Dermatology outpatient clinic

CTCL suspected?

Yes

Patient reassured and discharged

No

Biopsy taken and sent to pathology. Patient given appointment for two weeks

Patient attends clinic for Pathology Results (provisional).

CTCL confirmed?

Yes

Discussed by local skin or lymphoma MDT then referred to Newcastle CTCL MDT

ALL new CTCL diagnoses are discussed at the CTCL MDT +/- integrated patient review

Yes

TSEI, PUVA or systemic treatment at Newcastle

Recurrence

No

Biopsy sent to RVI for second opinion and/ or further investigations

Patient reassured and discharged or follow up arranged

Appendix 2

Recommendations communicated promptly to patient and referring Dr

PUVA or systemic treatment at referring hospital
Newcastle Specialist Haematology Network MDT Referral Proforma

(Highlighted areas are essential information for the MDT – Please complete)

<table>
<thead>
<tr>
<th>For Meeting On: 26/7/13</th>
<th>Diagnosis: Cerebral Lymphoma</th>
<th>New Patient: NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td>Last reviewed at MDT: 7/6/13</td>
</tr>
<tr>
<td>Infection Risk: MRSA</td>
<td></td>
<td>Referring Hospital: NCCC</td>
</tr>
<tr>
<td>D.O.B:</td>
<td></td>
<td>Referring Consultant:</td>
</tr>
<tr>
<td>Hospital No:</td>
<td></td>
<td>Dr Lewis</td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
<td>Deputy Presenting:</td>
</tr>
<tr>
<td>Staging Radiology: n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compare Scans: n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Cutaneous Lymphoma: n/a</td>
<td></td>
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</tr>
</tbody>
</table>

Clinical History:
Known CNS lymphoma
Recurrence of R leg numbness
Mri brain may 2013 complete response brain disease
New sensory level t4 level and bilateral leg numbness and weakness
Urgent mri spine probable disease intra medullary t3to 5
Completed 20Gy in 5# to T2-T6 and 30Gy in 15# to whole spine 17/6/13.
Symptoms improved and at NTGH rehab where numbness L5/S1 and right lower leg weakness of 3/5 recurred. Was on reducing
dose of dex but increased in view of worsening symptoms.
Repeat MRI spine from 22/7/13 to be reviewed.

Radiology:

Histology:

|-------|--------|-------|------|-------|-------|-------|------------|-------|--------|-------|-------|-------|

Special Blood Requirements:
<table>
<thead>
<tr>
<th>Clinical Trial Available: n/a</th>
<th>If No why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, Patient Entered into Trial: n/a</td>
<td>Name of Trial:</td>
</tr>
<tr>
<td>If Patient Not Entered into Trial Please State Reason:</td>
<td>Patient declined to enter trial:</td>
</tr>
<tr>
<td>Patient not eligible for trial:</td>
<td>Other: (Please state)</td>
</tr>
</tbody>
</table>

Classification of Indication for HSCT: Standard of care
Conditioning Therapy:

Proposed HSCT Date:
Donor Search Initiated: n/a

Other Info:

**Question for MDT:**

Review MRI spine 22/7/13; ? disease status.

---

**TO BE COMPLETED AT MDT MEETING**

MDT Outcome:

---

<table>
<thead>
<tr>
<th>Decision to Treat Date:</th>
<th>First Definitive Treatment Date:</th>
</tr>
</thead>
</table>

*Completed MDT referral proforma must be Emailed or Fax to the MDT co-ordinator before 12 noon on the Wednesday before the required meeting.*

Email:  Tnu-tr.HaematologyMDT@nhs.net
Phone: 0191 21(37286)  Fax: 0191 2231491
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Operational Policy for Named Key Worker
for Cancer Patients

Effective: November 2009
Review: November 2013

1. Policy Aim
Cancer care is complex; spanning health and social care settings and often requires the involvement of those in primary, secondary and tertiary care together with those in statutory and voluntary organisations. As Health Care Professional involvement is often sustained over many years, from diagnosis to end of life, there is a need to ensure integration and co-ordination of care, throughout the patient’s cancer journey. The Manual for Cancer Services (DoH 2004) introduced the concept of key worker and this was subsequently supported by national guidelines (NICE 2004).

As these recommendations support the identification of this person or persons, this policy aims to ensure that patients who are diagnosed with cancer within the organization are allocated an appropriate health care professional to be their key worker and that the roles and responsibilities of this individual are standardized within the organization.

2. Policy Scope
This policy relates to cancer patients who have been referred to one of the Trust’s site specific multi-professional cancer or palliative care teams. Although this policy primarily applies to adult cancer patients the ethos and principles would generally apply to patients managed within paediatric oncology.

