Intelligence

National Cancer Action Team

Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

# Manual for Cancer Services:

## Acute Oncology - Including Metastatic Spinal Cord Compression Measures

Version 1.0

## DH INFORMATION READER BOX

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| **For Recipient's Use** | |

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# Introduction

## 1.1 Aim of the Manual for Cancer Services

The Manual for Cancer Services is an integral part of Improving Outcomes: A Strategy for Cancer and aligns with the aims of the Coalition Government: to deliver health outcomes that are among the best in the world. The Manual will support the National Cancer Peer Review quality assurance programme for cancer services and enable quality improvement both in terms of clinical and patient outcomes.

The National Cancer Peer Review Programme, which is led by the National Cancer Action Team and includes expert clinical and patient/carer representation, provides important information about the quality of clinical teams and a national benchmark of cancer services across the country.

National quality standards/measures for cancer services were first published in 2001 and were updated in 2004 and 2008. The range of measures has subsequently been extended to cover virtually all cancer-sites and cross cutting cancer services (e.g. chemotherapy, radiotherapy). It is intended that the National Cancer Intelligence Network (NCIN) clinical reference groups will review the measures within the manual for cancer services annually to ensure they are clinically relevant and it is intended that the measures will underpin the NICE Quality Standards relating to cancer.

An independent evaluation of the National Cancer Peer Review Programme demonstrated strong support for the programme to continue, subject to reducing the burden of peer review and putting greater emphasis on outputs and outcomes as and when data becomes available.

In response to this the number of measures has been reduced by over one third in 2008 and more recently by a further 10%. In addition "Clinical Lines of Enquiry" (CLE) have been introduced, based on outputs/outcomes to support the Manual for Cancer Services. The revised process for peer review will be implemented in April 2011 but the measures contained within this manual will remain an integral part of the review process.

Compliance with the manual has not been centrally imposed. Although the NHS is not mandated to adhere to the measures in the Manual for Cancer Services, it is currently used by the National Cancer Peer Review Programme as part of their local assessment of cancer services and to provide a ready specification for commissioning of cancer services within a given locality.

## 1.2 Background and Context

Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy sets out how the future direction for cancer will be aligned with Equity and Excellence: Liberating the NHS in addition to meeting its stated aim to saving an additional 5,000 lives every year by 2014/15, aiming to narrow the inequalities gap at the same time.

The strategy acknowledges the importance of comprehensive information about cancer services for individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

### 1.3 Measures within the National Cancer Peer Review Manual

The peer review is changing its emphasis to focus on both clinical and patient outcomes. In order to achieve this, 'Clinical Lines of Enquiry' have been introduced and it is intended these outcome indicators will form part of the measures along with a reduced number of structure and process measures.

The development of cancer measures is an ongoing process in order to:

- reflect new NICE Quality Standards and clinical guidelines and revisions to existing NICE guidance;
- allow greater influence by users of cancer services and their carers;
- allow greater influence by clinicians;
- take account of possible modifications to measures following peer review visits;
- ensure the scope of measures encompasses the broader implementation of the Improving Outcomes: A Strategy for Cancer;
- reflect new initiatives such as Iapco, information prescriptions.

The relationship between the NICE Improving Outcomes Guidance and Quality Standards and the Manual for Cancer Services is explained in more detail in appendix A.

### 1.4 Reviewing the Measures

The National Cancer Peer Review (NCPR) Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The benefits of peer review have been found to include the following:

- provision of disease specific information across the country together with information about individual teams which has been externally validated;
- provision of a catalyst for change and service improvement;
- identification and resolution of immediate risks to patients and/or staff;
- engagement of a substantial number of front line clinicians in reviews;
- rapid sharing of learning between clinicians, as well as a better understanding of the key recommendations in the NICE guidance.

The NCPR programme has been keen to take the opportunity to reduce the burden on the NHS in line with the efficiency gains asked of all NHS organisations. The revised methodology will reduce the burden on the service without substantially impacting on the quality assurance process. It is envisaged that these changes will reduce the burden on the service by almost 50% from the previous process.

# Appendix A

## Interpretation of the National Manual for Cancer Services

### 1.1 Guidance Compared to Cancer Measures

The NICE Improving Outcomes Guidance is exactly what it says - guidance in general and indeed is excellent for this purpose. Guidance involves giving advice and recommendations on how things should be done now, in the future and sometimes on how things should have been done for sometime already. It may involve describing in effect the "perfect" service, using phrases like "the best possible", "to all patients at all times", etc. It may involve all-inclusive and far-ranging objectives and aspirations involving many agencies in long, interlinked chains of events and tasks which all have to be fulfilled before the desired outcome of the guidance is achieved. A particular person's accountability for each task is often not stated.

It may use influential and important ideas and models, which are however complex or not precisely definable, such as "network-wide patient care pathways" or "culturally-sensitive information". It always contains useful and necessary value judgements which use words like "sufficient", "appropriate", "robust" and "comprehensive", but it often has to leave unanswered the key question - what exactly is it which makes the issue under examination "sufficient", "appropriate", "robust" and "comprehensive" or not? It uses concepts which, although crucial, may not be measurable. It ranges widely from things which everybody gets right as a matter of course already through to principles which, if taken literally, nobody would comply with ever.

All these features, although they may sound unhelpful as described above, are present in all guidance documents and are part of the necessary and accepted style of guidance writing. Without this underlying type of mindset, guidance would not inspire, lead, motivate or guide and would probably be almost unreadable. The Manual for Cancer Services has to take a different approach. It is written for and only for the specific purpose of being used to assess a service against it, to aid self assessment and team development (a) by a peer review visit; (b) on a specific occasion; (c) a visit which has to be fair compared to visits to other services elsewhere and (d) to past and future visits to the same service. Therefore, the measures have to:

- be objective - with as little room as possible for arguments between assessors and assessed; and between different teams of assessors;
- be measurable - and at least capable of definitely being complied with or not;
- be specific - not addressing several issues at once or long, linked chains of tasks all being done by different agencies;
- be verifiable - by evidence produced for the visit; state who exactly is responsible for what - or nobody may take responsibility for anything;
- sometimes deal with the implications of the guidance - which may not have been explicitly stated but which are essential for anything to actually happen;
- be discriminating - it's no use spending time and money on assessing something which everybody gets right already;
- be achievable - it's no use committing everybody to permanent and automatic failure because of the way something is worded;
- be clear and unambiguous - the words will be taken to mean exactly what they appear to say, and therefore they have to say exactly what we mean and nothing else;
- pick out and address the most important issues - the peer review process is limited in its scope;
- be developmental - encourage continuous quality improvement and not produce destructive competition or a sense of failure;
- be sensibly and fairly related to previous standards - in order to be developmental -not just arbitrarily moving the goal posts.

All this results in the rather esoteric style of the manual. Please judge the measures on their merits in the light of the above and not in comparison to the guidance.

### 1.2 "The Responsibility for Assessment Purposes"

This refers to the fact that someone, or some group, is always held nominally responsible for compliance with each one of the quality measures. This has to be specified or, in terms of organising the peer review and collecting the results, it would be unclear who was being held as compliant or non-compliant or who the results could be attributed to. Where it is unclear who has responsibility there tends to be inertia. This attribution of responsibility does not necessarily commit a given person to actually carrying out a given task - this can be delegated according to local discretion, unless it is clear that a given task really is limited to ascertain group.

### 1.3 "Agreement"

Where agreement to guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the three key documents including date and version. Similarly, evidence of guidelines, policies etc requires written evidence unless otherwise specified. The agreement by a person representing a group or team (chair or lead etc) implies that their agreement is not personal but that they are representing the consensus opinion of that group.

### 1.4 Confirmation of Compliance

Compliance against certain measures will be the subject of spot checks or further enquiries by peer reviewers when a peer review visit is under taken. When self assessing against these measures a statement of confirmation of compliance contained within the relevant key evidence document will be sufficient.

### 1.5 "Quality" Aspects of Cancer Service Delivery

Many of the measures expect that policies, procedures, job descriptions and other documents will be in place. In reviewing compliance with the measures (for instance measure met or not) during validation, verification and visits, reviewers will look only for the presence of such documents, unless aspects of the content are specified in the wording of the measure. Where some aspect of the content is specified then this will be taken into account in determining compliance. As part of the improvement of cancer services, reviewers may comment on the content of documents and agreements but this will not affect the determination of compliance.

Work is ongoing to enable us to subject more of the "quality" aspects of cancer service delivery to objective measures for future rounds of peer review.

Many reviewers have a legitimate and valuable contribution to make by way of comments on areas which are a matter of opinion rather than fact or authoritative and evidence based standards. This recognises the qualitative as well as quantitative approach to reviews. This contribution can be made by way of a textual report in addition to the objective recording of compliance against the measures. This report is separate from the review against the measures and is inevitably more subjective and open to debate. However, there are many ways in which it can add to the overall picture gained from the peer review.

### 1.6 Structure of the Measures

Each measure has a three part number, for example 11-1A- 201j.

- The first part indicates the year the measure was first issued, for example 11 is 2011.
- The second part relates to a particular topic see below, for example 1A.
- The third part is made up of a unique measure number in the topic and where relevant a suffix letter indicating a specific tumour and cross cutting services, for example 201j (see below).

### Index of Suffix Letters

| | |
|---|---|
| **a** - Generic to all tumour sites | **r** - Specialist Palliative Care specific |
| **b** - Breast specific | **s** - Chemotherapy specific |
| **c** - Lung specific | **t** - Radiotherapy specific |
| **d** - Colorectal specific | **u** - User Group specific |
| **e** - Gynaecology specific | **v** - Rehabilitation specific |
| **f** - UGI specific | **w** - Complementary Therapy specific |
| **g** - Urology specific | **x** - Psychological Support specific |
| **h** - Haematology specific | **y** - Acute Oncology |
| **i** - Head and Neck specific | |
| **j** - Skin specific | |

Each network will be made up of several localities/trusts and several NSSGs / cross cutting groups, each with multiple MDTs and services. These MDTs and services will each need to demonstrate compliance with the relevant quality measures. A network overview will be developed by bringing together the findings relating to individual MDTs and services as well as those concerning network organisation and structures.

### Manual for Cancer Services On-line

An on-line version of the Manual for Cancer Services has been developed. The on-line version allows individuals to identify and extract measures by tumour site, organisation type and subject area in a variety of formats.

The on-line manual can be accessed from the CQuINS web site at http://www.cquins.nhs.uk.

# ACUTE ONCOLOGY MEASURES

## INTRODUCTION

The National Chemotherapy Action Group (NCAG), guided partly by reports from NCEPOD and NPSA and from previous cancer peer review results, has recommended that a more systematic approach should be taken to dealing with cancer-related emergencies. These recommendations have been embodied in the concept of the 'Acute Oncology Service'. This has implications across cancer network organisational structures, hospitals of various types, chemotherapy, radiotherapy and other treatment delivery services, primary care and commissioning functions. The recommendations span all relevant services, tumour types and treatment modalities. For this reason, for the purpose of the cancer quality measures and peer review, acute oncology will be reviewed as a separate activity, integrated across the network. These measures also apply to some specific arrangements for one particular aspect of acute oncology, metastatic spinal cord compression (MSCC). This aspect takes into account, recommendations from the NICE guidance on MSCC. There is an option for some of the infrastructure for MSCC services to be provided as part of the wider infrastructure of acute oncology as a whole, or to be provided separately.

### The Range of Patients.

A cancer network may choose its own definition of the patients which the acute oncology service is intended to cater for, but this should cover at least the following: (this is also defined more precisely, where necessary, in individual measures.)

