Manual for Cancer Services
Acute Oncology - Including Metastatic Spinal Cord Compression Measures
Version 1.0
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<thead>
<tr>
<th>Date</th>
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</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
# ACUTE ONCOLOGY MEASURES

## Contents

### Section 1 - Measures

| 14-1E-101y | Network Configuration of the Acute Oncology Service |
| 14-1E-102y | Network Acute Oncology Group Membership |
| 14-1E-103y | Network Acute Oncology Group Meetings |
| 14-1E-104y | Annual Report and Work Programme |
| 14-1E-105y | Network Metastatic Spinal Cord Compression Group |
| 14-1E-106y | Acute Oncology Agreement for Specialist Cancer Hospitals |
| 14-1E-107y | Consultant Oncologist Telephone On Call Service |
| 14-1E-108y | Induction Training in the use of the Acute Oncology Service |
| 14-1E-109y | Assessors and Training for MSCC Coordinators |
| 14-1E-110y | Acute Oncology Patient Pathways |
| 14-1E-111y | The MSCC Case Discussion Policy |
| 14-1E-112y | Network Information on Early Detection of MSCC |
| 14-1E-113y | The Audit of Timeliness of the Investigation of MSCC |
| 14-1E-114y | The Audit of Timeliness of the Definitive Treatment of MSCC |
| 14-1E-115y | The Audit of the Outcome of Definitive Treatment of MSCC |

### Acute Oncology Measures for Hospitals with Accident and Emergency Departments and/or Acute Medical Take

| 14-3Y-101 | The Acute Oncology Team |
| 14-3Y-102 | Acute Oncology Induction Training for Accident and Emergency Staff |
| 14-3Y-103 | Acute Oncology Induction Training for Acute Medical Take and Medical Admissions Unit |
| 14-3Y-104 | Fast Track Referral Protocol and Appointment Slots |
| 14-3Y-105 | Oncology Communication Protocols |

### Acute Oncology Measures for Specialist Cancer Hospitals

| 14-3Y-201 | The Specialist Cancer Hospital Acute Oncology Team |
| 14-3Y-202 | Agreement of Acute Oncology Treatments and Procedures |
| 14-3Y-203 | Acute Oncology Referral Acceptance Protocol |

### General Acute Oncology Measures for Hospitals

| 14-3Y-301 | Core Membership |
| 14-3Y-302 | Patient Flagging System |
| 14-3Y-303 | Consultant Oncologist Telephone On Call Service |
| 14-3Y-304 | The MSCC Coordinator Service |
| 14-3Y-305 | Acute Oncology Induction Training |
Section 2 – Clinical Indicators / Lines of Enquiry

Service Profile
National Cancer Peer Review and The Manual for Cancer Services

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 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 acute oncology (AO) will be reviewed as a separate activity, integrated across the network.

These measures also apply to some specific arrangements for one particular aspect of AO, 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 AO as a whole, or to be provided separately.

The AO Network

The following definition applies for the purpose of the AO peer review.

The term ‘network’ in these measures refers to the provider clinical networking arrangements and infrastructure for the management and delivery of the AOS. The extent of a given AO network consists of the relevant activities and hospitals which are associated with one named network acute oncology group (NAOG)--see below. This will constitute the network being reviewed.

The NAOG's role applied to the management of metastatic spinal cord compression (MSCC) may be undertaken for the same network, by a separate, network MSCC group, or may be carried out by the NAOG. This reflects the recommendations of the NICE guideline - Metastatic spinal cord compression: Diagnosis and management of adults at risk of and with metastatic spinal cord compression (CG75 2008).

The Hospital Acute Oncology Team

A hospital requiring an AO service should have or be covered by a single acute oncology team (AOT). This is a co-ordinating, policy making body for AO for the hospital. It does not as a team deal with individual patients. It is NOT analogous to a site-specific MDT. Individual hospitals, not AOTs, are reviewed against the hospital AO measures. So if there are two hospitals sharing one AOT, which is acceptable, peer review would produce two sets of compliance results depending on how the measures were fulfilled within each separate hospital.

