# Cancer Services Performance Indicators

DRAFT

Data Collection Method 2017 – released 29 May 2018

VICTORIA State Government | Health and Human Services

# Contents

# 1. Introduction

The Victorian cancer service performance indicator program was established to measure progress with the implementation of Victorian Government cancer reform policy. The four key priorities for reform have been identified as the focus for service improvement at the Integrated Cancer Service (ICS) and state-wide levels:

- multidisciplinary care;
- care coordination across the cancer care pathway;
- supportive care;
- reducing unwarranted variation in practice.

The four priority areas are integrally linked to each other and initiatives may impact across priority areas.

Integrated Cancer Services were established within metropolitan and regional Victoria and there is one state-wide Paediatric Integrated Cancer Service (PICS). The development of ICS has supported networking and linking of hospitals, community and primary care services to ensure that cancer can be detected and treated by groups of health care professionals who have committed to working together to plan and coordinate patient care across specified geographic areas.

The cancer service performance indicator program was established in 2007 and has evolved over the years. The indicator program is one component of a number of cancer quality evaluation and benchmarking strategies including the state-wide multidisciplinary team meeting survey, cancer patient experience survey, cancer clinical indicators, clinical audit, program evaluation and cancer peer review. These quality and evaluation initiatives underpin the model for safety and quality in Victorian cancer services as outlined in *Clinical Excellence in Cancer Care* (DHS, 2007).

This performance indicator program is consistent with *"a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change"*. (NICE, 2002)

There are four performance indicators for which there is time series data:

- Documented evidence of multidisciplinary team recommendations
- Documented evidence of disease staging in the multidisciplinary team recommendations
- Documented evidence of communication of initial treatment plan to GP
- Documented evidence of supportive care screening.

The last state-wide cancer service performance indicator program audit reported against 2015 service provision and was undertaken in 2016. During 2017 an alternate audit activity was undertaken with a particular focus on supportive care. The specific aim of the point prevalence study was to assess the prevalence of cancer supportive care screening and to identify and assess the resulting actions for those screened and not screened in order to identify areas for local and state-wide improvement. This work will be reported Q3 2018 and include data on patients diagnosed in 2017.

This method paper outlines the performance indicators, sample definition and reporting requirements for an audit of 2017 service provision.

The indicator program provides a high-level report that is intended for distribution and reporting at health service, ICS and state-wide levels to monitor processes of care and identify where care can be improved. Indicators provide a flag rather than a definitive answer; they indicate potential problems that may require further investigation. The indicator program is designed to contribute to a culture of evaluation, benchmarking, feedback and continuous quality improvement.

The Cancer Strategy and Development section of the Department of Health & Human Services encourages ICS secretariats to produce a local level indicator report for participant member health services and to collect additional locally relevant performance data as part of this process.

The cancer service performance indicators are periodically reviewed and the methods refined as required to promote a robust and useful cancer service performance indicator program. The review includes feedback from the ICS secretariats including the data / quality staff administering the data collection.

# 2. Data collection period

The cancer service performance indicator program promotes the timely collection, analysis and reporting of patient data across all ICS. The data collection period is defined by:

- All ICS will conduct data collection once in 2017.
- Patients will be identified based on cancer diagnosis (actual or inferred) and treatment during 2017 for inclusion in the audit. This will allow for patients to have undertaken treatment planning and/or commenced treatment.
- All ICS will receive a data collection file pre-populated with details of their patient sample.

The following table (Table 1) outlines the timeframes for the audit round for 2017.

**Table 1: Schedule for data collection and submission of data to DHHS**

| 2017 data collection schedule | Audit round |
|---|---|
| Tumour streams to be included in audit | All tumour streams |
| **Submit audit data** | **3 Sep 2018** |
| Data collection | 29 May to 31 Aug 2018 |
| Cancer diagnosis date* timeframe | 1 Jan 2017 to 31 Dec 2017 |

*diagnosis date for audit may be actual or inferred

# 3. Patient sample

The cancer service performance indicator program requires a consistent method for the identification of the patient sample, ensuring an adequate sample size. The target population for the indicator program is newly diagnosed Victorian[1] cancer patients meeting the criteria outlined below. A centralised sample selection process will identify patients for inclusion in the audit using the Victorian Admitted Episode Dataset (VAED). It is acknowledged that there are still limitations to this method as this will not be based on the linked VAED-Victorian Cancer Registry (VCR) data or capture patients who have only been treated with radiotherapy or oral therapy or who are under active surveillance alone.

