Integrated Impact Assessment Report for Service Specifications			
Service Specification Reference Number	Service Specification 1642		
Service Specification Title	Sarcoma Proposal **for routine commissioning**		
Lead Commissioner	Rupi Dev	**Clinical Lead**	Jeremy Whelan
Finance Lead	Justine Stalker Booth	**Analytical Lead**	Not applicable.

Integrated Impact Assessment – Index		
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About this Impact Assessment: instructions for completion and explanatory notes
• Each section is divided into themes. • Each theme sets out a number of questions. • All questions are answered by selecting a drop down option or including free text. • Free text boxes are provided to enable succinct relevant commentary to be added which explains the rationale for response or assumption. Please limit responses to 3 sentences of explanatory text. • Data in this document is either drawn from one of the relevant service specification documents or a source for the information is provided. • Where assumptions are included where data is not available, this is specified.

Section A - Activity Impact	
A1 Current Patient Population & Demography / Growth	
A1.1 Prevalence of the disease/condition.	Sarcomas are rare cancers and there are over 100 different subtypes. There are approximately 3,800 new cases of sarcoma diagnosed each year, making up 1% of the total cancer diagnoses in the UK. Sarcomas are grouped into either soft-tissue sarcomas or primary bone sarcomas; of these soft-tissue are more common than primary bone. *Source: Service Specification Proposition section 3.1*
A1.2 Number of patients currently eligible for the service according to the proposed service specification commissioning criteria.	The proposed sarcoma service specification covers all patients with a sarcoma and combines the existing soft-tissue sarcoma service specification and primary bone sarcoma service specification. Whilst both types of sarcoma will be covered by a single service specification, primary bone sarcoma services will continue to only be commissioned from a smaller number of centres relative to the number that are commissioned to treat soft tissue sarcomas. Services for primary bone sarcomas will no longer be categorised as Highly Specialised Services, though they will continue to be commissioned nationally as a Specialised Service. The estimated number of patients eligible for the service according to the proposed service specification commissioning criteria is 3,800 (of which 3,300 patients are diagnosed with a soft tissue sarcoma (including 700 cases of GIST) and 500 patients with a bone sarcoma). *Source: Service Specification Proposition, section 3.2*

A1.3 Age group for which the service is proposed according to the service specification commissioning criteria.	All ages The sarcoma service specification should be read in conjunction with the service specifications for children and young adult cancer services, radiotherapy and chemotherapy.
A1.4 Age distribution of the patient population eligible according to the proposed service specification commissioning criteria	In general, patients with a soft tissue sarcoma or bone sarcoma tend to be younger than the majority of cancer patients. 57% of soft tissue sarcomas affect those under 65 years and about a quarter of all bone sarcomas occur before the age of 30 years. Sarcomas make up 15% of all childhood cancers (0-14 years) and 11% of all cancer diagnosis in teenagers and young people (15-25 years). *Source: Service Specification Proposition, section 3.2*
A1.5 How is the population currently distributed geographically?	Not applicable – there are no significant differences in how sarcomas are distributed geographically.
A2 Future Patient Population & Demography	
A2.1 Projected changes in the disease/condition epidemiology, such as incidence or prevalence (prior to applying the new service specification) in 2, 5, and 10 years?	The incidence of bone sarcoma has been relatively stable over the last decade. If population levels stay consistent, then bone sarcoma incidence is projected to fall by 5% in the UK between 2014 and 2035 (Cancer Research UK, 2016). Data from Cancer Research UK (2016) indicates that bone sarcoma incidence is projected to be at 568 cases in 2035, equating to approximately 500 cases in England. Incidence rates for soft tissue sarcoma are expected to be consistent with ageing population trends only although some changes may be seen in