Ground Rules for Networking

For there to be a functioning network based on agreed, rational pathways, there have to be ground rules underpinning the relationships between different components of the network's infrastructure. These ground rules are often tacitly or unconsciously assumed. They are set out below. The network configuration measure requires compliance with them.

1. The NAOG (and a separate network MSCC group if relevant) should be the only such group for all the hospitals it is associated with.

2. Any given hospital should only be associated with one NAOG (and only one network MSCC group if relevant).

3. There should be only one AOT in or covering a given hospital.

Note: An AOT may still cover more than one hospital.
The Range of Patients

An acute oncology network may choose its own definition of the patients which the AO 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.

AO and Carcinoma of Unknown Primary

Some patients, presenting acutely ill will be recognised early on in the diagnostic pathway as cases of malignancy of undefined primary origin (MUO). In theory, the AO arrangements and assessment infrastructure as well as the Carcinoma of Unknown Primary (CUP) assessment infrastructure will be available for their initial management. The CUP peer review measures allow for the CUP assessment arrangements to be offered as part of AO if desired, or to be a separate entity. If the two assessment services are set up as separate entities, the measures do not deal with any process for determining which of these infrastructures an acutely ill MUO/CUP patient should initially be referred to. It would depend on whether the diagnostic process or the immediate management of the presenting condition took precedence. The details governing this type of decision are a matter for individual clinical judgement.

AO and Haemato-oncology

AO covers haemato-oncology as well as solid tumour oncology. All haemato-oncology services and patients are considered to be subject to these AO 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 (see below).
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 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:

4. a network lead and network group for acute oncology (NAOG);
5. a network review of chemotherapy services and of the configuration of AO as a whole, across the network;
6. 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;
7. training in the use of the AOT;
8. 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;
9. protocols for the treatment of the AO presentations;
10. IT applications to identify potential AO patients (patient flagging system);
11. a minimum specification of oncologists' and specialist nurses' time for providing rapid AO triage, and consultant assessment within 24 hours;
12. the delivery of antibiotics within one hour to patients with potential neutropaenic sepsis ('1 hour to antibiotic policy');
13. provision of fast track outpatient appointment slots, specified for AO patients;
14. there are particular modifications of the AO service for specialist cancer hospitals;
15. specifically designated senior clinical advisors and hospital co-ordinators for MSCC for the network;
16. there are audits of the treatment of neutropaenic sepsis and of the MSCC service.

From the point of view of providing an AO 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 AOS that they should be offering and for which they should be peer reviewed.

**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 into only one group. This determines the selection of hospital based AO measures which apply to the hospital in question.

<table>
<thead>
<tr>
<th>Group</th>
<th>Type of Hospital</th>
<th>Examples</th>
<th>Relevant Measures</th>
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<tbody>
<tr>
<td>1</td>
<td>Any hospitals with one or both of (a) an A&amp;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.</td>
<td>Most acute hospitals, e.g. a general teaching hospital, a DGH with haematology-oncology beds, hospitals with some acute services where A&amp;E and other acute services have split between hospitals in a multi-hospital city.</td>
<td>Sections 14-3Y-100, 11-3Y-300, 14-3Y-400. Note: Certain measures apply only to hospitals with A&amp;E departments. This is indicated in the measures where relevant.</td>
</tr>
<tr>
<td>2</td>
<td>Hospitals with specialist oncology beds and OP chemotherapy but without either an A&amp;E department or acute medical beds used as in group 1.</td>
<td>Specialist stand – alone 'cancer' hospitals or specialist oncology units within hospitals with other specialties but without an A&amp;E or any other acute medical admissions.</td>
<td>Sections 14-3Y-200, 14-3Y-300, 14-3Y-400 (except 14-3Y-402: See note in the introduction to this measure).</td>
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<tr>
<td>3</td>
<td>Hospitals with OP chemotherapy but with none of the following; (a) an A&amp;E department, (b) acute medical beds used as in group 1 or (c) specialist oncology beds.</td>
<td>Outreach chemotherapy in non-acute 'community' hospitals (or non-hospital settings).</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Hospitals with none of the following; (a) an A&amp;E department, (b) acute medical beds used as in group 1, (c) specialist oncology beds or (d) OP chemotherapy.</td>
<td>'Community' hospital with no outreach chemotherapy.</td>
<td>None of the sections apply.</td>
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</table>

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 network configuration of the AO service and therefore whether those beds should be considered to be subject to the AO measures.