[1] Victorian cancer patients are those receiving cancer treatments at a Victorian health service where their usual residence is a Victorian address.

## 3.1 Identification of the patient sample

The Victorian Admitted Episode Dataset (VAED) will be used to identify patients for the audit.

- ICD-10 diagnosis and procedure codes (provided in Attachment 1) will be used to identify a patient with a cancer diagnosis who has undergone treatment. The use of these codes will allow ICS to identify patients who have had treatment and not just watchful observation within the required timeframe and locally.
- Selection will ensure each patient has not had a prior admission for the same ICD cancer code/s within the prior three years (i.e. are newly diagnosed).
- The ICD-10 codes will include only malignant codes; benign, in-situ and uncertain tumours will continue to be excluded.
- The diagnostic codes will be used to categorise patients into established tumour stream groupings, for example genitourinary instead of prostate.
- For this 2017 round the sampling for PICS will be managed separately.

## 3.2 Size and type of patient sample

The cancer service performance indicator program requires an adequate sample size to ensure the results are meaningful and can identify change in performance over time. Clinical epidemiological advice was sourced by Cancer Strategy and Development to estimate the required sample size. The sample size required to estimate percentage to within +/-5% with 95% confidence was considered. The final sample for the regional ICS is lower than the epidemiological advice recommends but this is in part to account for the need for regional patients to travel for the treatment of some tumour streams. Similarly the metropolitan ICS sample is somewhat inflated to account for the referral of patients from outside of the ICS for rarer tumour stream care.

The minimum number of records to be audited has been specified in the table following (Table 2). If this number cannot be achieved either overall or by tumour stream, a note to this effect (including an explanation as relevant) is to be provided to the department when the data are submitted. All identified pancreatic cancer patients in the data collection form are to be audited in addition to the specified minimum sample. Note that the pancreatic sample will exclude some cases due to the case identification process (will exclude Death Certificate only cases) and to ensure utility (will exclude patients who die within 4 weeks of diagnosis/first known contact).

**Table 2: 2017 Audit Requirements - minimum record numbers and tumour streams and due date**

| ICS | Minimum Records | Tumour Streams | Date Due |
|---|---|---|---|
| Metro | 650 | All* | |
| Regional | 250 | All* | **3-Sep-18** |
| Paeds | 90 | Paediatrics | |
| Total N | 3290 | | |

***Notes to Table 2:***

- *Record numbers are a minimum and ICS are encouraged to capture data above the required minimum if considered important locally. Provided sample files will include additional cases above the sample size.*
- *All* = whilst the selection of cases will aim to ensure representative data capture across the ICS and/or tumour streams it is important to avoid any obvious and/or systematic bias in actual data collection which would skew results.*

- *In order to audit a representative sample of pancreatic cancer (noting the exclusions above) cases more than the minimum number of records will need to be reviewed.*

# 4. Data source

**The Central Medical Record**

The central medical record is the source of data for the indicator program. The central medical record is considered the main medical record for a patient, and may be electronic or paper-based. It should be a central repository to ensure easy access to all relevant information. The central medical record reinforces the standard that patient information should be available to all multidisciplinary team members in a central location to promote safe care.

To promote a consistent indicator methodology, information held in locations other than the central medical record (such as MDM software, databases, stored in ICS offices or other offices) should not be included as a source of data unless otherwise recognised by the health service as a legal component of the patient's central medical record. ICS are to advise the department where these systems occur. Printouts from databases and software programs that are then incorporated / filed in the central medical record are acceptable.

**Health Services**

The patient sample will be identified from a range of member health services and data collected from these services. Any public or private health service included in the ICS Memorandum of Understanding (MOU) may be considered for auditing if the facility provides a reasonable volume of treatment services such as surgery, chemotherapy or radiotherapy. For example a regional hospital providing diagnostic services rather than active treatment will be excluded. ICS will be required to confirm to the department (prior to case selection) those health services within their catchment that are participant health services (ie. MOU signatories with audit and data sharing arrangements agreed) for the purpose of the audit.

The auditing of a range of health service sites is required each audit cycle. For regional ICS the main host site should be included each data collection cycle and contribute at least 50% of patient cases each cycle. Alternatively (depending on relative caseloads) the top two cancer service providers in the region should account for at least 70% of the sample. This approach provides an emphasis on the monitoring of the main regional cancer centres in each regional ICS. Each ICS can provide advice on recommended stratification of local cases/health services for sampling.