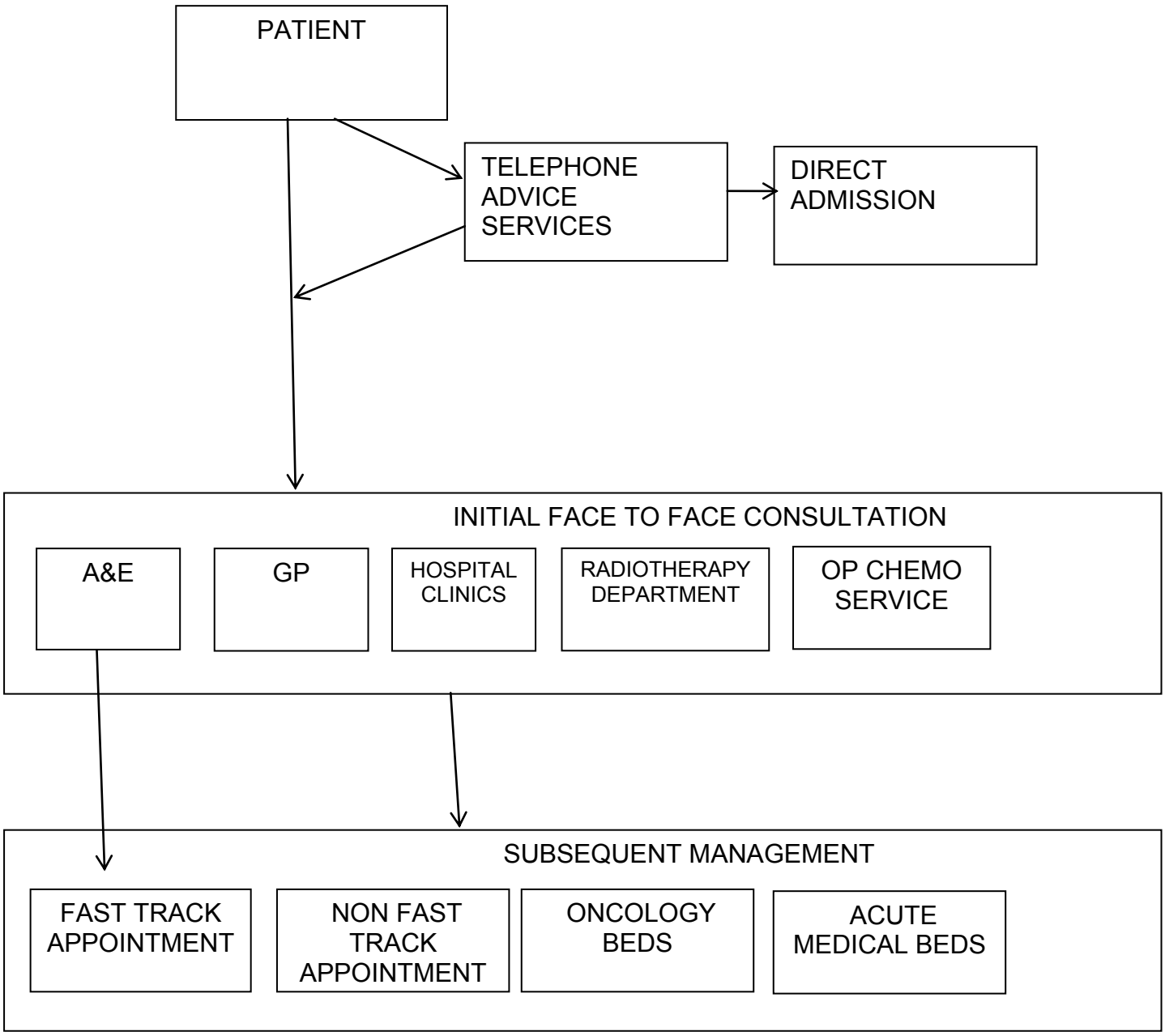
- patients potentially suffering from the acute complications of cancer treatment. The emphasis ,where an emphasis has to be made, will be on non-surgical treatment, since guidelines and care pathways concerning acute post-operative emergencies would normally be well established and would supersede any others;
- patients potentially suffering from certain emergencies caused by the disease process itself, whether the primary site is known, unknown or presumed. The emphasis, again, for similar reasons to those above, will be on such emergencies which require non-surgical treatment. A notable exception to this is the inclusion of arrangements for dealing with MSCC, which may need initial treatment with either surgery or radiotherapy.

The management of patients with a malignancy of unknown primary, who are not ill enough to fall into the acute oncology category, will be covered by measures in a future revision following the publication of the NICE guidance on carcinoma of unknown primary site.

### The Shape of the service.

The major care pathways associated with such patients are summarised in Figure 1. These pathways cut across services, hospitals and trusts. There are elements and accompanying measures which are relevant to the key organisations and facilities along these pathways. A given organisation along the pathway will only have a particular selection of elements, aimed at that particular type of organisation.

Figure 1 Simplified Patient Pathways for Acute Oncology Presentations



The following are the principle issues covered by the measures:

- a network lead and network group for acute oncology (NAOG);
- a network review of chemotherapy services and of the configuration of acute oncology as a whole, across the network;
- an acute oncology team (AOT) for each acute hospital, combining staff from A&E departments, acute medicine and oncology. This has the role of coordinating the service in that hospital;
- training in the use of the acute oncology service;
- operational policies and protocols describing timely and correct communication between primary care, the AOT, providers of emergency treatment, oncologists, telephone advice services and patients and carers;
- protocols for the treatment of the acute oncology presentations;
- IT applications to identify potential acute oncology patients (patient flagging system);
- a minimum specification of oncologists' and specialist nurses' time for providing rapid acute oncology triage, and consultant assessment within 24 hours;
- the delivery of antibiotics within one hour to patients with potential neutropaenic sepsis ('1 hour to antibiotic policy');
- provision of fast track outpatient appointment slots, specified for acute oncology patients;
- there are particular modifications of the acute oncology service for specialist cancer hospitals;
- specifically designated senior clinical advisors and hospital co-ordinators for MSCC for the network;
- there are audits of the treatment of neutropaenic sepsis and of the MSCC service.

From the point of view of providing an acute oncology service, hospitals themselves cannot be considered as a single type of organisation. It has been necessary to categorise hospitals, according to a group of criteria which determine which are the relevant components of the acute oncology service that they should be offering and for which they should be peer reviewed. Also, the haemato-oncology service is considered to be subject to these measures and peer review. For instance, where a hospital only has inpatient beds for haemato-oncology patients, these would count as 'oncology beds' in the categorisation of hospital types. This is summarised in the following table.

**Hospital Groupings for Acute Oncology Measures.**

**Introduction**

Prior to applying the hospital measures, the following table should be used, to determine which group any given hospital under review, falls into, it should fall in to only one group, and the selection of hospital based acute oncology measures which apply to the hospital in question.

| Group | Type of Hospital | Examples | Relevant Measures |
|---|---|---|---|
| 1 | Any hospitals with **one** or **both** of (a) an A&E department and (b) acute medical beds which are open to direct emergency admissions (often locally referred to by specific terms such as 'GP take'). This can be with or without specialist oncology beds or OP chemotherapy. | Most acute hospitals, e.g, a general teaching hospital, a DGH with haemato-oncology beds, hospitals with some acute services where A&E and other acute services have split between hospitals in a multi-hospital city. | Sections 11-3Y-100, 11-3Y-300, 11-3Y-400.<br><br>Note: Certain measures apply only to hospitals with A&E departments. This is indicated in the measures where relevant. |
| 2 | Hospitals with specialist oncology beds and OP chemotherapy but without **either** an A&E department **or** acute medical beds used as in group 1. | Specialist stand – alone 'cancer' hospitals or specialist oncology units within hospitals with other specialties but without an A&E or any other acute medical admissions. | Sections 11-3Y-200, 11-3Y-300, 11-3Y-400<br><br>(except 11-3Y-402: See note in the introduction to this measure). |
| 3 | Hospitals with OP chemotherapy but with **none** of the following; (a) an A&E department, (b) acute medical beds used as in group 1 or (c) specialist oncology beds. | Outreach chemotherapy in non-acute 'community' hospitals (or non-hospital settings). | None of the sections apply but the chemotherapy service will be subject to some of the chemotherapy measures, including ones which cover certain aspects of acute oncology. |
| 4 | Hospitals with **none** of the following; (a) an A&E department, (b) acute medical beds used as in group 1, (c) specialist oncology beds or (d) OP chemotherapy. | 'Community' hospital with no outreach chemotherapy. | None of the sections apply. |

*Note: For hospitals with palliative care beds, the admissions policy governing those beds and the policy on treatments to be made available to patients occupying those beds should be agreed as part of the review of acute oncology services and therefore whether those beds should be considered to be subject to the acute oncology measures.*

**Reviewing Acute Oncology.**

Acute oncology will be peer reviewed in three sections:

**Network Board Measures for Acute Oncology (AO).**

This covers the categorisation of the network's hospitals from the AO point of view and the configuration of the network's AO service and the establishment of structures to coordinate and lead it across the network, including the establishment of a single network acute oncology group (NAOG). It is reviewed under topic 1A. For the purposes of peer review this is considered to be the responsibility of the Chair of the Network Board and compliance counts once towards the review of the Network Board.

**Functions of the NAOG.**

This covers the agreement and production of network-wide programmes for AO, such as protocols, guidelines, training and certain service specifications. It is reviewed under topic 1E. For the purposes of peer review this is considered to be the responsibility of the chair of the group and compliance counts once towards the review of the group.

**Hospital Measures for AO.**

This covers the implementation by individual hospitals of the network programmes agreed by the NAOG and also a number of hospital-based protocols and programmes. It includes the establishment of hospital AO teams and AO assessment services. The application of these hospital measures depends on how the hospital is categorised from the AO point of view. It is reviewed under topic 3Y. For the purposes of peer review the hospital is identified on the CQUINS database as a unique 'site', the responsibility is considered to be that of the hospital acute oncology lead and compliance counts once towards the review of the hospital (i.e. 'site'). Thus there will be as many hospital AO reviews, each counting separately for the network as there are relevant hospitals in the network.

## GLOSSARY OF ABBREVIATIONS

AO Acute oncology.

AOT Acute oncology team.

DCC PA Direct clinical care programmed activity.

CQuINS Cancer Quality Improvement Network System.

MSCC Metastatic spinal cord compression.

NAOG Network acute oncology group.

NCAG National Chemotherapy Advisory Group.

NCCG Non Consultant Career Grade

NCEPOD National Confidential Enquiry into Perioperative Deaths.

NICE National Institute for Clinical Excellence.

PA Programmed activity.

# TOPIC 11-1A-3y - NETWORK BOARD MEASURES FOR ACUTE ONCOLOGY

*MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE*

The responsibility for review purposes for the measures in this section lies with the Chair of the Network Board.

**NETWORK CONFIGURATION OF ACUTE ONCOLOGY**

**DECLARATION OF THE ACUTE ONCOLOGY AND RELATED SERVICES**

**Introduction**

This allows acute oncology services across the network to be reviewed against the relevant measures for each hospital.

The configuration of network chemotherapy and oncology pharmacy services is dealt with here in the acute oncology section of the network measures, since it is a key driver of the configuration of acute oncology services as a whole and an integral part of the service review referred to below.

It is especially relevant to clarify things in this declaration, in the situations where there could be confusion over whether a hospital facility is offering active cancer treatment and /or acute oncology or not, e.g. hospice beds or palliative care units within acute hospitals.

**Declaration of the Acute Oncology and Related Services**

**11-1A-301y**

The Network Board should declare all the hospitals in the network catchment area and categorise them with regards to their current status, according to the classification table.

The network should specify which and only which hospitals should definitively treat MSCC (with radiotherapy and/or surgery).

Chemotherapy for malignant disease should be divided pragmatically into that number and configuration of clinical chemotherapy services as the Network Board agrees is appropriate on the grounds of patient flow, case mix, and the concentration of facilities, expertise and population, and in consultation with trust lead cancer clinicians.