Reviewing Acute Oncology
AO will be peer reviewed in five sections:

**NAOG Measures**
This is reviewed under topic 1E-1y 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.

**AO Measures Specific to Hospitals with A&E Departments or Acute Medical ON Take Rotas**
This is reviewed under topic 3Y-1 For the purposes of peer review this is considered to be the responsibility of the hospital acute oncology lead and compliance counts towards the review of the hospital.

**AO Measures Specific to Specialist Cancer Hospitals /Units Without an A&E Department or an Acute General Medical Take**
This is reviewed under topic 3Y-2 For the purposes of peer review this is considered to be the responsibility of the hospital acute oncology lead and compliance counts towards the review of the hospital.

**General AO Measures for hospitals**
This is reviewed under topic 3Y-3 For the purposes of peer review this is considered to be the responsibility of the hospital acute oncology lead and compliance counts towards the review of the hospital.

**Measures for the AO In-Patient assessment Service**
This is reviewed under topic 3Y-4 For the purposes of peer review this is considered to be the responsibility of the hospital acute oncology lead and compliance counts towards the review of the hospital.

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
# Acute Oncology Network Site Specific Group Measures

## Introduction
The responsibility for review purposes for measures dealing with the functions of the network Acute Oncology group (NAOG) lies with the chair of the NAOG. The contents of the first measure should also be agreed with the medical director(s) of the relevant area team(s).

## Key Theme
### Structure and Function

**Objective**
*Patients have access to appropriate care supported by best practice guidance.*

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<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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<tr>
<td>14-1E-101y</td>
<td>Network Configuration of the Acute Oncology Service</td>
<td>(1) This includes hospitals in groups 3 and 4, to ensure that the scope of the network and the coverage of the peer review of AO and chemotherapy is comprehensive. Constitution.</td>
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</table>

The NAOG should be named together with the associated hospitals in its catchment area for the AO network.

Whether the co-ordinating function for MSCC is undertaken by a single, separate network MSCC group or this is done by the NAOG, should be declared. The MSCC co-ordinating function should not be shared between the two groups.

The hospitals should be classified in relation to an AO service according to the table in the introduction to these measures. (1,2)

The relationship between the acute oncology teams, the hospitals and the NAOG and MSCC group should fulfill the following ground rules for networking. (3)

1. The NAOG (and a separate Network MSCC group if relevant) should be the only such group for all the hospitals it is associated with.
2. Any given hospital should only be associated with one NAOG (and only one network MSCC group if relevant).
3. Any given hospital should have or be covered by only one acute oncology team.

All the above arrangements, which constitute the configuration of the CUP clinical network, should be agreed by the medical director(s) of the relevant area team(s).

(1) This includes hospitals in groups 3 and 4, to ensure that the scope of the network and the coverage of the peer review of AO and chemotherapy is comprehensive.

(2) 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 network configuration of the AOS and therefore whether those beds should be considered to be subject to the AO measures.

(3) A full version of the generic ground rules for networking, for all types of MDT, network groups and also cross cutting service groups can be found in Appendix 1.

## 14-1E-102y | Network Acute Oncology Group Membership

There should be a single NAOG which includes the representatives listed below, with a named chair who should be drawn from the list: (1)

- the hospital acute oncology leads from the network; (measure 14-3Y-101)
- if not included in the above and if they exist as part of the network’s arrangements:
  - the Chair of the Network Chemotherapy Group;

(1) The Chair of the NAOG would then be considered to be the network lead for AO.
- 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 14-1E-111y), 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;

- a specialist nurse who is a member of an acute oncology assessment service;
- a designated oncology pharmacist;
- a physiotherapist
- two user representatives. (3) (4) (5)

There should be terms of reference agreed for the NAOG which specify:

- the provision of advice on issues relating to acute oncology in the network;
- 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;
- consulting with the NSSGs and the network chemotherapy and radiotherapy groups on the acute oncology treatment and referral guidelines.