	the sub-types of sarcoma being recorded. *Source: Service Specification Proposition, section 3.3*
A2.2 Are there likely to be changes in demography of the patient population and would this impact on activity/outcomes?	Yes Aging population and changes in the demographics of the patient population could impact on activity. **Bone sarcoma** Age specific incidence rates for bone sarcoma are bi-modal, with incidence peaks observed in teenagers and young adults, as well as the elderly. Higher incidence rates of bone sarcoma were observed in males between 2004 and 2012, however this disparity between genders is no longer evident in more recent years. **Soft tissue sarcoma** The incidence of soft tissue sarcoma increases with age. The age specific incidence rate is highest in males aged 85 years. Age specific incidence rates for soft tissue sarcomas in females aged 45 to 59 years are slightly higher than those in males, due to the incidence of gynaecological sarcomas. There was no disparity in incidence rates between males and females for soft tissue sarcoma until 2012 where females had a significantly lower incidence rate than males (Public Health England). *Source: Service Specification Proposition, section 3.2*
A2.3 Expected net increase or decrease in the number of patients who will be eligible for the service, according to the proposed	Current activity levels for sarcoma are difficult to quantify due to known issues in recording and coding of these patients. Data from CRUK

service specification commissioning criteria, per year in years 2-5 and 10?	indicates that if population levels stay consistent, the incidence of bone sarcoma is expected to decrease between 2014 and 2035 by 5%. Incidence of soft tissue sarcoma is expected to be consistent with ageing population trends only. *Source: Service Specification Proposition, section 3.3*
A3 Activity	
A3.1 What is the purpose of new service specification?	Revision to an existing published service specification. It should be noted that the revised service specification is a merger of two existing service specifications, rather than a revision to a single service specification. See section B1.2 for further details on proposed changes.
A3.2 What is the annual activity associated with the existing pathway for the eligible population?	3,800 *Source: Service specification proposition section 3.2*
A3.3 What is the estimated annual activity associated with the proposed service specification proposition pathway for the eligible population?	3,800 *Source: Service specification proposition section 3.2*
A4 Existing Patient Pathway	
A4.1 **Existing pathway** Describe the current patient pathway and service.	Sarcomas are rare and complex diseases. As a result, surgery for primary bone sarcoma and for most soft-tissue sarcomas is already

	concentrated into designated providers. Currently in England there are 15 designated soft tissue surgery Specialist Sarcoma Centres, of which 5 are jointly designated for bone and soft tissue surgery. These Centres are responsible for hosting the sarcoma multi-disciplinary team (MDT) and providing a comprehensive sarcoma service including diagnosis, treatment and follow-up care. These Specialist Sarcoma Centres work on a network basis with Local Units. Sarcoma networks are referred to as Sarcoma Advisory Groups (SAGs) and are responsible for ensuring there are clear referral pathways and treatment protocols in place for the management of sarcoma care across their given network. There are currently 11 SAGs across England. Local Units are responsible for hosting site-specific MDTs and providing some aspects of the diagnosis, treatment and follow-up care of sarcoma patients, Units are usually situated within District General Hospitals, but they may be within other tertiary cancer centres that are not designated as Specialist Sarcoma Centre. All patients with suspected or confirmed diagnosis of sarcoma are expected to be referred to the sarcoma MDT for review and discussion. The MDT is expected to advise on the best treatment plan for the patient and the most appropriate care location. Treatment for patients with sarcoma may be delivered in the Centre or in other cancer centres as agreed by network protocols (i.e., the SAG). All surgery for bone sarcoma must be delivered in one of the five designated bone sarcoma Centres. However, while most soft tissue patients should also be in a designated Specialist Sarcoma Centre (for soft tissue), surgery for some forms of soft tissue sarcoma cancer (e.g., gynaecology, head and neck) that requires the surgical expertise of other MDTs may be performed outside of the Specialist Sarcoma Centre, by agreement of the SAG; follow-up care for these patients may also be delivered outside