The named hospitals and chemotherapy subspecialties (solid tumour and haemato-oncology) which each service covers should be declared.

The configuration of the services should comply with the minimum constraints outlined in appendix 3 - Delineating chemotherapy and oncology pharmacy services (excluding intrathecal chemotherapy).

Oncology pharmacy should be divided pragmatically into a number of oncology pharmacy services as the Network Board agrees is appropriate on grounds of patient flow and concentration of facilities and population, and in consultation with trust lead cancer clinicians.

The named hospitals covered and chemotherapy subspecialties supported by each service should be declared.

The configuration of the services should comply with the minimum constraints outlined in appendix 3 - Delineating chemotherapy and oncology pharmacy services (excluding intrathecal chemotherapy). In particular there should not be more than one oncology pharmacy service in any one given hospital.

*Notes: This declaration should be made for the current services, which includes those in existence before the review of services (see below) is implemented or even, if this is the case, undertaken.*

*If a service is non compliant with the minimum constraints outlined in appendix 3, the network would be non-compliant with this measure, but the services themselves should still be reviewed against the relevant measures.*

## MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

*Compliance:* The named, categorised hospitals, agreed by the trust lead cancer clinicians, the hospitals agreed as definitively treating MSCC and the whole configuration agreed by the Chair of the Network Board.

The named chemotherapy services, with a list of hospitals and subspecialties covered by each service, agreed by the trust lead cancer clinicians and the whole configuration agreed by the Chair of the Network Board.

The named oncology pharmacy services with a list of hospitals covered and subspecialties supported by each service, agreed by trust lead cancer clinicians and the whole configuration agreed by the Chair of the Network Board.

### Review of Acute Oncology and Related Services by the Network

**11-1A-302y** The Network Board should carry out a review of the provision of chemotherapy, oncology pharmacy services and acute oncology services across the network, which fulfils the following:

- there is agreement for planning purposes over the intended sites of chemotherapy delivery and the case mix, with respect to intensity of treatment and potential degree of acute complications, at each service site;
- there is agreement for planning purposes over the intended configuration of acute oncology services;
- the issue has been addressed, of co-ordination between the sites / case-mixes of chemotherapy provision and the configuration of acute oncology services;
- the issue has been addressed, of a balance between (a), consolidation and co-siting of services for different tumour types (for viability and efficiency), and (b), provision of services local to the patient;
- the time limit for planning purposes for implementation of the review's agreements should be by 2011.

There should be an implementation programme with dated milestones, for achieving the intended network configuration of acute oncology and chemotherapy services.

*Notes:*

- *The recommendations in, 'Chemotherapy Services in England: Ensuring Quality and Safety', Chapter 3, The Acute Oncology Service, National Chemotherapy Advisory Group, 2009'; provide guidance for such a review.*
- *Although the configuration of chemotherapy services in a network is a major factor in determining the configuration of acute oncology services, the latter encompass more than just the treatment of chemotherapy related complications. The scope of acute oncology for the purposes of this review should encompass at least the definition in the Introduction to the Acute Oncology Measures.*

*Compliance:* The review and the implementation programme, agreed by the Chair of the Network Board.

*Note: For reviews or self assessments subsequent to the initial one, the reviewers should assess the declared configurations of hospitals and of the clinical chemotherapy and oncology pharmacy services at the time of each assessment against the milestones and the intended configurations, from the review and this should then form the basis on which to judge compliance.*

## ACUTE ONCOLOGY AGREEMENT FOR SPECIALIST CANCER HOSPITALS WITHOUT AN A&E OR ACUTE GENERAL MEDICAL TAKE ONLY (GROUP 2)

### Introduction

It is inevitable and, in most cases appropriate, that patients with the acute complications of cancer and its treatment should be referred to a specialist cancer hospital or unit when they have been receiving their definitive treatment under that hospital's care. However, such hospitals do not necessarily offer all the general, emergency supportive care and facilities available in an acute general hospital. In some cases this could result in sub-optimal care and/ or avoidable delay if they have to be referred on elsewhere. This measure and the corresponding measures in the specialist hospital measures section and guidelines and protocols sections are designed to ensure agreement with commissioners over which treatments and procedures *will* be available and to produce referral guidelines compatible with this level of service.

## MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

### Acute Oncology Agreement for Specialist Cancer Hospitals Without an A&E or Acute General Medical Take Only (Group 2)

**11-1A-303y** The Network Board should agree, for planning purposes, the range of treatments and procedures for acute oncology patients which should be offered on site at the specialist cancer hospital.

If this agreement needs any service change, an implementation programme with dated milestones for achieving these agreed acute oncology services at the specialist cancer hospital.

This agreement should be distributed to relevant commissioners of primary care in the network.

*Compliance:* The treatments and procedures, and the implementation programme, agreed by the Chair of the Network Board.

*Note: For reviews or self assessments subsequent to the initial one, the reviewers should assess progress against the dated milestones and this should then form the judgement of compliance.*

### The Network Acute Oncology Group

**11-1A-304y** There should be a single NAOG which includes the representatives listed below, with a named chair who should be drawn from the list:

*Note: The Chair of the NAOG would then be considered to be the network lead for acute oncology.*

- the hospital acute oncology leads from the network;
- if not included in the above and if they exist as part of the network's arrangements:
  - the Chair of the Network Chemotherapy Group;
  - the Chair of the Network Radiotherapy Group;
  - a clinical oncologist who is a member of an acute oncology assessment service;
  - a medical oncologist who is a member of an acute oncology assessment service;
  - a haemato-oncologist who is a member of an acute oncology assessment service;
  - an A&E consultant who is a member of a hospital acute oncology team;
  - a member of a specialist palliative care team who is also a member of a hospital acute oncology team;
  - a consultant physician who is a member of a hospital acute oncology team.
  - a senior clinical advisor for MSCC (see measure 11-1E-109y), from both the spinal surgical and clinical oncology disciplines. One of these individuals should be the Chair of the Network MSCC Group if the network chooses to have a separate group for this;
    *Note: This individual would then be considered to be the network lead for MSCC, if there were no separate MSCC group, one of the two should be nominated as the network lead for MSCC.*
  - a specialist nurse who is a member of an acute oncology assessment service;
  - a designated oncology pharmacist;
  - a physiotherapist
  - two user representatives.

*Notes:*

- *The network may agree additional members besides those on the list and there may be an alternative local name for the group. The group may work as part of the meeting (or subgroup) of a related group e.g. the network chemotherapy group and vice versa, providing the correct groups of people and their functions are put forward against the relevant measures.*
- *If the local user group does not wish to, or is unable to nominate user representatives but there is an agreed mechanism for obtaining user advice, then the measure will be deemed to have been complied with.*
- *If otherwise correctly qualified, an individual may occupy more than one of the*

| MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE | |
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| | *specified roles on the list.*<br><br>There should be terms of reference agreed for the NAOG which specify that the group should be:<br><br>• the network's primary source of advice on issues relating to acute oncology in the network;<br>• the group with corporate responsibility, delegated by the Network Board for ensuring co-ordination and consistency across the network for implementing the acute oncology measures and for ensuring co-ordination and consistency across the network for the acute oncology practice in hospitals;<br>• the group for consulting with the NSSGs and the network chemotherapy and radiotherapy groups on the acute oncology treatment and referral guidelines.<br><br>*Note: The network may agree additional terms of reference and members for the group.*<br><br>The network leads for acute oncology and MSCC should agree a list of responsibilities for the roles with the Chair of the Network Board.<br><br>*Note: Examples of such lists for illustrative purposes may be found in appendix 2.* |
| *Compliance:* | The named members and what they represent, together with the named chair, agreed by the Chair of the Network Board.<br><br>The lists of responsibilities, agreed by the Chair of the Network Board and the network lead for acute oncology (the Chair of the NAOG) and the network lead for MSCC.<br><br>The terms of reference, agreed by the Chair of the Network Board and the Chair of the network oncology group. |

# TOPIC 11-1E-1y - FUNCTIONS OF THE NETWORK ACUTE ONCOLOGY GROUP

| *MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE* | |
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| The responsibility for review purposes for the measures in this section lies with the Chair of the NAOG. | |
| **GENERAL ACTIVITIES** | |
| **Network Acute Oncology Group Meetings** | |
| **11-1E-101y** | The NAOG should meet regularly and record attendance. |
| *Compliance:* | Documentation to show that a meeting took place within six months prior to the peer review visit / assessment.<br>A programme of meeting dates.<br>An example of an attendance list. |
| **The Network Acute Oncology Group Annual Review, Work Programme and Report** | |
| **11-1E-102y** | The Chair of the NAOG should have an annual review with the network lead clinician.<br>The NAOG should have agreed a work programme with the board for the contracting year in which the peer review/assessment takes place.<br>The NAOG should have produced an annual report for the board for the complete calendar or contacting year prior to the peer review visit/assessment. |
| *Compliance:* | Documentation sufficient to show that a review meeting took place with the network lead clinician in the year prior to the peer review visit/ assessment.<br>The work programme agreed by the Chair of the NAOG and the Chair of the Network Board.<br>The annual report, agreed by the Chair of the NAOG.<br>*Note: An agreed extract or summary of a document is sufficient if it shows compliance with the measure.* |
| **The Network Consultant Oncologist Telephone On Call Service** | |
| **11-1E-103y** | The NAOG, in consultation with the hospital acute oncology leads should agree the minimum specification of the 24/7 consultant oncologist telephone on call service, which should stipulate that:<br>• it is available, 24 hours a day, seven days a week, for telephone advice to health professionals only;<br>• there is coverage from one service arrangement or another, over the whole network;<br>• it may be divided into more than one local service, each covering one or more localities, each service with its own contact number, or it may have one service and one contact number for the whole network. This set of geographical arrangements i.e. the configuration of the network-wide coverage should be agreed as part of the minimum specification;<br>• each contact number should give telephone access during the time of the call to a consultant oncologist, making up a 24/7 duty rota.<br>*Note: This service is in addition to any existing non-consultant oncology on call rotas. It does not imply of itself, any commitment across the whole network for consultants to be available for immediate duty in the hospitals. Such availability may or may not be in place, for* ***individual*** *hospitals, but is not subject to review here. Where consultants are currently available for telephone advice as part of existing rotas which also involve them being available to come in to the hospital, this telephone availability may be used to provide part of the network consultant telephone advice service described in this measure.* |
| *Compliance:* | The minimum service specification, agreed by the Chair of the NAOG, covering the points |

above.

*Notes:*

*The NAOG for its compliance with this measure should produce the specification and the individual hospitals, for compliance with their relevant measures, should agree to the specification and provide their components of the staffing.*

**NETWORK ACUTE ONCOLOGY REFERRAL GUIDELINES**

**Acute Oncology Referral Guidelines**

**11-1E-104y** The NAOG in consultation with the chemotherapy heads of service, the radiotherapy heads of service and the hospital acute oncology leads should produce guidelines which should cover at least the following:

- when patients with acute oncology presentations consult primary care or hospitals/services outside the acute oncology system, the guidelines should indicate which and only which hospitals (and which services within those hospitals) they should be referred to. i.e. the relevant contact points of the acute oncology service;
- where a network encompasses a specialist cancer hospital which does not offer the full range of support services of a general acute hospital, the guidelines should specify which and **only which** types of acute oncology presentation may result in referral of the patient to the specialist cancer hospital, for urgent treatment. The guidelines should be compatible with the treatments and procedures agreed as being permanently available at the hospital. (See measure 11-1A-303y);
- the guidelines should include the contact points for the hospital MSCC co-ordinators across the network;
- in the case of MSCC the guidelines should include the symptoms and signs suggestive of MSCC (See appendix 3 - Metastatic spinal cord compression early symptoms and signs).