The network leads for acute oncology and MSCC should agree a list of responsibilities for the roles with the Chair of the NAOG.

### 14-1E-103y Network Acute Oncology Group Meetings

| The NAOG should meet regularly and record attendance. | Constitution. Annual Report including meeting attendance spread sheet. |

### 14-1E-104y Annual Report and Work Programme

| The NAOG should produce an annual work programme in discussion with the strategic clinical network (SCN) and agreed with the director of the relevant area team. It should include details of any planned service developments and should specify the personnel | Annual Report. Work Programme |
responsible and the timescales for implementation. The network group should produce an annual report for the SCN and relevant area team.

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<tr>
<th>Network Metastatic Spinal Cord Compression Group</th>
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<tr>
<td><strong>Introduction</strong></td>
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<tr>
<td>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 all the elements of the measures for the NAOG. If it chooses in addition, to run a specific network group for MSCC, the following measure applies.</td>
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<tr>
<th>14-1E-105y</th>
<th>Network Metastatic Spinal Cord Compression Group</th>
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| The Chair of the network MSCC group should be one of the senior advisors for MSCC in the network (measure 14-1E-111y), and 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. |  |

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<th>Acute Oncology Agreement for Specialist Cancer Hospitals</th>
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<tr>
<td><strong>Introduction</strong></td>
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<tr>
<td>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.</td>
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<tr>
<th>14-1E-106y</th>
<th>Acute Oncology Agreement for Specialist Cancer Hospitals</th>
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<tr>
<td>The NAOG 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.</td>
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<table>
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<tr>
<th>Objective</th>
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<td><em>Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.</em></td>
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<tr>
<th>14-1E-107y</th>
<th>Consultant Oncologist Telephone On Call Service</th>
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<tr>
<td>The NAOG, in consultation with the hospital acute oncology leads should agree the minimum specification of the 24/7 consultant oncologist. This service is in addition to any existing non-consultant oncology on call rotas.</td>
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telephone on call service, which should stipulate that:

- it is available, 24 hours a day, seven days a week, for telephone advice to health professionals only;
- there is coverage from one service arrangement or another, over the whole network;
- 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;
- each contact number should give telephone access during the time of the call to a consultant oncologist, making up a 24/7 duty rota.

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.

**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.

The measure here and the related ones in other sections are aimed at ensuring staff get to know the local and network AO arrangements and referral pathways.

These measures do not require the production of any training in how to manage the specific clinical problems associated with AO.

**14-1E-108y Induction Training in the use of the Acute Oncology Service**

The NAOG, in consultation with the hospital acute oncology leads, should agree network induction training in the use of the AO service. It should at least cover the following:

- the network configuration of the AOS service;
- the AO patient pathways; (measure 14-1E-110y)
- the protocols associated with the AO service;
- the roles and responsibilities and relevant contact points associated with;
  - the NAOG;
  - the hospital AO teams;
  - the AO 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.

**14-1E-109y Assessors and Training for MSCC Coordinators**

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.

Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive co-ordinated care.