	of the Specialist Sarcoma Centre in line with pathways and protocols agreed by the SAG. In addition, chemotherapy and radiotherapy services for sarcoma patients may also be delivered outside of the Specialist Sarcoma Centre, by agreement of the SAG. Follow-up care may be delivered in the Specialist Sarcoma Centre or in Local Units but in line with SAG agreed pathways.
A4.2. What are the current service access and stopping criteria?	Patients can be referred into the sarcoma service from primary, secondary and tertiary care providers through various admission routes including 2 week wait clinics, elective inpatient services and emergency routes. Patients continue to be managed by the service throughout their treatment and post-treatment. Patients are usually discharged from the service after a period of follow-up, in line with network agreed protocol.
A4.3 What percentage of the total eligible population are: a) Referred b) Meet any existing criteria for care c) Considered to meet any existing exclusion criteria	Draft data from NCRAS from 2015 indicates that between 45 – 65% of patients with a sarcoma are being recorded as being discussed in a specialist sarcoma MDT. However, it is noted that data capture and collection is an issue in sarcoma cancer and therefore the numbers could be higher. Anecdotal evidence from SAGs indicates the number of patients being referred into a specialist sarcoma MDT is higher and continues to grow. Approximately 40% of patients undergo surgical treatment for their sarcoma in a specialist sarcoma centre (NCRAS, 2015). Currently it is difficult to confirm if surgery performed outside of the centre is in line with local network agreements.

<table>
<tr><th colspan="2">A5 New Patient Pathway / New Service Specification</th></tr>
<tr><td>A5.1 What percentage of the total eligible population is expected to:
a) Be referred to the proposed service
b) Be eligible for care according to the proposed criteria for the service
c) Take up care according to the proposed criteria for the service
d) Continue care according to the proposed criteria for the service?</td><td>a) 3,800 patients
b) 100%
c) 100%
d) 100%

With the revised service specification, we expect all patients with a new diagnosis to be referred to the specialist MDT. All patients should have a care plan agreed which could include radical treatment or palliative care and treatment should be carried out in line with network protocols/agreements.

See section B1.2 for further details.</td></tr>
<tr><td>A5.2 Specify the nature and duration of the proposed new service or intervention.</td><td>Not applicable.</td></tr>
<tr><th colspan="2">A6 Service Setting</th></tr>
<tr><td>A6.1 How is this service delivered to the patient?</td><td><table>
<tr><td>Emergency/Urgent care attendance</td><td>☐</td></tr>
<tr><td>Acute Trust: inpatient</td><td>☒</td></tr>
<tr><td>Acute Trust: day patient</td><td>☒</td></tr>
<tr><td>Acute Trust: outpatient</td><td>☒</td></tr>
</table></td></tr>
</table>

	Mental Health provider: inpatient ☐ Mental Health provider: outpatient ☐ Community setting ☐ Homecare ☐ Other ☐
A6.2 What is the current number of contracted providers for the eligible population by region?	NORTH: 2 for Joint Bone and Soft Tissue; 4 for Soft Tissue alone. MIDLANDS & EAST: 1 for Joint Bone and Soft Tissue; 2 for Soft Tissue alone. LONDON: 1 for Joint Bone and Soft Tissue; 1 for Soft Tissue alone. SOUTH: 1 for Joint Bone and Soft Tissue; 3 for Soft Tissue alone.
A6.3 Does the proposition require a change of delivery setting or capacity requirements?	Not yet known See section B1 and B3.
A7 Coding	
A7.1 Specify the datasets used to record the new patient pathway activity.	*Select all that apply:* Aggregate Contract Monitoring * ☒

*expected to be populated for all commissioned activity	Patient level contract monitoring ☒ Patient level drugs dataset ☐ Patient level devices dataset ☐ Devices supply chain reconciliation dataset ☐ Secondary Usage Service (SUS+) ☒ Mental Health Services DataSet (MHSDS) ☐ National Return** ☐ Clinical Database** ☐ Other** ☐
A7.2 Specify how the activity related to the new patient pathway will be identified.	OPCS v4.8 ☒ ICD10 ☒ Service function code ☐ Main Speciality code ☐ HRG ☒ SNOMED ☐ Clinical coding / terming methodology used by clinical profession ☐
A7.3 **Identification Rules for Drugs:** How are drug costs captured?	Not applicable.