The Paediatric ICS should audit across two of its three member health services each data collection cycle, Peter MacCallum being exempt as it does not provide primary treatment for paediatrics.

# 5. Exclusion criteria

The cancer service performance indicator program promotes appropriate and consistent collection of data.

The following exclusion criteria apply:

- Patients treated across more than one ICS should only be counted once and this should be at the site where the patient received their primary treatment including their treatment planning. If a multidisciplinary treatment recommendation from a health service in another ICS is located in the

patient medical record (where it is not part of a formal linked MDM), this patient should be excluded from the data collection.

- Correspondence regarding treatment recommendations from another health service/ICS cannot be used as evidence for a different health service/ICS except under a formal intra-ICS outreach service arrangement.
- Non-Victorian residents treated in Victorian health services.

# 6. Performance indicators

The performance indicators being evaluated by the current medical record audit program for 2017 are:

6.1 documented evidence of multidisciplinary team recommendations,

6.2 documented evidence of disease staging in the multidisciplinary team recommendations

6.3 documented evidence of patient Eastern Cooperative Oncology Group (ECOG) performance status in the multidisciplinary team recommendations

6.4 documented evidence of communication of initial treatment plan to GP

6.5 documented evidence of supportive care screening

In addition, the audit will capture some key dates which will facilitate assessment of derived performance indicators:

- date of the first documented multidisciplinary team discussion
- whether the first documented multidisciplinary team discussion was prospective (Y / N).

For the 2017 CSPI cycle the adult sector ICS will be required to audit incident pancreatic cancer cases (with the exception of patients who died within 4 weeks of diagnosis/first contact as these patients (by definition) will not be able to adhere to the OCP timeframes) to inform the upcoming tranche of Optimal Care Pathway implementation. The required sample of cases will be included in the pre-populated data collection form. Four additional data points for these patients are to be collected:

- referral to the first treating/admitting service – date of referral and date first seen by Health Service
- stage of disease - where stage is documented
- date of referral to/first documented consultation by palliative care (whichever comes first)
- whether or not the patient's record documents that the patient has an advance care plan.

Each performance indicator is discussed below, including rationale, acceptable and unacceptable evidence for the performance measure, along with the target for this audit cycle. The tumour stream, tumour site and the health service site and patient medical record number will be pre-populated on the data collection forms. The performance indicators will be presented as results by ICS and by tumour stream.

## 6.1 Documented evidence of multidisciplinary team recommendations

**Rationale:** Multidisciplinary care is a key component to providing best practice care for cancer patients. Documentation of multidisciplinary team recommendations in the medical record ensures such information is accessible to all team members. *Achieving best practice cancer care – A guide for implementing multidisciplinary care* (DHS, 2007) states 'recommendations are recorded in the patient's medical record and signed by the presenting or treating clinician'. Effective communication between all team members involved in a patient's care is critical for maximising patient care coordination. This performance measure provides an indication of the level of documentation of multidisciplinary team recommendations in the central medical record.

| | |
|---|---|
| *Numerator* | Total number of new cancer patients with documented evidence of multidisciplinary team recommendations |
| *Denominator* | Total number of new cancer patients audited |

***Target for 2017:*** **80 per cent**

*Victoria's Cancer Action Plan 2008-2011* (VCAP)[2] ) states 'we will work to increase the number of newly diagnosed cancer patients that have a documented multidisciplinary care treatment plan … with the aim of achieving 80 per cent documentation by 2012' (p68). MDM discussion of newly diagnosed cancer patients is also highlighted as best practice in the Optimal Care Pathways[3].

**Acceptable evidence:**

- Written summary of recommendations located in the central medical record.
- MDM outcomes or recommendations form filed in the central medical record.
- Printout from MDM management software of recommendations and filed in the central medical record.
- Recommendations outlined in correspondence between medical clinicians with a copy filed in the central medical record.

**Not acceptable evidence:**

- Reference in the central medical record to an MDM discussion having taken place, but without the recommendations being outlined.
- A brief statement such as "medical oncology opinion" or similar.

*Note*: This performance indicator relates to 'team recommendations' whereas the VCAP target relates to 'treatment plan'. This measure highlights the process required to achieve the VCAP target. Other evaluations such as the multidisciplinary survey process and quality audits will supplement the evaluation of policy implementation.