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<th>Measure</th>
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<tr>
<td>14-1E-110y</td>
<td>Acute Oncology Patient Pathways</td>
<td>It is recommended that pathway descriptions should be avoided which state which presentations should not be referred to a given hospital, or which hospitals AO patients should not be referred to; as the principle of negative pathways 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. An AO presentation, for the purpose of this measure is defined in Appendix 3.</td>
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The NAOG in consultation with the chemotherapy heads of service, the radiotherapy heads of service and the hospital AO leads should produce patient pathways which should cover at least the following:

- when patients with AO presentations consult primary care or hospitals/services outside the AO system, the pathways 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 AO 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 pathways should specify which and only which types of AO presentation may result in referral of the patient to the specialist cancer hospital, for urgent treatment. The pathways should be compatible with the treatments and procedures agreed as being permanently available at the hospital; (See measure 14-1E-106y)
- the pathways should include the contact points for the hospital MSCC co-ordinators across the network;
- in the case of MSCC the pathways should include the symptoms and signs suggestive of MSCC (See appendix 3).
The MSCC Case Discussion Policy

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 senior clinical advice rota. (1)

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). (2)

(1) This discussion should take place whenever it is needed, urgently as each 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, it is expected that staff apart from the specialist staff making up the rota would be able to make the 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.

(2) 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.

Key Theme

Patient Experience

Objective
All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

Network Information on Early Detection of MSCC

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 AO 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.

<table>
<thead>
<tr>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>14-1E-112y</td>
<td>Network Information on Early Detection of MSCC</td>
<td>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.</td>
</tr>
</tbody>
</table>
Key Theme
Clinical Outcomes / Indicators

Objective
All patients receive treatments intended to provide the best possible outcomes, consistent across the network.

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.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-1E-113y</td>
<td>The Audit of Timeliness of the Investigation of MSCC</td>
<td>The results should be expressed as collated across the network and also by each hospital hosting an imaging department.</td>
</tr>
<tr>
<td>Taking the group of patients who have imaging requested for a clinical suspicion of MSCC, there should be an audit of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. the time taken from making the request to the imaging taking place;</td>
<td></td>
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<tr>
<td>2. the type of primary imaging requested and delivered, including the proportion of patients getting primary MRI.</td>
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<tr>
<td>The NAOG should have discussed the results of the completed network audit project and agreed any actions resulting from the audit with the relevant hospitals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-1E-114y</td>
<td>The Audit of Timeliness of the Definitive Treatment of MSCC</td>
<td>The results should be expressed as collated across the network and also by each hospital delivering definitive treatments (primary surgery or primary radiotherapy).</td>
</tr>
<tr>
<td>Taking the group of patients who receive definitive treatment for MSCC (Primary surgery or primary radiotherapy), there should be an audit of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. the time from the request for imaging for clinically suspected MSCC to the start of definitive treatment;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. the time from the completion of imaging to the start of definitive treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The NAOG should have discussed the results of the completed network audit project and have agreed any actions resulting from the audit with the relevant hospitals.</td>
<td></td>
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</tbody>
</table>
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).

The NAOG should have discussed the results of the completed network audit project and have agreed any actions resulting from the audit with the relevant hospitals.

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.
**Introduction**
The responsibility for peer review purposes for measure 14-3Y-101 lies with the lead cancer clinician of the trust. The responsibility for the subsequent measures lies with the hospital acute oncology lead.

**Key Theme**
Structure and Function

**Objective**
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

**The Acute Oncology Team**

**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 AO problems in the course of their everyday practice. The team is organisational, dealing with AO policies, protocols and procedures for the hospital. Each hospital is separately reviewed, even if it shares an Acute Oncology Team (AOT) with another hospital. Compliance against the hospital measures counts towards the hospital, not the AOT.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
</table>
| 14-3Y-101 | The Acute Oncology Team | (1) 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.  
(2) If haematologists take part in the hospital's AO assessment service, the haematologist should be one of those.  
(3) The actual amount of time is not subject to review.  
(4) The AOT acute oncology team according to local arrangements may be a team representing one hospital or it may be a single team representing more than one hospital, e.g. one whole trust. This is not subject to review save that there should be no more than one AOT acute oncology team in or covering for a single given hospital.  
(5) The attendance rates of individual members are not subject to review. | Operational Policy. |
• a physiotherapist or occupational therapist who should be named as the rehab lead for MSCC.