A7.4 **Identification Rules for Devices:** How are device costs captured?	Not applicable. .
A7.5 **Identification Rules for Activity:** How are activity costs captured?	Already correctly captured by an existing specialised service line (NCBPS code within the PSS Tool). NCBPS01L Soft Tissue Sarcoma NCBPS01L Bone Sarcoma
A8 Monitoring	
A8.1 **Contracts** Specify any new or revised data flow or data collection requirements, needed for inclusion in the NHS Standard Contract Information Schedule. Please identify any excluded drugs or devices relevant to the service and their current status with regard to NHS England specialised services commissioning.	None
A8.2 **Business intelligence** Is there potential for duplicate reporting?	No
A8.3 **Contract monitoring** Is this part of routine contract monitoring?	Yes
A8.4 **Dashboard reporting** Specify whether a dashboard exists for the proposed intervention?	No A dashboard is planned for development and is awaiting prioritisation.

A8.5 **NICE reporting** Are there any directly applicable NICE or equivalent quality standards which need to be monitored in association with the new service specification?	Yes NICE Quality Standard for Sarcoma (NICE, 2015)
Section B - Service Impact	
B1 Service Organisation	
B1.1 Describe how the service is currently organised? (i.e. tertiary centres, networked provision etc)	See section A4.1
B1.2 Will the proposition change the way the commissioned service is organised?	Yes. The fundamental service model, with sarcoma services being governed through SAGs and provided by Specialist Sarcoma Centre(s) and Local Units has not been altered. The role of providers in delivering sarcoma care is largely unchanged and the revised service specification maintains existing standards relating to minimum Specialist MDT caseload volumes (which are based on 'new patients' discussed by the SMDT), as stipulated in the Improving Outcomes Guidance (IOG) for sarcoma. Whilst this does not constitute a change to the service specification, it is the case that during the implementation of the revised service specification, NHS England will be taking steps to understand and ensure compliance with these standards. The revised service specification aims to: • Clarify the role and structure of the Sarcoma Advisory Groups (SAGs) in managing and co-ordinating network arrangements for sarcoma care;

	• Clarify the role of the Specialist Sarcoma Centre and sarcoma MDT by mandating that all patients with a sarcoma cancer diagnosis be referred to the sarcoma MDT for case discussion; • Clarify the function of Local Units in the sarcoma care pathway and accurately describe their role in delivering not only diagnostic care but also treatment and follow-up care for sarcoma patients; • Clarify the working relationships between the sarcoma MDT and the children and teenager and young adult MDTs with a view to strength joint working between these MDTs and networks; and • Provide narrative on the care pathways for rarer forms of sarcoma cancer including stipulating network arrangement and minimum case numbers where appropriate to do so. As a consequence of implementing the service specification, the following changes to the organisation of commissioned services are expected: • **There should be an increase in the number of patients being referred into the Specialist Sarcoma MDT for discussion.** Data from NCRAS from 2015 indicates that between 45 – 65% of patients diagnosed with sarcoma are discussed at a Specialist Sarcoma MDTs. However, SAG Chairs have highlighted that there are a number of issues with data quality meaning that it is not possible to quantify precisely the impact. • **Some treatment activity may move between providers however the number of providers delivering sarcoma care is expected to remain unchanged**. The service specification aims to ensure sarcoma patients receive care in the most appropriate place and under the care of the relevant specialist; this will be achieved through increasing referrals to the sarcoma MDT. As a result, it is possible that some activity may transfer from Local Units to the Specialist Sarcoma Centre (and vice versa). Due to data quality issues, it has been difficult to quantify the impact of these changes. It is probable that these decisions will be made on