*Notes:*

- *It is recommended that guidelines should be avoided which state which **presentations** should **not** be referred to a given hospital, or which **hospitals,** acute oncology patients should **not** be referred to; as the principle of negative guidelines and protocols should be avoided in clinical services, due to their tendency to produce the opposite effect to that which was intended, with consequent serious errors. Example: A busy Dr has an acute oncology patient, and remembers some past guideline amongst the hundreds of guidelines they receive, and the Dr recalls it mentions the name of a certain hospital which is a moderately memorable fact but forgets that the guideline said '**don't** refer to this hospital' which is a boring, eminently forgettable point; so refers the patient to that hospital and valuable time is wasted.*
- *An acute oncology presentation, for the purpose of this measure is defined as in appendix 3 - Acute Oncology Presentations.*

*Compliance:* The guidelines agreed by the Chair of the NAOG and the acute oncology lead for the cancer hospital.

The reviewers should check that negative guidelines are avoided.

The reviewers should enquire as to distribution to NHS Direct.

*Note: The NAOG for compliance with this measure should produce the guidelines and the hospitals for compliance with their relevant measures, should agree to abide by them, supply local contact numbers and distribute them to the relevant referrers in their catchment area.*

**ACUTE ONCOLOGY SELF-REFERRAL GUIDELINES FOR PATIENTS AND CARERS**

**Introduction.**

It isn't practical or appropriate to require cancer patients to be given guidance on all the possible acute presentations of malignancy, so this aspect of acute oncology is largely confined to advice on the acute

complications of the non-surgical treatment of cancer to be given to people actually undergoing such treatment. Measures for this will appear in the sections of the Manual for chemotherapy and radiotherapy services. An exception to this principle is the recommendation in the NICE guidance on MSCC. Here, the consequences of failing to detect this at a very early stage and the rapidity of deterioration beyond the point of salvage are the rationale behind the following measure.

**Network Information on Early Detection of MSCC**

**11-1E-105y** The NAOG should, in consultation with the MSCC senior clinical advisors and the hospital acute oncology leads, agree information which may be offered to patients and/or carers of patients with spinal metastases, or at high risk of developing spinal metastases. The information should describe the signs and symptoms which may enable them to detect impending MSCC at a salvageable stage.

*Notes: A recommended template for this information may be found in the NICE/MSCC guidelines, Appendix 2 'An Example of a Patient Information Leaflet'.*

*Because of the difficulties of defining precisely a high risk patient and because the decision whether and when to give patients this information should be taken on a case by case basis, this measure is about the information itself-the decision when to use it is one for clinicians' discretion.*

*Compliance:* The information, agreed by the Chair of the NAOG.

*Note: The NAOG for compliance with this measure should produce the guidelines and the hospitals for compliance with their relevant measures, should agree to abide by them, supply local contact numbers and distribute them to the leads of the MDTs they host.*

**INDUCTION TRAINING IN THE USE OF THE ACUTE ONCOLOGY SERVICE.**

**Introduction.**

As this is in the context of emergency presentations and as some level of essential service has to stay in place, personnel who do not have such training cannot be excluded from current practice.

As the process of gathering of services, protocols and referral pathways together and defining them as an acute oncology service, is a new development, the measures here and the related ones in other sections are aimed at ensuring staff get to know the new local and network arrangements and referral pathways. These measures do **not** require the production of any training in how to manage the specific clinical problems associated with acute oncology.

**Induction Training in the use of the Acute Oncology Service.**

**11-1E-106y** The NAOG, in consultation with the hospital acute oncology leads, should agree network induction training in the use of the acute oncology service. It should at least cover the following:

- the network configuration of the acute oncology service;
- the acute oncology referral guidelines;
- the protocols associated with the acute oncology service;
- the roles and responsibilities and relevant contact points associated with; the NAOG, the hospital AOTs, the acute oncology assessment service, the 24/7 chemotherapy patient advice service, fast track referral to OP clinics, the consultant oncologist on call service, the MSCC hospital co-ordinators and the MSCC senior clinical advisors;
- it should contain locally specific information;
- it needs written confirmation of completion.

*Compliance:* The network induction training agreed by the Chair of the NAOG, covering the points above.

*Notes: The NAOG may agree more extensive training and for more staff groups. This is at the network's discretion and is not subject to review.*

**Training for MSCC Coordinators**

**11-1E-107y** The NAOG should, in consultation with the MSCC senior clinical advisors, agree the professional qualifications and training, prerequisite for a staff member to be on the

MSCC hospital co-ordinator rota, additional to the induction training in the use of the acute oncology service.

There should be a single list of authorised assessors of competence for the training for MSCC co-ordinators. They should be able to assess competence from the point of view of use of the acute oncology service in general and the additional training specific to MSCC co-ordinators.

The list should fulfil the following:

- entry on to the list and maintenance on the list is dependent on authorisation by the Chair of the NAOG or a person(s) designated by the chair;
- a prerequisite for authorisation is to have been trained and assessed as competent by another authorised assessor or one of the MSCC clinical advisors.

*Note: From the time of publication of these measures, MSCC senior clinical advisors may be considered initially capable of assessing staff competency as MSCC co-ordinators.*

*Compliance:* The professional qualifications and training, agreed by the Chair of the NAOG.

The current list agreed by the Chair of the NAOG or designated person(s).

The reviewers should enquire as to the working practice of the network regarding the criteria for inclusion on the list.

## NETWORK MEASURES FOR MSCC

### Introduction

The NAOG may choose whether or not to run a specific co-ordinating group for MSCC for the network. Whether it does or not, it should still comply with the all elements of the measure on the NAOG (11-1A-306y). If it chooses in addition, to run a specific network group for MSCC, the following measure applies.

### The Network MSCC Group

**11-1E-108y** The Chair of the network MSCC group should be one of the senior advisors for MSCC in the network (see the 'MSCC senior clinical advisor service', below).

This individual at least, should be a MSCC representative member of the NAOG.

The MSCC group should agree terms of reference which include the following:

- it should report to the NAOG;
- it should be the group with corporate responsibility, delegated by the NAOG, for ensuring co -ordination and consistency across the network for the management of MSCC and implementation of the acute oncology measures as applied to MSCC. *Note: This individual could be the same one nominated as the spinal services lead, required by SHAs. This is not subject to review, however.*

*Compliance:* The named chair, agreed by the Chair of the NAOG.

The membership list of the NAOG.

The terms of reference, agreed by the Chair of the MSCC group and the Chair of the NAOG.

### The MSCC Senior Clinical Advisor Service

**11-1E-109y** The NAOG should, in consultation with the hospital acute oncology leads, produce a minimum service specification for a network MSCC, senior clinical advisor service, which includes the following:

- it should be available 24 hours a day, 7 days a week for advice to secondary care clinicians and MSCC co-ordinators, managing or referring patients with MSCC who have been judged suitable for active definitive treatment;
- each senior clinical advisor should be able to view the patient's imaging during the discussion. The caller should provide the clinical case details;

- it may be divided into more than one local service, each covering one or more hospitals, each service having its own contact number, or it may have one service and contact number for the whole network. This configuration should be agreed as part of the minimum specification;
- the service may be offered across more than one network if all the relevant NAOGs agree;
- there should be a rota made up of consultants (known as the senior clinical advisors for MSCC) from the three disciplines: (i), spinal surgery, (of orthopaedic or neurosurgical disciplines), (ii), clinical oncologists who treat MSCC, (iii), radiology. The rota should be such that, at any one time, at least one of each discipline is on call for giving advice;
- contacting the service should enable the caller to initiate a discussion of the case in question between at least a spinal surgeon from the rota, a clinical oncologist from the rota (and a radiologist from the rota, if this is deemed necessary).

*Notes:*

- *Provided the advisors fulfil the specification on availability, they may be occupied in other tasks during the time they are on duty for this rota.*
- *Following case discussion the patient may be referred to a senior advisor for treatment or, with agreement, may be treated by local surgeons and/or oncologists.*
- *The discussion need not (and usually would not) involve direct patient consultation with the senior advisors.*
- *If the caller is a senior advisor who is either a spinal surgeon or clinical oncologist, they need only discuss the case with their opposite number of the two specialties.*
- *The rota is for convenience and efficiency, but if, for a given case, the necessary senior advisors are more readily at hand but off 'rota duty', the rota need not be used.*

*Compliance:* The specification, with the contact numbers for the network, according to the agreed configuration, agreed by the Chair of the NAOG.

An example of the rota.

*Note: For compliance with this measure, the NAOG should produce the specification and for compliance with their relevant measure, the hospitals should agree to abide by it and provide any agreed staff members for the rota.*

**The MSCC Case Discussion Policy**

**11-1E-110y** The NAOG should agree a network-wide policy which specifies the following:

- cases of MSCC should, prior to definitive treatment be subject to a case discussion by network MSCC senior clinical advisors representing at least spinal surgery, and clinical oncology (and radiology if deemed necessary);
- senior clinical advisors are defined by being those admitted to the network MSCC advice rota.

*Notes:*

- *This discussion should take place whenever it is needed, urgently as each individual case newly presents. It need only be by phone if necessary. This is **not** an MDT discussion, so that decisions should not be delayed by this professional grouping only coming together at pre-set regular intervals.*
- *As the service is intended for the discussion about the different forms of definitive treatment, the implication is that it is expected that staff apart from the specialist staff making up the rota would be able to make the prior judgement that a given patient is not fit for definitive treatment and therefore needs no case discussion. It is inevitable in practice, however that the rota staff might be asked to advise on this judgement for some patients.*

*Compliance:* The policy, agreed by the Chair of the NAOG.

*Note: for compliance with this measure, the NAOG should produce the policy and for*

*compliance with their relevant measure, the hospitals should agree to abide by it and the reviewers should enquire regarding its implementation.*

## THE NETWORK MSCC AUDITS

### Introduction

For review purposes, a network audit in MSCC is an audit project in MSCC which is co-ordinated across the network by the NAOG and carried out by the hospitals and services which are relevant to the particular parts of the patient pathway, being audited. The NAOG may internally delegate responsibility for this to the network lead for MSCC (who is a member of the NAOG), as recommended in the NICE/MSCC guidelines, but for practical reasons, for the purposes of peer review, it is considered the responsibility of the NAOG.

The pathway of a given patient with MSCC, from diagnosis to definitive treatment might cross more than one hospital and service, so the compliance for the overall audit counts towards the review of the NAOG. The results however, by their nature, may inevitably highlight the performance of individual hospitals and services.

The subsequent audit measures concentrate on:

1. the timeliness of the investigation of MSCC;
2. the timeliness of the definitive treatment of MSCC;
3. the outcome of the definitive treatment of MSCC.

## THE AUDIT OF TIMELINESS OF THE INVESTIGATION OF MSCC

### Introduction

Taking the group of patients who have imaging requested for a clinical suspicion of MSCC, there should be an audit of:

1. the time taken from making the request to the imaging taking place;
2. the type of primary imaging requested and delivered, including the proportion of patients getting primary MRI.

*Note:*

*The results should be expressed as collated across the network and also by each hospital hosting an imaging department.*

### The Audit of Timeliness of the Investigation of MSCC.

**11-1E-111y**

The NAOG should have obtained agreement to the audit being incorporated as part of the relevant trust audit programmes.

The NAOG should have discussed the results of the completed network audit project.

The NAOG should have agreed any actions resulting from the audit with the relevant hospitals.

*Compliance:* The agreement by the Chair of the NAOG and the relevant trust managers.

An extract of the minutes of an NAOG meeting sufficient to show compliance with the measure.

The actions agreed by the chair of the NAOG and the acute oncology leads of the relevant hospitals.