[2] Although Victoria's cancer plan 2016-2020 (released 2016) updates strategic priorities for cancer control it does not set specific performance targets such as those established through VCAP. This monitoring framework remains based on VCAP targets.

[3] https://www.cancervic.org.au/for-health-professionals/optimal-care-pathways

## 6.2 Documented evidence of cancer staging in the multidisciplinary team recommendations

**Rationale:** Staging is the cornerstone of treatment planning. MDT meetings across the state are working hard to include appropriately credentialed specialists to inform both clinical and histopathological staging. The optimal care pathways outline staging requirements for each tumour stream. Staging should be recorded using the AJCC staging (TNM), SEER or other accepted staging system for the disease type as endorsed by local tumour groups or MDTs. One example of a well-accepted 'other' staging systems is 'Dukes staging' for colorectal cancer, another is 'FIGO' for gynaecological cancer.

| | |
|---|---|
| *Numerator* | Total number of new cancer patients with documented evidence of cancer staging in the MDT recommendations |
| *Denominator* | Total number of new cancer patients with documented MDT recommendations |

***Target for 2017:*** **100 per cent**

**Acceptable evidence:**

- As per evidence required for indicator 6.1 including a diagnosis with clinico-pathological stage noted.
- Descriptions of stage (SEER): localised, regional (locally advanced, with nodal involvement) or distant (advanced, metastatic) are all acceptable.
- For Small Cell Lung Cancer (SCLC) the use of the terms; invasive, limited or extensive are appropriate.
- For Haematology staging systems listed on p 17 are acceptable
- For CNS tumours the WHO grading system of grades I-IV is acceptable

**Not acceptable evidence:**

- The use of descriptive terms such as extensive or invasive without the use of the staging system defined above (except SCLC).

*Notes:*
The denominator is the numerator for indicator 6.1.
SEER: Surveillance Epidemiology and End Results. For further information http://seer.cancer.gov/

## 6.3 Documented evidence of patient ECOG performance status in the multidisciplinary team recommendations

**Rationale:** ECOG performance status scales and criteria are used by doctors and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis. The Improving Cancer Outcomes Act 2014 also requires recording of ECOG status in notifications sent to the state-wide Victorian Cancer Registry to enable appropriate risk adjustment and comparative analyses of patient health outcomes. Documentation of ECOG in the multidisciplinary team recommendations would enable easy identification of ECOG for notifying VCR.

| | |
|---|---|
| *Numerator* | Total number of new cancer patients with documented evidence of ECOG performance status (grade) in the MDT recommendations |
| *Denominator* | Total number of new cancer patients with documented MDT recommendations |

***Target for 2017:*** **100 per cent**

**Acceptable evidence:**

- As per evidence required for indicator 6.1 including a diagnosis with ECOG performance status (grade) noted.
- The following table displays the ECOG performance status scale and criteria:

| ECOG PERFORMANCE STATUS* | |
|---|---|
| **Grade** | **ECOG** |
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours |
| 3 | Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair |
| 5 | Dead |

* As published in Am. J. Clin. Oncol.:
*Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982.*

*Notes:*

- The denominator is the numerator for indicator 6.1.

## 6.4 Documented evidence of communication of initial treatment plan to GP (or paediatrician)

**Rationale:** The GP (or paediatrician) is a key member of a team of care providers for patients with a new diagnosis of cancer. Timely communication of a patient's treatment plan to the GP or paediatrician will assist in enhancing the quality and coordination of care for the patient. An initial treatment plan is a single document that should include both confirmation of the cancer diagnosis and details of the next steps for the care of the patient. This measure provides an indication of the level of documentation of communication of the treatment plan to the GP or paediatrician.

| | |
|---|---|
| *Numerator* | Total number of new cancer patients with evidence of communication of the treatment plan to the General Practitioner (or paediatrician) |
| *Denominator* | Total number of new cancer patients audited |

***Target for 2017:*** **100 per cent**

**Acceptable evidence:**

Evidence of communication (listed below) should be dated/sent within two weeks of multidisciplinary discussion or commencement of treatment date (whichever comes first):

- Letter to, or copied to the GP or paediatrician that communicates the treatment plan (copy located in the central medical record).
- Summary of MDM recommendations sent to the patients GP or paediatrician (copy located in the central medical record).
- Record of telephone call or email in the central medical record if it is stated that the telephone call or email outlined the treatment plan
- Discharge summaries in the central medical record for the GP that provide details of the patient's treatment plan.