<table>
<tr><td></td><td>a case by case basis and the impact will vary network by network depending on existing network agreed pathways.</td></tr>
<tr><td>B1.3 Will the proposition require a new approach to the organisation of care?</td><td>Implement a network model to support appropriate selection of treatment

See section B1.2 above for further detail.</td></tr>
<tr><td colspan="2">B2 Geography & Access</td></tr>
<tr><td>B2.1 Where do current referrals come from?</td><td>:<table><tr><td>GP</td><td>☒</td></tr><tr><td>Secondary care</td><td>☒</td></tr><tr><td>Tertiary care</td><td>☒</td></tr><tr><td>Other</td><td>☐</td></tr></table></td></tr>
<tr><td>B2.2 What impact will the new service specification have on the sources of referral?</td><td>Increase

Implementation of the service specification is expected to result in an increase in the number of referrals into the sarcoma MDT primarily through secondary care and tertiary care providers.

See section B1.2 above for further detail.</td></tr>
<tr><td>B2.3 Is the new service specification likely to improve equity of access?</td><td>Increase

Source: Equalities Impact Assessment</td></tr>
</table>

B2.4 Is the new service specification likely to improve equality of access and/or outcomes?	Increase *Source: Equalities Impact Assessment*
B3 Implementation	
B3.1 Will commissioning or provider action be required before implementation of the proposition can occur?	Service organisation action and Data monitoring action. Local commissioning teams will need to work with SAGs, providers and Cancer Alliances to: • Ensure a sarcoma network is in place and compliant with the revised service specification; • Understand the impact of the service specification on patient flows between providers (in particular MDT case discussions and any changes to treatment flows); and • Monitor compliance against the MDT caseload standards in the service specification (in line with IOG guidance). These are not new standards, however, as part of implementing the revised service specification, NHS England will be taking steps to and monitor and ensure compliance. It should be noted that the current service specification is expected to result in an increase in the number of patients being referred to the sarcoma MDT.
B3.2 **Time to implementation:** Is a lead-in time required prior to implementation?	No - go to B3.4
B3.3 **Time to implementation:** If lead-in time is required prior to implementation, will an interim plan for implementation be required?	No - go to B3.4

B3.4 Is a change in provider physical infrastructure required?	No Currently it is anticipated there will be no changes required to provider physical infrastructure. Local commissioning teams will need to work with providers to understand the impact of any changes to patient flows/patient pathways between the Specialist Sarcoma Centre and Local Units as a result of the revised service specification.
B3.5 Is a change in provider staffing required?	No Currently it is anticipated there will be no changes required in provider staffing levels. Local commissioning teams will need to work with providers to understand the impact of any changes to patient flows/patient pathways between the Specialist Sarcoma Centre and Local Units as a result of the revised service specification.
B3.6 Are there new clinical dependency and/or adjacency requirements that would need to be in place?	No
B3.7 Are there changes in the support services that need to be in place?	No
B3.8 Is there a change in provider and/or inter-provider governance required? (e.g. ODN arrangements / prime contractor)	Yes See section B3.1.
B3.9 Is there likely to be either an increase or decrease in the number of commissioned providers? If yes, specify the current and estimated number of providers required in each region	No change

	The aim of the service specification is to ensure that patients receive the appropriate treatment under the relevant clinical team. Although there may be changes in patient flows between Local Units and Specialist Sarcoma Centres, the number of providers involved in providing care is not expected to change. However should a change in the provider landscape be required in order to ensure the best outcomes for patients and services are delivered by the most capable providers, these changes would be carried out in line with NHS England's standard procedures and would be assessed under in line with 13Q to ensure appropriate public consultation is sought.
B3.10 Specify how revised provision will be secured by NHS England as the responsible commissioner.	In the first instance local commissioners will work with current designated providers, existing SAGs and Cancer Alliances to understand compliance against the revised specification.
B4 Place-based Commissioning	
B4.1 Is this service currently subject to, or planned for, place-based commissioning arrangements? (e.g. future CCG lead, devolved commissioning arrangements, STPs)	No
Section C - Finance Impact	
C1 Tariff/Pricing	
C1.1 How is the service contracted and/or charged? Only specify for the relevant section of the patient pathway	*Select all that apply:* **Drugs** — Not separately charged – part of local or national tariffs — ☐