*Note: This agreement may be delegated to a hospital MSCC lead where this role is fulfilled by a separate individual.*

## THE AUDIT TIMELINESS OF DEFINITIVE TREATEMENT OF MSCC

### Introduction

Taking the group of patients who receive definitive treatment for MSCC (Primary surgery or primary radiotherapy), there should be an audit of :

1. the time from the request for imaging for clinically suspected MSCCto the start of definitive treatment;
2. the time from the completion of imaging to the start of definitive treatment.

*Note:*

*The results should be expressed as collated across the network and also by each hospital delivering definitive treatments (primary surgery or primary radiotherapy).*

| MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE | |
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| **The Audit of Timeliness of Definitive Treatment of MSCC** | |
| **11-1E-112y** | The NAOG should have obtained agreement to the audit being incorporated as part of the relevant trust audit programmes.<br>The NAOG should have discussed the results of the completed network audit project.<br>The NAOG should have agreed any actions resulting from the audit with the relevant hospitals. |
| *Compliance:* | The agreement by the Chair of the NAOG and the relevant trust managers.<br>An extract of the minutes of an NAOG meeting sufficient to show compliance with the measure.<br>The actions agreed by the chair of the NAOG and the acute oncology leads of the relevant hospitals.<br>*Note: This agreement may be delegated to a hospital MSCC lead where this role is fulfilled by a separate individual.* |
| **THE AUDIT OF THE OUTCOME OF DEFINITIVE TREATMENT OF MSCC** | |
| **Introduction**<br>Taking the group of patients who receive definitive treatment for MSCC (primary surgery or primary radiotherapy), there should be an audit of the outcome of treatment (30 day mortality, 3 months functional outcome, 2 years functional outcome and time to death).<br>*Note:*<br>*The results should be expressed as collated across the network and also by each hospital delivering definitive treatments (primary surgery or primary radiotherapy) and by the two types of primary definitive treatment themselves.* | |
| **The Audit of the Outcome of Definitive Treatment of MSCC** | |
| **11-1E-113y** | The NAOG should have obtained agreement to the audit being incorporated as part of the relevant trust audit programmes.<br>The NAOG should have discussed the results of the completed network audit project.<br>The NAOG should have agreed any actions resulting from the audit with the relevant hospitals. |
| *Compliance:* | The agreement by the Chair of the NAOG and the relevant trust managers.<br>An extract of the minutes of an NAOG meeting sufficient to show compliance with the measure<br>The actions agreed by the chair of the NAOG and the acute oncology leads of the relevant hospitals.<br>*Note: This agreement may be delegated to a hospital MSCC lead where this role is fulfilled by a separate individual.* |

# TOPIC 11-3Y - ACUTE ONCOLOGY HOSPITAL MEASURES

**Introduction**

Which particular measures apply regarding the acute oncology service, depends on which type of hospital is under review. Hospitals are classified from the point of view of the peer review of acute oncology, according to certain categories based on their collection of in- house services and facilities, relevant to acute oncology.

The measures are in sections, each section covering a component of the service. The components are as follows:

- the acute oncology team (acute general hospitals);
- the acute oncology team (specialist cancer hospitals without an A&E or acute general medical take);
- agreed selection of acute oncology services in specialist hospitals;
- acute oncology induction training for A&E and acute medicine;
- acute oncology assessment service (consultants);
- acute oncology assessment service (specialist nurses);
- acute oncology training for the assessment service;
- patient flagging system;
- fast tracking to OP;
- 24/7 assessment service provision;
- relevant in-house hospital protocols;
- MSCC measures.

**Hospital Groupings for Acute Oncology Measures.**

Prior to applying the hospital measures, the following table should be used, to determine which group any given hospital under review, falls into, it should fall in to only one group, and the selection of hospital based acute oncology measures which apply to the hospital in question.

| Group | Type of Hospital | Examples | Relevant Measures |
|---|---|---|---|
| **1** | Any hospitals with **one or both** of (a) an A&E department and (b) acute medical beds which are open to direct emergency admissions (often locally referred to by specific terms such as 'GP take'). This can be with or without specialist oncology beds or OP chemotherapy. | Most acute hospitals, e.g. general teaching hospital, a DGH with haemato-oncology beds, hospitals with some acute services where A&E and other acute services have split between hospitals in a multi-hospital city. | Sections 11-3Y-100, 11-3Y-300, 11-3Y-400.<br><br>Note: Certain measures apply only to hospitals with A&E departments. This is indicated in the measures where relevant. |
| **2** | Hospitals with specialist oncology beds and OP chemotherapy but without **either** an A&E department **or** acute medical beds used as in group 1. | Specialist 'cancer' hospitals or specialist oncology units within hospitals with other specialties but without an A&E or any other acute medical admissions. | Sections 11-3Y-200, 11-3Y-300, 11-3Y-400<br><br>(except 11-3Y-402: See note in the introduction to this measure). |
| **3** | Hospitals with OP chemotherapy but with **none** of the following; (a) an A&E department, (b) acute medical beds used as in group 1 or (c) specialist oncology beds. | Outreach chemotherapy in non-acute 'community' hospitals (or non-hospital settings). | None of the sections apply but the chemotherapy service will be subject to some of the chemotherapy measures, including ones which cover certain aspects of acute oncology. |
| **4** | Hospitals with **none** of the following; (a) an A&E department, (b) acute medical beds used as in group 1, (c) specialist oncology beds or (d) OP chemotherapy. | 'Community' hospital with no outreach chemotherapy. | None of the sections apply. |

*Note: For hospitals with palliative care beds, the admissions policy governing those beds and the policy on treatments to be made available to patients occupying those beds should be agreed as part of the review of acute oncology services and therefore whether those beds should be considered to be subject to the acute oncology measures.*

# TOPIC 11-3Y-1 - ACUTE ONCOLOGY MEASURES SPECIFIC TO HOSPITALS WITH A&E DEPARTMENTS AND/OR ACUTE MEDICAL ON TAKE ROTAS

*MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE*

The responsibility for peer review purposes for measure 11-3Y-101 lies with the lead cancer clinician of the Trust. The responsibility for the subsequent measures lies with the hospital acute oncology lead.

**THE GENERAL ACUTE ONCOLOGY TEAM. (AOT).**

**Introduction**

This team is not an MDT, so the terminology, functions and measures relating to it are different and should not be compared to, an MDT. In particular, this team's role, as a team, is not intended to be one of dealing with individual patients although individual members may be involved with acute oncology problems in the course of their everyday practice. The team is organisational, dealing with acute oncology policies, protocols and procedures for the hospital.

**The Acute Oncology Team**

**11-3Y-101**

There should be a single AOT, for the hospital, with a minimum membership, chair, terms of reference and secretarial/administrative support as follows:

Membership:

- one of the members listed below, should be the hospital acute oncology lead who should be chair of the group;
  *Note: If the hospital has chosen to designate a separate individual for the role of hospital lead for MSCC, this individual should also be a member of the AOT.*
- the oncologists who are members of the acute oncology assessment service;
- a haematologist, if the hospital has a haematology service, treating malignant disease;
  *Note: If haematologists take part in the hospital's acute oncology assessment service, the haematologist should be one of those.*
- the specialist oncology nurses who are members of the acute oncology assessment service;
- a specialist haematology nurse, dealing with patients with haematological malignancy, if the hospital has a haematology service, dealing with malignancy;
- if not included in the above and if the hospital has a chemotherapy service, the head of service of chemotherapy;
- if not included in the above and if the hospital has a radiotherapy department, the head of service of radiotherapy;
- if the hospital has an A&E department, an A&E consultant;
- a physician who is on the acute medical take rota;
- a person agreed as representing management of acute oncology services;
- a representative of a specialist palliative care team;
- a physiotherapist or occupational therapist who should be named as the rehab lead for MSCC.

There should be specified and timetabled time in the job description(s) of named secretarial/administrative staff, for support for the work of the acute oncology service for the hospital.

There should be an agreed list of responsibilities for this role.

*Notes: The actual amount of time is not subject to review.*

Terms of reference:

- each member (or one of them from each profession, as relevant), from the professions listed above, should be their profession's and/or directorate's lead for acute oncology, for the hospital;
- the team should have delegated responsibility from the hospital's management to;
  ( i) act as the co-ordinating body for matters relating to acute oncology between the hospital's clinical directorates and departments and between the hospital and other hospitals in the cancer network;
  (ii) ensure the implementation of the acute oncology measures for the hospital.
- the team should report to the NAOG and the hospital management team.

*Note: The acute oncology team according to local arrangements may be a team representing one hospital or it may be a single team representing one whole trust. This is not subject to review save that there should be no more than one acute oncology team for a single given hospital.*

Team Meetings:

The team should meet regularly, at least every six months, record attendance and discuss operational policies for acute oncology and their implementation for the hospital.

*Compliance:* The named members, chair (the acute oncology lead), and terms of reference agreed by the lead cancer clinician of the trust, the Chair of the NAOG and a relevant hospital manager.

The named secretarial/administrative staff, with their job description(s), and the list of responsibilities, all agreed by the hospital lead for acute oncology and the line manager of the staff.

An extract of the minutes of a meeting having taken place within six months prior to the peer review/self assessment, and a programme of dated meetings.

The attendance record of a meeting.

*Note: The attendance rates of individual members are not subject to review.*

**ACUTE ONCOLOGY INDUCTION TRAINING FOR A&E DEPTS AND STAFF IN ACUTE MEDICAL UNITS (MEASURES 11-3Y-102 AND 11-3Y-103)**

Note: These measures should be read in conjunction with the relevant network measures in section 1E.

**Acute Oncology Induction Training for A&E Staff**

**11-3Y-102**

The A&E consultants and NCCG medical staff in the A&E department should be trained according to the network induction training in the use of the acute oncology service.

Contracted nurses of band 6 and above, in the A&E department should be trained according to the network induction training in the use of the acute oncology service.

*Note: The hospital may choose to train other members of the A&E staff, e.g. junior medical staff. This is not subject to review.*

*Compliance:* Confirmation of completion of training for the named staff.

The reviewers should enquire whether all relevant staff have been included.

**Acute Oncology Induction Training for Staff on the Acute Medical Take Rota and Medical Admissions Unit**

**11-3Y-103**

Consultant physicians and any NCCG medical staff, on the acute medical take rota of the hospital, should be trained according to the network induction training in the use of the acute oncology service.

*Note:*

*The hospital may choose to train other members of the acute take staff, e.g. junior medical staff. This is not subject to review.*

*The remaining part of this measure is applicable only to hospitals running an acute*

*medical admissions unit.*

Contracted nurses of band 6 and above, in the medical admissions unit should be trained according to the network induction training in the use of the acute oncology service.

*Note: It is not practical for this measure to require mandatory training for nurses on all acute medical wards apart from a medical admissions unit. However, the hospital may* ***choose*** *to train other members of the nursing staff. This is not subject to review.*

*Compliance:* Confirmation of completion of training for the named staff.
The reviewers should enquire whether all relevant staff have been included.

**FAST TRACK OPD APPOINTMENT SLOTS**

**Introduction.**

**The Context.**

There are a variety of pathways for potential acute oncology cases to follow, after an assessment in A&E, including:

- acute admission without intervening assessment other than by A&E staff;
- assessment in A&E by a member of the acute oncology urgent assessment service;
- discharge home without further appointment;
- discharge with a routine OP appointment;
- discharge with an appointment for a fast track OPD slot according to the acute oncology, fast track slot measures.

The decision regarding which particular pathway to use in a given case is not the subject of the fast track measures. This decision is primarily one for clinical judgement. The measures essentially try to ensure that one of these pathways, the fast track appointment slot option, is in place for a case where it is clinically indicated. Illustrative *guidance* on when this might be considered is given in the text below.