3. Objectives
- Define the role of the Key Worker.
- Guide tumour specific multi disciplinary teams (MDTs) in the identification and clarification of the most appropriate health professional to be designated as the patient’s Key Worker.
- Support tumour specific MDTs to incorporate the Key Worker role within their Operational policies / procedures / guidelines.

4. Definitions
The term key worker is defined as follows:
"a person who, with the patient’s consent and agreement, takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice” (NICE 2004)

The principle of the key worker model is that there is one person who acts as both a provider and coordinator of care. This individual will take responsibility
for ensuring the patient’s health and social care needs are met while optimising their quality of life and promoting well being.

The role of the key worker (with the patients consent)
- Provide a point of contact for the patient
- Assess (NECN 2009), develop and, where appropriate, provide individualised holistic care and support to the patient / family and their carer/s. (The key worker is also responsible for monitoring and evaluating their care)
- Co-ordinates

The patient journey ensuring interventions take place and results are subsequently communicated to the patient in a timely fashion.

The provision of timely and individualised information enabling patients / carers to make informed choices about their current and future health / care needs.
- Communicates with appropriate health care professionals / individuals in the hospital and community, including the primary care team.
- Case manage, in partnership with other individuals / agencies, the needs of the patient with cancer as they move between care settings along their pathway e.g. during non-surgical oncology interventions. This may require changing key worker according to agreed protocols
- Act as the patient’s advocate e.g. represents the patient’s views / concerns at the MDM.
- Maintains accurate documentation.

N.B. Within the organisation, in most instances, the tumour site specific Clinical Nurse Specialist will usually perform the key worker role. Any core MDT member may, at the request of the patient / carer, be asked to take on this role.

5. Operational Policy
5.1 All newly diagnosed patients and often patients with complex needs are discussed at tumour specific MDMs. During these meetings a patient’s named key worker is identified and this is recorded in the patient’s medical notes and within the MDM notes. Some patients may meet with, and be given the contact details of an oncology CNS at their initial hospital appointment, prior to their diagnosis. In these instances the MDT may only be required to confirm and record this information within the patients and MDM notes.
5.2 The key worker is responsible for advising the patient as to their role and, having acquired consent, provide them with their contact details using the Cancer Network’s key worker card (Appendix1). (Prior to diagnosis as identified above, a patient may have initially been given a CNS’s contact details via a business card / information leaflet).
5.3 Appropriate professionals / agencies will be informed, as required, in writing of the details of the patient’s key worker. A GP will be advised of the patient’s key worker at diagnosis in accordance with the MDT’s operational policy.
5.4 The impact / effectiveness of the key worker will be regularly evaluated and audited within regular patient satisfaction surveys.

5.5 Transfer – The needs of patients invariably change over time. It is therefore essential that the most appropriate professional takes responsibility for the ongoing management of a patient within their pathway without compromising continuity of care. The referral of the patient to another key worker should always be undertaken in consultation with the patient and the health care professional who is proposing to become the patient’s key worker. The patient must be involved in the initial discussions, advised of the rational for referral, and providing they are in agreement, provided with the new key worker’s name, title and contact details. This information must be documented in the patient’s notes.

5.6 Discharge - Some patients may reach a point when they no longer require a key worker i.e. those patients who have completed curative treatment. The discharge of a patient should also be undertaken in consultation with the patient who should also be advised to contact their GP if they have any concerns. This information must also be documented in the patient’s notes.

5.7 Training and preparation for the key worker role - In most instances the key worker should possess:

- Accredited advanced communications skills training.
- Specialist knowledge of the specific cancer, its treatments and the disease trajectory, particularly relating to the stage of the patient’s journey that they are anticipating to be involved in.

N.B This policy should be read in conjunction with site specific MDM operational policies and patient pathways as these will provide specific information pertaining to key worker within each tumour group.

6. Monitoring and Review
The effectiveness of the policy will be monitored via the Cancer Peer Review process. Evaluating service user involvement, and specifically measures relating to key worker, is defined within each tumor group’s Cancer Peer Review measures.

7. Consultation and Ratification Process
This policy has been developed in consultation with the cancer team and medical and nursing staff from each of the site specific MDTs responsible for the management of cancer patients within the organisation. The policy has been approved by the Specialist and Senior Oncology Nurses Group and the Cancer Services Group. Comments on content / implementation should be directed to M Vincent, Nurse Consultant, Cancer Services. The document will be reviewed in 2 years or as determined by available evidence / modifications in practice.

8. References


9. Bibliography
National Institute for Clinical Excellence. Improving Outcomes Guidance (Tumour site specific) http://www.nice.org.uk/