**Not acceptable evidence:**

- Medical documentation (letters or discharge summaries) that do not provide details of the treatment plan.

*Note:* Where health services solely hold electronically generated discharge summaries in ICT systems such as Cerner and do not add a copy to the central medical record, this is acceptable as evidence. This information is to be noted in the data collection template.

## 6.5 Documented evidence of supportive care screening

**Rationale:** Supportive care, which addresses a wide range of needs across the continuum of care for those affected by cancer, is increasingly seen as a core component of cancer care. Improving supportive care for those affected by cancer is one of the priority areas for the ICS. This measure provides an indication of the level of documented appropriate supportive care screening.

| | |
|---|---|
| Numerator | Total number of new cancer patients with documented evidence of supportive care screening |
| Denominator | Total number of new cancer patients audited |

***Target for 2017: 8*0 per cent**

The relevant target documented in VCAP states: 'We will aim to document supportive care screening for 50 per cent of newly diagnosed cancer patients by 2012'. Following interim results of the supportive care point prevalence study indicating that 63 per cent of patients have a documented supportive care screen the target for this indicator has been increased to 80 per cent.

**Acceptable evidence:**

- For adults, a completed, validated, supportive care screening tool that assesses the five inter-related domains of care (physical, social, psychological, spiritual and information) located in the central medical record (such as the Distress Thermometer and problem checklist or the Peter Mac Supportive Care Needs Tool). Evidence of validation is usually available in the published literature.
- For paediatrics, the recently validated screening tool being used in the clinical setting in Australia. The use of the social work screening tool will **no longer** be considered adequate evidence. The results will continue to be reported separately from the state-wide data.
- If the medical record includes documentation that a patient declined to complete screening, this will be considered that the individual has been screened. However, it must be noted in the comments section that screening was declined.

**Not acceptable evidence:**

- Informal referral notes in the central medical record.
- A note stating that screening was undertaken without detailing outcomes.
- Evidence of supportive care assessment without evidence of screening.
- A supportive care screening tool that is located in a place other than the central medical record.

# 7. Data elements

## 7.1 Tumour stream

**Rationale:** To enable analysis of cancer performance indicators by tumour stream thus directing quality improvement activities to areas of need. ICS will be receiving a pre-populated data collection form with tumour stream (and type) for all cases recorded.

**MICS & RICS Options:**

- breast
- central nervous system
- colorectal
- endocrine and thyroid
- haematological
- genitourinary
- gynaecological
- head and neck
- lung
- upper gastrointestinal
- skin

**PICS Options:**

- haematological cancer
- central nervous system (CNS) tumour
- solid tumour.

## 7.2 Health service / hospital site

**Rationale:** Auditing medical records from a range of health services will better represent the care provided to those affected by cancer throughout Victoria.

Auditors will be provided with sample lists which include a record of the name of, and the VAED campus code, for the health service / hospital site housing the medical record. ICS are not to amend these details but can record comments in the data collection tool if required.

## 7.3 Additional dates/data items

**Rationale:** To enable analysis of timeliness of care ICS will be required to record some key dates as documented in the medical record into the Audit data collection tool. These dates include:

- date of the first documented multidisciplinary team discussion
- whether the first documented multidisciplinary team discussion was prospective (Y / N). Prospective is defined as whether the MDM discussion date precedes definitive treatment dates (excepting where surgery date = date of diagnosis which for this audit will be deemed prospective)
- date of referral to the first treating service, including palliative care (for pancreatic cases only)
- stage of disease at presentation as documented (for pancreatic cases only)
- date of referral to/first documented consultation by palliative care (whichever comes first) (for pancreatic cases only)
- whether or not the patient's record documents that the patient has an Advance Care Plan (Y/N) (for pancreatic cases only).

# 8. Submission of data

The data is to be collected using the Excel file, *Data Collection Template 2017* (this will be supplied pre-populated with patient sample details). Absolutely no changes to this template or format are permitted. All data from each cycle will be listed on this sheet with the tumour streams grouped. ICS are to add or remove lines depending on the number of patient medical records audited. A brief comments section is provided for data explanation, complexity of interpretation concerns, notes or suggestions.