<table>
<tr><td></td><td>
<table>
<tr><td></td><td>Excluded from tariff – pass through</td><td>☐</td></tr>
<tr><td></td><td>Excluded from tariff - other</td><td>☐</td></tr>
<tr><td rowspan="4">Devices</td><td>Not separately charged – part of local or national tariffs</td><td>☐</td></tr>
<tr><td>Excluded from tariff (excluding ZCM) – pass through</td><td>☐</td></tr>
<tr><td>Excluded from tariff (excluding ZCM) – other</td><td>☐</td></tr>
<tr><td>Via Zero Cost Model</td><td>☐</td></tr>
<tr><td rowspan="8">Activity</td><td>Paid entirely by National Tariffs</td><td>☐</td></tr>
<tr><td>Paid entirely by Local Tariffs</td><td>☐</td></tr>
<tr><td>Partially paid by National Tariffs</td><td>☒</td></tr>
<tr><td>Partially paid by Local Tariffs</td><td>☒</td></tr>
<tr><td>Part/fully paid under a Block arrangment</td><td>☐</td></tr>
<tr><td>Part/fully paid under Pass-Through arrangements</td><td>☐</td></tr>
<tr><td>Part/fully paid under Other arrangements</td><td>☐</td></tr>
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</td></tr>
<tr><td>C1.2 Drug Costs
Where not included in national or local tariffs, list each drug or combination, dosage, quantity, list price including VAT if applicable and any other key information e.g. Chemotherapy Regime.
NB discounted prices or local prices must not be included as these are subject to commercial confidentiality and must not be disclosed.</td><td>Not applicable.</td></tr>
<tr><td>C1.3 Device Costs</td><td>Not applicable.</td></tr>
</table>

Where not included in national or local tariff, list each element of the excluded device, quantity, **list or expected** price including VAT if applicable and any other key information. NB: Discounted prices or local prices must not be included as these are subject to commercial confidentiality and must not be disclosed.	
C1.4 **Activity Costs covered by National Tariff** List all the HRG codes, HRG descriptions, national tariffs (excluding MFF), volume and other key costs (e.g. specialist top up %)	Chemotherapy and radiotherapy treatments for sarcoma are covered under national tariffs.
C1.5 **Other Activity Costs not Covered by National or Local Tariff** Include descriptions and estimates of all key costs.	Bone and soft tissue sarcoma surgery are both funded by local tariffs. It has been difficult to extract data on prices and activity through the current contracts. Current reporting and recording rules for sarcoma vary between providers. It anticipated that over the next 12-24 months the National Team at NHS England will explore the options available to introduce national tariffs for the surgical treatment for bone and soft tissue sarcoma surgery. As part of this work, the National Team will look to produce recording rules for providers to help identify ongoing activity for both bone and soft tissue sarcomas.
C1.6 Are there any prior approval mechanisms required either during implementation or permanently?	No
C2 Average Cost per Patient	

C2.1 What is the estimated cost per patient to NHS England, in years 1-5, including follow-up where required? Are there any changes expected in year 6-10 which would impact the model?	Due to difficulties in accessing local price information, it has not been possible to calculate these costs. See section C1.5 for further detail.
C3 Overall Cost Impact of this Service specification to NHS England	
C3.1 Specify the budget impact of the proposal on NHS England in relation to the relevant pathway.	Cost neutral
C3.2 If the budget impact on NHS England cannot be identified set out the reasons why this cannot be measured.	Not applicable.
C3.3 If the activity is subject to a change of commissioning responsibility, from CCG to NHS England, has a methodology for the transfer of funds been identified, and calculated?	Not applicable.
C4 Overall cost impact of this service specification to the NHS as a whole	
C4.1 Specify the budget impact of the proposal on other parts of the NHS.	Budget impact for CCGs: No impact on CCGs Budget impact for providers: Unknown