**The Fast Track Appointment Slots.**

- For the purpose of the peer review, the fast track appointment slot is defined as one where the patient will be seen within one week, in order for it to be a viable alternative to acute admission from A&E.
- For guidance, it is intended, as proposed by NCAG, to be for patients not ill enough to need immediate admission from A&E but needing a quicker than routine appointment.
- It is intended that a patient can be given such an appointment by A&E staff **without** needing any further intervention at that stage by any oncology staff, such as the acute oncology assessment service.
- For acute oncology patients where the diagnosis of malignancy and its likely primary site is known, or judged to have been made in A&E, the fast track slots should be in site-specific clinics. The hospital's existing arrangements for site-specificity of clinics will be considered compliant for this fast track issue
- The measures require fast track appointment slots to be available. These may be in existing clinics. The slots do not necessarily have to be in newly and /or purpose-formed wholly 'fast track' clinics.
- For ill patients where a diagnosis of malignancy is judged to have been made in A&E, but it's likely primary site has **not**, there will be measures in a future revision, following publication of the NICE guidance on Carcinoma of Unknown Primary.
- Where a patient is already under the care of a known oncologist, the local protocols may require them to be referred back to that oncologist. This is not subject to review, but any local arrangements should conform to the fast track appointment slot requirements.

**Who to Peer Review?**

A given A&E department needs to be associated with a set of fast track appointment slots to refer its patients to. Depending on local arrangements, these slots may be across a range of hospitals. Each and every acute hospital does not have a requirement to provide such slots and certainly not a full set of them, so it is only practical to assess this issue via the A&E departments and their referral arrangements, not the hospitals, via their outpatient departments

**Fast Track Referral Protocol - Applicable only to hospitals with an A&E department on site.**

**11-3Y-104** There should be a protocol for the A&E department for fast tracking patients which fulfils the following:

- for acute oncology patients where the diagnosis of malignancy and its likely primary site is known, or judged to have been made in A&E, where clinically indicated, patients should be referred to fast track slots in named site-specific clinics.

| MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE |
|---|
| *Note: See the introduction above regarding local protocols for the case of patients under the care of a known oncologist.* |
| *Compliance:* The protocol, agreed by the hospital lead for acute oncology.<br>The reviewers should enquire as to the working practice of the A&E department regarding this protocol. |
| **Acute Oncology Fast Track Appointment Slots.** |
| **11-3Y-105** There should be a list of named clinics associated with the A&E department which fulfil the following:<br>• they should have appointment slots identified for patients referred from the A&E department according to the acute oncology fast track referral protocol to be seen within one week;<br>• there should be named site-specific clinics offering this service and covering at least the following cancer sites:<br>  • breast, lung, colorectal, upper GI tract, gynaecological, urological, head and neck, haematological, skin and CNS.<br>*Notes:*<br>  • *A given hospital's current arrangements for the site-specificity of clinics will be considered compliant as regards this measure*<br>  • *See the introduction above regarding local protocols for malignancy of unknown origin and the case of patients under the care of a known oncologist.*<br>  • *The clinics may be in a different hospital than the A&E department.*<br>  • *The measure may be fulfilled by slots reserved in existing clinics or an undertaking to overbook to accommodate such patients.* |
| *Compliance:* The list of named clinics identified as offering the fast track from A&E, service in OP department timetables The fast track referral protocol, naming the clinics.<br>The booking rules of such clinics.<br>The reviewers should enquire of the working practice of the A&E department and the clinics with regard to this measure. |
| **A&E and Acute Medical Admissions Oncology Communication Protocols** |
| **11-3Y-106** The AOT should agree a set of protocols which include the specification that:<br>• the A&E department, if relevant, should inform a member of the hospital's urgent oncology assessment service if a patient has been seen in A&E, who fulfils the criteria of an acute oncology presentation as specified in the note below;<br>• an acute medical team should inform a member of the hospital's urgent oncology assessment service, if a patient has been admitted non-electively, under its care, who fulfils the criteria of an acute oncology presentation as specified in the note below;<br>• the oncology assessment service member should be informed during the same working day, if the patient is seen or admitted within normal working hours, or by the morning of the next working day if seen outside working hours; (Monday morning if seen or admitted over the weekend).<br>*Notes: This measure currently assumes that the urgent oncology assessment service will only be available during weekdays as a minimum.*<br>*An acute oncology presentation, for the purpose of this measure is defined as the conditions in the list in appendix 3. - Acute Oncology Presentation.*<br>The hospital should have the protocols, naming the hospital's in-house contact points, available in the A&E department (if relevant) and acute medical admission unit and wards. |
| *Compliance:* The protocol, with in-house contact points, agreed by the hospital acute oncology lead.<br>The reviewers should enquire as to the working practice of the hospital with regards to |

| MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE |
| --- |
| this protocol and with regards to its distribution in the hospital. |

# TOPIC 11-3Y-2 - SPECIALIST ACUTE ONCOLOGY MEASURES SPECIFIC TO SPECIALIST CANCER HOSPITALS/ UNITS WITHOUT AN A&E DEPARTMENT OR AN ACUTE GENERAL MEDICAL TAKE

## *MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE*

The responsibility for peer review purposes for measure 11-3Y-201 lies with the lead cancer clinician of the trust. The responsibility for the subsequent measures lies with the hospital acute oncology lead.

### THE SPECIALIST CANCER HOSPITAL ACUTE ONCOLOGY TEAM (AOT)

**Introduction.**

This team is not an MDT, so the terminology, functions and measures relating to it are different and should not be compared to, an MDT. In particular, this team's role, as a team, is not intended to be one of dealing with individual patients although individual members may be involved with acute oncology problems in the course of their everyday practice. The team is organisational, dealing with acute oncology policies, protocols and procedures for the hospital.

### The Specialist Cancer Hospital Acute Oncology Team

**11-3Y-201** There should be a single AOT, for the hospital, with a minimum membership, chair and terms of reference, as follows:

Membership:

- one of the members listed below, should be the hospital acute oncology lead who should be chair of the group;
  *Note: If the hospital has chosen to designate a separate individual for the role of hospital lead for MSCC, this individual should also be a member of the AOT.*
- an oncologist who is a member of the acute oncology assessment service;
- a haematologist, if the hospital has a haematology service, treating malignant disease;
  *Note: If haematologists take part in the hospital's acute oncology assessment service, the haematologist should be one of those.*
- a specialist oncology nurse;
- a specialist haematology nurse, dealing with patients with haematological malignancy, if the hospital has a haematology service, dealing with malignancy;
- if not included in the above and if the hospital has a chemotherapy service, the head of service of chemotherapy;
- if not included in the above and if the hospital has a radiotherapy department, the head of service of radiotherapy;
- a person agreed as representing management of acute oncology services;
- a representative of a specialist palliative care team;
- a physiotherapist or occupational therapist who should be named as the rehab lead for MSCC.

There should be specified and timetabled time in the job description(s) of named secretarial/administrative staff, for support for the work of the acute oncology service for the hospital.

There should be an agreed list of responsibilities for this role.

*Notes: The actual amount of time is not subject to review.*

*See appendix 2 for an illustrative list of responsibilities of this role.*

Terms of reference:

- each member from the professions listed above, should be their profession's and/or directorate's (if applicable) lead for acute oncology, for the hospital;
- the team should have delegated responsibility from the hospital's management to;
  ( i) act as the co-ordinating body for matters relating to acute oncology between the hospital's clinical directorates (if applicable) and departments and between the

hospital and other hospitals in the cancer network;
(ii) ensure the implementation of the acute oncology measures for the hospital.

- the team should report to the NAOG and the hospital management team.

Team Meetings:

The team should meet regularly, at least every six months, record attendance and discuss operational policies for acute oncology and their implementation for the hospital.

*Compliance:* The named members, chair (the acute oncology lead), and terms of reference agreed by the lead cancer clinician of the Trust, the Chair of the NAOG and a relevant hospital manager.

The named secretarial/administrative staff and their job description(s), agreed by the hospital acute oncology lead and the line manager of the staff.

The list of responsibilities of the secretarial/administrative staff, agreed by the hospital acute oncology lead.

An extract of the minutes of a meeting having taken place within six months prior to the peer review/self assessment, and a programme of dated meetings.

The attendance record of a meeting.

*Note: The attendance rates of individual members are not subject to review*

**AGREEMENT OF ACUTE ONCOLOGY TREATMENTS AND PROCEDURES**

This measure should be read in conjunction with 11-1A-301y.

**Agreement of Acute Oncology Treatments and Procedures**

**11-3Y-202** The specialist hospital should agree the selection of acute oncology treatments and procedures which should be permanently available on site in the hospital, and the implementation programme towards achieving them, with the Network Board.

*Compliance:* The named treatments and procedures and the implementation programme, agreed by the Chair of the Network Board, the hospital acute oncology lead and a relevant manager for the hospital.

**ACUTE ONCOLOGY REFERRAL ACCEPTANCE PROTOCOL.**

This measure should be read in conjunction with 11-1A-301y.

**Acute Oncology Referral Acceptance Protocol**

**11-3Y-203** The specialist hospital should have a protocol as follows:

- having agreed the particular range of acute oncology treatment procedures that are provided by the specialist cancer hospital (11-3Y-202 ), the protocol should specify which types of acute oncology presentations (corresponding to the available treatment procedures) are suitable for referral to the hospital and which types should be referred elsewhere;
- the protocol should name the procedures agreed as being available.

The protocol should be available to the staff forming the acute oncology assessment team and any other staff who decide on acceptance of acute oncology referrals.

The protocol should be distributed to trust cancer lead clinicians of hospitals which are encompassed in the hospital's catchment area for acute oncology referrals.

*Compliance:* The protocol, agreed by the hospital acute oncology lead.

The reviewers should enquire as to the availability of the protocol in the hospital and its distribution to referring hospitals.

# TOPIC 11-3Y-3 - GENERAL ACUTE ONCOLOGY MEASURES FOR HOSPITALS

## *MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE*

The responsibility for review purposes for the first measure lies with the trust cancer lead clinician and for the subsequent measures in this section it lies with the hospital acute oncology lead.

These measures should be read in conjunction with the relevant network measures.

### The Hospital Acute Oncology Lead.

**11-3Y-301**

There should be a single named acute oncology lead for the hospital, agreed by the trust lead cancer clinician.

The hospital acute oncology lead should have agreed a list of responsibilities for the post with the trust cancer lead clinician.

The acute oncology lead should have at least one session (PA or timetabled notional half day, as relevant to their discipline's job planning convention) specified in their job plan for the duties of the post.

*Notes: See appendix 2 for a list of responsibilities of the role, for illustration only.*

*The post holder could be from any of the three clinical professional groups (nursing, medical, pharmacy) but should be of consultant status.*

*The trust may include the duties of hospital lead for MSCC in those of this post or name a separate individual who fulfils this measure independently for the minimum single session and against a list of responsibilities for the MSCC lead only.*

*Compliance:* The named hospital lead, their job description specifying the designated time and the lists of responsibilities, agreed by, the lead cancer clinician of the trust and the individual's line manager.

### Patient Flagging System

**11-3Y-302**

The hospital should have implemented a system for immediate essential patient information retrieval which includes at least the following specifications:

- it should be intended for the management of patients presenting acutely with the complications of systemic chemotherapy for malignant disease and of radiotherapy;
  *Note: These are defined as in the relevant parts of appendix 3 - Acute Oncology Presentations.*
- it should identify patients who have received systemic chemotherapy for malignant disease or radiotherapy within the previous six weeks;
  *Note: Chemotherapy is defined as in The Manual for Cancer Services, Chemotherapy Measures: Introduction.*
- the information should include, as well as their standard demographic parameters, the following:
  - their current cancer diagnosis;
  - their most recent systemic treatment regimen and date of most recent administration;
  - the treatment intention.
    *Note: Treatment intention is defined as in The Manual for Cancer Services, Chemotherapy Measures, Recording of Chemotherapy Treatment.*
- the patient population for a given system should include at least all those patients being treated by the hospital under review;
- the information should be viewable electronically by medical staff during the first medical consultation undergone in the A&E department or acute medical admissions ward or of acute admissions to oncology beds, whichever occurs first;
- the arrangements should be different than, and an improvement on, the default situation of hard copies of the patient's case notes having to be retrieved from storage.