Data and information must be reviewed locally and be approved by the program manager/director prior to submission. It should be noted that the Department provides funding to the ICS to enable audits to be undertaken and compliance is a requirement of the ICS funding.

The ICS are also reminded that the collection and reporting of accurate data is required as per the Financial Management Act 1994. Adequate data must be submitted and notification of any data errors must occur in a timely manner to the Cancer Strategy and Development section.

# 9. Definitions

**Advance care plan**

*The Advance care planning strategy 2014-2018* (2014) provides guidance for health services in Victoria to develop and implement advance care planning. This has been formalised through *The Medical Treatment Planning and Decisions Act 2016.* The advance care plan belongs to the person. They keep the original documentation but the health service needs to ensure a record of the conversation and/or advance care plan is retained in the medical record.

**Financial Management Act 1994 (Standing Order 3.4.13)**

Public Sector Agencies must take reasonable steps to ensure that data is accurate and adequate when it is collected, and that its accuracy is maintained during subsequent use and reporting. The standard for accuracy and adequacy is to be determined by reference to what is expected for the purposes of effective risk management and financial and operational reporting.

Access: http://bfm.dtf.vic.gov.au/CA25713E0002EF44/pages/financial-management-compliance-framework-standing-directions-and-associated-rules

**ICD-10 coding**

International Statistical Classification of Diseases and Health Related Problems, 10th Revision, 2007.

**Multidisciplinary care (MDC)**

An integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient (National Breast Cancer Centre, 2005).

**Multidisciplinary meeting (MDM)**

A scheduled meeting of core and invited team members for the purpose of prospective treatment and care planning of newly diagnosed cancer patients as well as those requiring review of treatment plans or palliative care. Note: Retrospective case review is a valuable approach to multidisciplinary learning, review and audit of prospectively planned treatment and care; however, it cannot replace multidisciplinary prospective treatment and care planning (Department of Human Services, 2006).

**MDM Software**

ICT systems designed specifically for the management and administration of cancer care coordination services and multidisciplinary team meetings (e.g. CANMAP).

**Multidisciplinary team (MDT)**

Team comprising health care practitioners required for all treatment and care decisions in a particular tumour stream. Team members can be from the primary, community and acute sectors, public and private sector and can be from several health services. Core team members will commonly include radiologists, pathologists, general practitioners, surgeons, physicians, medical oncologists, palliative care practitioners, radiation oncologists, social workers and/or psychologists, oncology nurses, data managers, allied health and research nurses (Department of Human Services, 2006).

**Performance Indicator**

A performance indicator is a statistic or other unit of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved or the quality of the processes leading to the outcome. Performance indicators are one source which informs an evaluation process and may help to identify or flag further issues or questions.

**Referral**

The patient management frameworks provide details of referral requirements for a variety of tumour types. A referral letter, form or note must be signed and dated by the referring practitioner.

**Staging systems**

- TNM Classification of Malignant Tumours (UICC) and American Joint Committee on Cancer (AJCC) Cancer Staging Manual
- Durie & Salmon for multiple myeloma staging
- French-American-British (FAB) for leukaemia classification
- Australian Clinico-Pathological Staging (ACPS) System for colorectal cancer
- International Federation of Gynecologists & Obstetricians (FIGO) for gynaecological cancers
- Dukes/Modified Dukes for colorectal cancer
- Ann Arbor staging system for lymphomas
- Binet Staging Classification for chronic lymphocytic leukaemia
- Rai staging system for chronic lymphocytic leukaemia
- Chronic Myeloid Leukaemia (CML) staging system
- International Staging System (ISS) for myeloma
- WHO grading system Grades I – IV for CNS tumours

**Supportive care**

Supportive care includes five inter-related domains of care: physical, social, psychological, spiritual and information (Department of Human Services, 2009). Physical domain includes a wide range of physical symptoms that may be acute, relatively short-lived or ongoing, requiring continuing interventions or rehabilitation (NBCC and NCCI 2003). Social domain includes a range of social and practical issues that will impact on the individual and family such as the need for emotional support, maintaining social networks, and financial concerns (NICE 2004). Psychological domain includes a range of issues related to the person's mental health wellbeing and personal relationships (NBCC and NCCI 2003). Spiritual domain focuses on the person's changing sense of self and challenges to their underlying beliefs and existential concerns (NICE 2004). Information domain transects the above domains with people needing to access information about their disease and treatment, support services and the health system overall (NBCC and NCCI 2003).