C4.2 Taking into account responses to C3.1 and C4.1, specify the budget impact to the NHS as a whole.	Cost neutral Although there have been difficulties in assessing local prices (see section C1.5 for further detail and follow-up actions), the service specification is unlikely to impact overall sarcoma activity numbers. The impact of pathway changes on individual providers is likely to be minimal (although not currently known) and the overall impact on the NHS is expected to cost neutral.
C4.3 Where the budget impact is unknown set out the reasons why this cannot be measured	Not applicable.
C4.4 Are there likely to be any costs or savings for non-NHS commissioners and/or public sector funders?	No
C5 Funding	
C5.1 Where a cost pressure is indicated, state known source of funds for investment, where identified, e.g. decommissioning less clinically or cost-effective services.	Not applicable.
C6 Financial Risks Associated with Implementing this Service specification	
C6.1 What are the material financial risks to implementing this service specification?	None identified.
C6.2 How can these risks be mitigated?	Not applicable.

C6.3 What scenarios (differential assumptions) have been explicitly tested to generate best case, worst case and most likely total cost scenarios?	Not applicable.
C6.4 What scenario has been approved and why?	Not applicable.
C7 Value for Money	
C7.1 What evidence is available that the service is cost effective?	No published evidence available
C7.2 What issues or risks are associated with this assessment? *e.g. quality or availability of evidence*	Not applicable.
C8 Non-Recurrent Costs	
C8.1 Are there non-recurrent revenue costs associated with this service specification?	No
C8.2 Are there any non-recurrent provider capital costs associated with the service specification?	No

Appendix 1

Summary of minimum volumes as set out in the revised service specification for sarcoma services.

Caseload Requirement	**Minimum volumes**
Minimum number of new bone sarcomas discussed in the Specialist MDT per year	50
Minimum recommended number of new soft tissue sarcomas discussed in the Specialist MDT per year	100
Minimum recommended caseload number for primary gastro-intestinal stromal sarcoma per designated centre per year	24
Minimum recommended caseload number for for primary intra-abdominal sarcoma (including retroperitoneal sarcoma) per designated centre per year	24

Appendix 2

Specialist Sarcoma Centres across England and SAGs as of March 2018

Sarcoma Advisory Group (SAG)	Specialist Sarcoma Centre	Sarcoma Designation
Avon, Somerset and Wiltshire	North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust	Soft tissue only
Cheshire and Mersey	Royal Liverpool and Broadgreen University Hospitals NHS Trust	Soft tissue only
East Midlands	Nottingham University Hospitals NHS Trust and University Hospitals Of Leicester NHS Trust	Soft tissue only
Greater Manchester, Lancashire and South Cumbria	Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	Combined bone and soft tissue
	The Christie NHS Foundation Trust and Manchester University NHS Foundation Trust	Soft tissue only
London South East Sarcoma Network	London Royal National Orthopaedic Hospital NHS Trust with University College London Hospitals NHS Foundation Trust	Combined bone and soft tissue
	The Royal Marsden NHS Foundation Trust	Soft tissue
North and West Yorkshire and Humber	Leeds Teaching Hospitals NHS Trust	Soft tissue only
Northern Clinical Networks and Senate	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Combined bone and soft tissue
Sheffield	Sheffield Teaching Hospitals NHS Foundation Trust	Soft tissue only
South West	Plymouth Hospitals NHS Trust	Soft tissue only
	Royal Devon and Exeter NHS Foundation Trust	Soft tissue only
Thames Valley	Oxford University Hospitals NHS Trust	Combined bone and soft tissue
West Midlands	The Royal Orthopaedic Hospital NHS Foundation Trust	Combined bone and soft tissue
	University Hospital Birmingham NHS Foundation Trust	Soft tissue only