*Notes: The hospital may choose a more comprehensive system with a wider range of patient type or larger patient population. This is not currently subject to review.*

*Compliance:* The reviewers should enquire as to the working practice of the hospital regarding whether this service is being provided in the departments and wards cited above.

**The Network Consultant Oncologist Telephone On Call Service**

**11-3Y-303** The hospital should agree the network specification for the consultant telephone on call service and provide its agreed contribution of staff on the rota.

*Note: It may agree with the NAOG that it need not provide any contribution to the service.*

*Compliance:* The network specification agreed by the hospital acute oncology lead.

The rota with the hospital's named staff members who contribute, agreed by the Chair of the NAOG, or an agreement that the hospital does not provide a contribution.

**THE MSCC COORDINATOR SERVICE**

Applicable only to hospitals agreed by the network as definitively treating cases of MSCC with surgery and/or radiotherapy.

*Note: This measure should be read in conjunction with the relevant network measures in Section 1E.*

**The MSCC Coordinator Service**

**11-3Y-304** The hospital should have a MSCC co-ordinator service which fulfils the following:

- there should be a single contact number for the hospital's service;
- there should be a 24 hours a day, 7 days a week rota of named staff, whereby, at any time, at least one person is available for the role of MSCC co-ordinator;
- the staff on the rota should agree a list of responsibilities for the co-ordinator role with the hospital acute oncology lead;
  *Note: See appendix 3 for a list for illustrative purposes only.*
- the staff on the rota should fulfil the network requirements on seniority and be trained according to the network MSCC co-ordinator training and be assessed as competent by a network assessor.

*Compliance:* The contact number.

An example of the rota with named staff and their professional qualifications.

Written confirmation of competence of staff.

The list of responsibilities, agreed by each staff member on the rota and the hospital acute oncology lead.

*Note: The role of MSCC co-ordinator may be fulfilled during weekday normal working hours by the nurses on the general acute oncology rota, provided this is agreed with the hospital acute oncology lead.*

**ACUTE ONCOLOGY INDUCTION TRAINING**

*Note: This measure should be read in conjunction with the relevant network measures in Section 1E.*

**Acute Oncology Induction Training**

**11-3Y-305** Staff of the hospital under review, who are on the consultant oncologist 24/7 on call rota and the 24/7 chemotherapy advice service rota should be trained according to the network induction training in the use of the acute oncology service.

*Note: There is a separate measure covering training for the MSCC co-ordinators.*

*Compliance:* Confirmation of completion of training for the named staff.

The reviewers should enquire whether all relevant staff have been included.

## MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE

### HOSPITAL PROTOCOLS/GUIDELINES

#### Acute Oncology Assessment Service Communication Protocols

**11-3Y-306**

There should be a set of protocols for the hospital which include the specification that:

- an acute oncology assessment service should inform a consultant's team currently responsible for the patient's ongoing cancer management, when a patient is referred to them for acute oncology assessment;
- the consultant's team should be informed during the same working day, if the patient is seen or admitted within normal working hours, or by the morning of the next period of normal daytime working hours, if seen outside the working day.
  *Note: This applies, whether the consultant's team is based in the same hospital as the urgent oncology assessment team, or a different hospital.*

*Compliance:* The protocol agreed by the acute oncology lead clinician of the hospital.

#### The Acute Oncology Treatment Protocols

**11-3Y-307**

The hospital should agree treatment protocols for the acute oncology presentations as specified in appendix 3 - Acute Oncology Presentations.

The protocols should be available in the chemotherapy and radiotherapy areas of treatment delivery, A&E department, acute medical admissions wards and oncology in-patient wards, as relevant to the type of hospital.

*Note: This entails the protocols for the acute management of MSCC in addition to being available as above, also being available on orthopaedic wards where patients with acute spinal cord compression are admitted as part of the ward's agreed policy.*

*Compliance:* The protocols, agreed by the hospital acute oncology lead.

The reviewers should enquire as to the working practice of the hospital with regards to these protocols and their distribution in the hospital.

*Note: There are measures relating specifically to chemotherapy and radiotherapy services, which will be included in the chemotherapy and radiotherapy measures.*

#### The One Hour to Antibiotic Pathway

**11-3Y-308**

The hospital should agree a patient pathway specification which includes the following:

- any patient with certain signs, symptoms and clinical circumstances (to be decided by the hospital as part of the specification) which suggest the likelihood of neutropaenic sepsis, should be entered on the pathway;
- the pathway should be designed for the patient to receive a first dose of antibiotics within one hour of entry onto the pathway, i.e. from the time the diagnosis of likely neutropaenic sepsis was made;
- the diagnosis of the likelihood of neutropaenic sepsis and entry to the pathway should **not** require prior confirmation of neutropaenia by blood test and **neither** should starting the antibiotic within the one hour treatment deadline;
- the pathway should **not** be confined **only** to patients identified by the patient flagging system;
- the nature of and route of administration of the antibiotics depends on clinical circumstances and should be covered by the network acute oncology treatment protocols.

*Compliance:* The pathway, agreed by the hospital acute oncology lead.

The reviewers should enquire as to the working practice of the hospital with regards to this pathway and its distribution in the hospital.

#### The One Hour to Antibiotic Audit

**11-3Y-309**

There should be an audit of the following parameter, for the hospital, across all settings which deal with the assessment and initial management of patients with neutropaenic

sepsis:

The percentage of all patients clinically diagnosed as likely to have neutropaenic sepsis (according to the specifications in the hospital's one hour to antibiotic pathway) who receive their first dose of antibiotic within one hour of them being clinically diagnosed.

The audit should be carried out of all patients received over a continuous period of six months, taken from the twelve month period immediately prior to the peer review or self-assessment.

The results of the hospital's one hour to antibiotic audit should be presented to and discussed at a meeting of the NAOG and any actions agreed as a result of the audit.

*Compliance:* The results of the audit, agreed by the hospital acute oncology lead.

A relevant extract of a meeting of the NAOG showing that such a discussion has taken place and actions agreed.

*Note: The results themselves are not subject to the peer review. They are used here as evidence that the audit has been performed.*

**The MSCC Service Specification and Case Discussion Policy**

**11-3Y-310**

The hospital should:

- agree the network MSCC senior clinical advisor service specification and provide its agreed staff members for the MSCC advisors' rota;
- agree the multidisciplinary case discussion policy.

*Compliance:* The MSCC service specification and the case discussion policy, agreed by the hospital acute oncology lead.

The relevant staff members of the hospital on the rota agreed by the hospital acute oncology lead and the Chair of the NAOG, or an agreement by both that the hospital does not provide any.

The reviewers should enquire as to the working practice of the hospital regarding the case discussion policy.

**Patient Information on Early Detection of MSCC**

**11-3Y-311**

The hospital should agree the network patient information on early detection of MSCC, incorporate any relevant local contact points and distribute this to at least the lead clinicians of the MDTs hosted by the hospital.

The hospital should recommend that it be given to patients who know that they have been diagnosed with spinal metastases.

*Compliance:* The information, with the accompanying recommendation, and with any relevant local contact points, agreed by the hospital acute oncology lead.

The reviewers should enquire as to the distribution.

## *MEASURE DETAILS & DEMONSTRATION OF COMPLIANCE*

### Acute Assessment by Oncologists: Staffing

**11-3Y-401** There should be DCC PAs, worked in the hospital, in the job plans of consultant oncologists, which fulfil the following specifications:

- the oncologists may be medical, clinical or haemato-, oncologists;
- there should be a minimum of two oncologists involved;
- there should be a minimum of one DCC PA for each of the 5 weekdays;
- during the specified PAs, the oncologist should be available for consultations with and/or ward visits to patients presenting with acute oncology problems, admitted during the previous 24 hrs, (or over the weekend, for a Monday PA).

*Notes: Providing the above specifications are fulfilled, the oncologist may be available for other duties during the specified time.*

*The definition of acute oncology presentations for the purpose of this measure is as found in appendix 3* - Acute Oncology Presentations

There should be a rota of named staff, for the 'acute assessment by oncologist' sessions.

*Notes:*

- *This does **not** imply that an assessment in the first 24hrs **only by a member of this rota** is the only way to meet the requirement. An assessment in the first 24 hrs by **any** consultant oncologist (e.g. the one the patient is normally under the care of), would suffice. Nevertheless, the hospital should produce a rota as above, to cover the default position if no other consultant is available.*
- *A specialist cancer hospital may wish to have more sessional provision for this than is stated above. This is not subject to review.*

*Compliance:* The named oncologists and their job plans, agreed by the hospital acute oncology lead and the clinical director(s) of the oncologists.

The rota showing the named oncologists.

### ACUTE ASSESSMENT BY SPECIALIST NURSES: STAFFING

Not applicable to specialist cancer hospitals without and A&E or acute general medical on take.

**Introduction.**

It has been decided that a mandatory specialist nurse, acute oncology assessment service was not intended in the NCAG report, for a specialist cancer hospital where so many of the available nursing staff and available medical staff on the wards would be trained to varying degrees in oncology. Such a hospital may provide a specialist nurse assessment service if it chooses, but this is not subject to review.

*Note: There may, however be rare instances of national services for one type of cancer where treatment is given in a hospital specialising in one, or a narrow range of cancer sites (specialist orthopaedic hospitals, for instance). The measure on acute oncology assessment by a specialist cancer nurse may be applicable in this instance and this is left to the discretion of the peer review.*

### Acute Assessment by Specialist Nurses: Staffing

**11-3Y-402** There should be sessions, worked in the hospital, in the job descriptions of specialist nurses, which fulfil the following specifications:

- there should be a minimum of two nurses involved;
- there should be a minimum of one nurse's session for each morning and each afternoon of the 5 weekdays;
- during the sessions, the nurse should be available for consultations with and/or ward visits to patients presenting with acute oncology problems, admitted during the previous 24 hrs, (or over the weekend, for a Monday PA).

*Notes: Providing the above specifications are fulfilled the nurse may be available for*

*other duties during the specified time.*

*The definition of acute oncology presentations for the purpose of this measure is as found in appendix 3* - Acute Oncology Presentations

There should be a rota of named staff, for the 'acute assessment by specialist nurse' sessions.

*Compliance:* The named nurses and their job descriptions, agreed by the hospital acute oncology lead and the line manager of the nurses.

The rota, showing the named nurses.

**ACUTE ONCOLOGY ASSESSMENT SERVICE: INDUCTION TRAINING**

*Note: This measure should be read in conjunction with the relevant network measures in Section 1E.*

**Acute Oncology Assessment Service: Induction Training**

**11-3Y-403** The consultant oncologists and NCCG oncology staff in the hospital who take part in the hospital's acute oncology assessment rota should be trained according to the network training in the use of the acute oncology service.

*Compliance:* Confirmation of completion of training for the named staff.

The reviewers should enquire whether all relevant staff have been included.

**The Acute Oncology Assessment Policy (Not applicable to MSCC)**

**11-3Y-404** There should be an acute oncology assessment policy for the hospital which specifies the following:

- for hospitals under review which are not specialist cancer hospitals; for the working days, Monday to Friday, an acute oncology admitted case should be seen and assessed during the day of admission, (or for admissions after midday, by the morning of the next working day), by a member of one or other of the acute assessment rotas or by any consultant oncologist.
  If not seen and assessed by a consultant oncologist during the above period, they should be seen and assessed by one within 24hrs of admission. For patients admitted during the weekend, they should be seen and assessed by a consultant oncologist during Monday morning;
- for specialist cancer hospitals; for the working days, Monday to Friday, an acute oncology admitted case should be seen and assessed during the day of admission, ( or for admissions after midday, by the morning of the following working day), by a consultant oncologist. For patients admitted during the weekend, they should be seen and assessed by a consultant oncologist during Monday morning.

*Note:*

*The expert assessment of patients with potential MSCC is recommended by the NICE MSCC guidance to be more urgent than might still be compliant with this measure. Thus, the urgency of the initial assessment for MSCC and its subsequent treatment is dealt with in the measures firstly by the need for the MSCC co-ordinator service and senior clinical advisor service to be available 24/7; secondly by the MSCC audit measures which address the timeliness of the stages in the patients' pathway.*

*Compliance:* The policy agreed by the acute oncology lead clinician for the hospital.

The reviewers should enquire as to the working practice of the hospital regarding this policy.

# APPENDIX 1

**This appendix is to follow.**

# APPENDIX 2

## 2.1 Role of Network (Tumour) Site Specific Groups (NSSGs)

### Membership

Network tumour site-specific groups should be multidisciplinary; with representation from professionals across the care pathway; involve users in their planning and review; and have the active engagement of all MDT leads from the relevant constituent organisations in the network.

### Service Planning

NSSGs should ensure that service planning:

- is in line with national guidance/standards (including reconfiguration where necessary);
- covers the whole care pathway;
- promotes high quality care and reduces inequalities in service delivery;
- takes account of the views of patients and carers;
- takes account of opportunities for service and workforce redesign;
- establishes common guidelines, including clear referral guidelines.

NSSGs should:

- recommend priorities for service development to the network board. (In some networks this is via an advisory clinical group, consisting of membership from chairs of network groups, trust lead clinicians and the network team);
- ensure decisions become integrated into constituent organisational structures and processes.

### Service Improvement/Redesign

- all NSSGs and individual cancer teams should commit to service improvements;
- process mapping and capacity and demand analyses should become part of the norm;
- requests for additional resources from NSSGs should be accompanied by evidence of involvement in service improvement/redesign;
- NSSGs should develop/approve high quality information for patient, for use across the network.

### Service Quality Monitoring and Evaluation

NSSGs should:

- agree on priorities for common data collection (in line with national priorities e.g. for waiting times, registries and NCASP), but go beyond this where possible;
- review the quality and completeness of data, recommending corrective action where necessary;
- produce audit data and participate in open review;
- ensure services are evaluated by patients and carers;
- monitor progress on meeting national cancer measures and ensure action plans agreed following peer review are implemented;
- report identified risks/untoward incidents to ensure learning is spread.

### Workforce Development

NSSGs should:

- consider the overall workforce requirements for the NSSG;
- consider the education and training needs of teams and, where appropriate, of individuals;
- liaise with the network board and with the workforce development confederation to ensure that appropriate workforce numbers and CPD are available;
- promote links between teams through rotation of staff;
- develop common recruitment/retention strategies;
- take account of opportunities for skill mix changes.

### Research and Development

- NSSGs should agree a common approach to research and development, working with the network research team, participating in nationally recognised studies whenever possible.

### Annual Work Plan and Report

NSSGs should:

- draw the above together in an annual work plan in the context of a prioritised clinical governance development plan, for approval by the network board;
- ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training;
- provide an annual report of activity to feed health economy clinical governance reporting processes.

## 2.2 The Responsibilities of MDT members

### Responsibilities of the MDT lead clinician

- ensure that objectives of MDT working (as laid out in Manual of Cancer Services) are met:
    - to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team's operational policies are multidisciplinary decisions;
    - to ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit;
    - to ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent;
- overall responsibility for ensuring that MDT meeting and team meet peer review quality measures;
- ensure attendance levels of core members are maintained, in line with quality measures;
- ensure that target of 100% of cancer patients discussed at the MDT is met;
- provide link to NSSG either by attendance at meetings or by nominating another MDT member to attend;
- lead on or nominate lead for service improvement;
- organise and chair annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members);
- ensure MDT's activities are audited and results documented;
- ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported;
- ensure target of communicating MDT outcomes to primary care is met.

## Responsibilities of the MDT Co-ordinator

- facilitate and co-ordinate the functions of the multidisciplinary team meetings;
- ensure the appropriate proportions of patients are discussed at MDTs;
- help with the introduction and changes to proformas used to ensure all patients are discussed, treated appropriately and outcomes are recorded and reviewed. Ensuring patients' diagnoses,
- investigations, and management and treatment plans are completed and added to the patient's notes;
- managing systems that inform GP's of patient's diagnosis, decisions made at outpatient appointment etc;
- working with staff to ensure all patients have a booked first appointment, investigation and procedure and record details of patients coming via a different route;
- working with key MDT members to identify areas where targets are not achieved, undertake process mapping to identify bottlenecks;
- undertake demand and capacity studies where appropriate;
- report changes to MDTs on a monthly basis;
- data collection and recording of data;
- to manage the systems according to guidelines, monitoring milestones and submitting the required reports in the given format and required times;
- keep comprehensive diary of all team meetings;
- record attendance at meetings;
- take minutes at the multidisciplinary meetings, type notes back in the required format and distribute to all concerned;
- the post holder will be expected to be instrumental in the development of databases to capture patient information and report this to the clinicians on a weekly basis;
- inform lead cancer manager of waiting times for patients when these exceed appropriate targets;
- ensure lists of patients to be discussed at meetings are prepared and distributes in advance;
- ensure all correspondence, notes, x-rays, results, etc are available for the meetings;
- ensure action plans for patient care are produced with agreed reviews;
- assist in capturing cancer data on all patients and assist in the development of systems to complement the cancer audit system;
- ensure members or their deputy are advised of meetings and any changes of date, venue, etc.

# APPENDIX 3

**Delineating chemotherapy and oncology pharmacy services (excluding intrathecal chemotherapy).**

There have to be some minimum constraints on the organisation of chemotherapy services from the point of view of service management and of peer review and the measures. Otherwise, for example, every individual consultant could declare themselves and their related staff and facilities a separate clinical chemotherapy service. This would defeat those aspects of the exercise which strive towards co-ordination and consistency of practice.

**It is strongly recommended that a single clinical chemotherapy service and a single oncology pharmacy service be put forward for assessment for a whole locality of the cancer network.**

If this is not possible for the clinical chemotherapy service then:

- There should be no more than one clinical chemotherapy service in a single given hospital for the whole of solid tumour oncology (whichever way, in terms of particular disease types, "solid tumour" oncology is locally defined).
- There should be no more than one clinical chemotherapy service in a single given hospital for the whole of haemato-oncology (whichever way, in terms of particular disease types, "haemato-oncology malignancy" is locally defined).
- Where such sub-specialties of chemotherapy share non-pharmacy facilities and staff, in the same hospital, they must be reviewed as one service.

**Acute Oncology Presentations**

- The following, as caused by the systemic treatment of cancer:
  - Neutropaenic sepsis.
  - Uncontrolled nausea and vomiting.
  - Extravasation injury.
  - Acute hypersensitivity reactions including anaphylactic shock.
  - Complications associated with venous access devices.
  - Uncontrolled diarrhoea.
  - Uncontrolled mucositis.
  - Hypomagnesaemia.
- The following, as caused by radiotherapy:
  - Acute skin reactions.
  - Uncontrolled nausea and vomiting.
  - Uncontrolled diarrhoea.
  - Uncontrolled mucositis.
  - Acute radiation pneumonitis.
  - Acute cerebral/other CNS, oedema.
- The following, as caused directly by malignant disease and presenting as an urgent acute problem. This section may refer to patients with known malignancy, whether or not they are picked up by the hospital's 'flagging system' or not, or patients with a previously unknown malignancy.
  - Pleural effusion.
  - Pericardial effusion.
  - Lymphangitis carcinomatosa.
  - Superior mediastinal obstruction syndrome, including superior vena caval obstruction.
  - Abdominal ascites.
  - Hypercalcaemia.
  - Spinal cord compression including MSCC
  - Cerebral space occupying lesion(s).
- Any other cases where the A&E staff or acute medical firm decide an urgent oncology assessment is needed.

**Metastatic spinal cord compression early symptoms and signs.**

(Reference: CG75 Metastatic spinal cord compression: Diagnosis and management of patients at risk of or with metastatic spinal cord compression. NICE 2008)

- Contact the MSCC coordinator urgently (within 24 hours) to discuss the care of patients with cancer and any of the following symptoms suggestive of spinal metastases:
  - pain in the middle (thoracic) or upper (cervical) spine;

    - progressive lower (lumbar) spinal pain;
    - severe unremitting lower spinal pain;
    - spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing);
    - localised spinal tenderness;
    - nocturnal spinal pain preventing sleep.
- Contact the MSCC coordinator immediately to discuss the care of patients with cancer and symptoms suggestive of spinal metastases who have any of the following neurological symptoms or signs suggestive of MSCC, and view them as an oncological emergency:
    - neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction;
    - neurological signs of spinal cord or cauda equina compression.

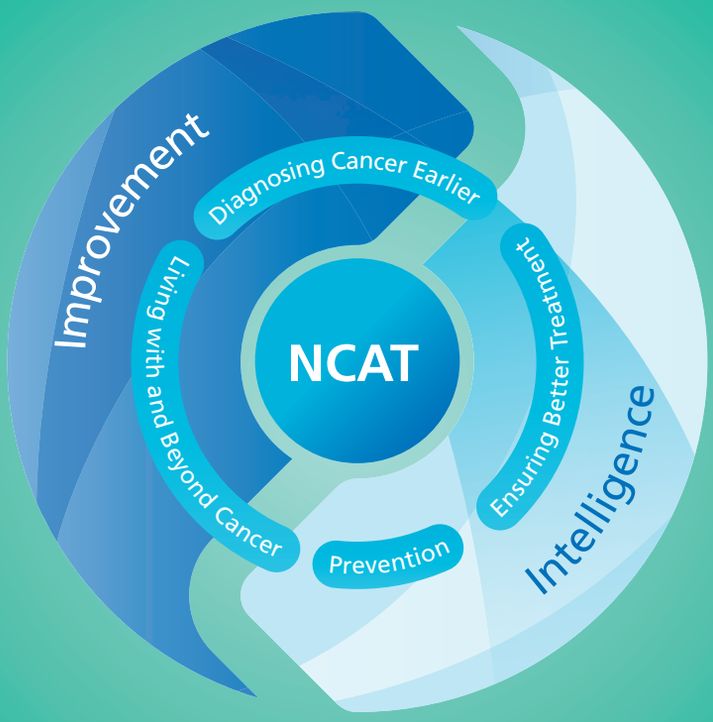
**MSCC Coordinator Responsibilities**

**Spinal Centre**

- Co-ordinate care for patients who present with actual or potential MSCC and who require access to the specialist supra-regional spinal oncology service.
- Provide detailed information to the referrers on referral criteria.
- Triage referrals, liaising with referrer, SCA & patient\carers ensuring prompt and effective patient management.
- Act as a co-coordinator of the pathway, facilitating multidisciplinary working across healthcare sectors, and organisational boundaries for the supra- regional service.
- Demonstrate sound knowledge of the principles of spinal oncology care ensuring optimum standards for patients.
- Be based within the specialist trust and liaise with acute and primary care trusts and other organisations across the region to ensure prompt and efficient referrals to the service.
- Provide a resource for advice and support across the network.

**DGH**

- Co-ordinate care for patients who present with actual or potential MSCC and who require access to the specialist supra-regional spinal oncology service.
- Provide point of reference and advice for clinical teams for patients with actual or potential MSCC.
- Provide detailed referral information to the specialist centre including patients assessment, imaging and reports. Ensure required imaging is done promptly.
- Liaise with referring team & patient\carers until management plan is agreed ensuring prompt and effective patient management and that patient transfers are arranged as appropriate.
- Provide a resource for advice and support across the DGH and link with the network.

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