There should be specified and timetabled time in the work plan(s) job description(s) of named secretarial/administrative staff, for support for the work of the AOS acute oncology service for the hospital. There should be an agreed list of responsibilities for this role. (3)

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 AO acute oncology, for the hospital;
• the team should have the delegated responsibility from the hospital's management to;
  • (i) act as the co-ordinating body for matters relating to AO acute oncology between the hospital's clinical directorates and departments and between the hospital and other hospitals in the cancer network; (4)
  • (ii) ensure the implementation of the AO 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. (5)

<table>
<thead>
<tr>
<th>14-3Y-102</th>
<th>Acute Oncology Induction Training for Accident and Emergency Staff</th>
</tr>
</thead>
</table>
| 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 AOS.
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 AOS. | This measure should be read in conjunction with the relevant network measures in section 1E. The hospital may choose to train other members of the A&E staff, e.g. junior medical staff. This is not subject to review. |

<table>
<thead>
<tr>
<th>14-3Y-103</th>
<th>Acute Oncology Induction Training for Acute Medical Take and Medical Admissions Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 AOS.</td>
<td>This measure should be read in conjunction with the relevant network measures in section 1E. The hospital may choose to train other members of the A&amp;E staff, e.g. junior medical staff. This is not subject to review.</td>
</tr>
</tbody>
</table>
Key Theme

Co-ordination of Care / Patient Pathways

Objective

All patients receive co-ordinated care.

Fast Track OPD Appointment Slots

Introduction

The Context

There are a variety of pathways for potential AO cases to follow, after an assessment in accident and emergency, including:

- acute admission without intervening assessment other than by accident and emergency staff;
- assessment in accident and emergency 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 AO 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 accident and emergency.
- For guidance, it is intended, as proposed by NCAG, to be for patients not ill enough to need immediate admission from accident and emergency but needing a quicker than routine appointment.
- It is intended that a patient can be given such an appointment by accident and emergency staff without needing any further intervention at that stage by any oncology staff, such as the AO assessment service.
- For AO patients where the diagnosis of malignancy and its likely primary site is known, or judged to have been made in accident and emergency, 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 accident and emergency, but it's likely primary site has not, the measures on malignancy of unknown origin (MUO) and carcinoma of unknown primary (CUP) apply, requiring referral to the CUP assessment service.
- 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 accident and emergency 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 accident and emergency departments and their referral arrangements, not the hospitals, via their outpatient departments.

14-3Y-104 Fast Track Referral Protocol and Appointment Slots

Applicable only to hospitals with an accident and emergency department on site.

There should be a protocol for the A&E department for fast tracking patients which specifies that for AO patients where the diagnosis of malignancy and its likely primary site is known, or judged to have been made in A&E, the patients should be referred where clinically indicated to fast track slots in named site-specific clinics. (1)

(1) See the introduction above regarding local protocols for the case of patients under the care of a known oncologist and for MUO/CUP patients.

(2) A given hospital's current arrangements for the site-specificity of clinics will
There should be a list of named clinics associated with the A&E department which fulfil the following:

- they should have appointment slots identified for patients referred from the A&E department according to the AO fast track referral protocol to be seen within one week;
- there should be named site-specific clinics offering this service and covering at least the following cancer sites:
  - breast, lung, colorectal, upper GI tract, gynaecological, urological, head and neck, haematological, skin and CNS. (2)

The clinics may be in a different hospital than the A&E department.

The measure may be fulfilled by slots reserved in existing clinics or an undertaking to overbook to accommodate such patients.

<table>
<thead>
<tr>
<th>14-3Y-105</th>
<th>Oncology Communication Protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AOT should agree a set of protocols which include the specifications that:</td>
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</tr>
<tr>
<td>- the A&amp;E department, if relevant, should inform a member of the hospital's urgent oncology assessment service if a patient has been seen in A&amp;E, who fulfils the criteria of an AO presentation;</td>
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<tr>
<td>- 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 AO presentation;</td>
<td></td>
</tr>
<tr>
<td>- 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).</td>
<td></td>
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</tbody>
</table>

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.

An AO presentation, for the purpose of this measure is defined as any of the conditions in the list in appendix 3.

This measure currently assumes that the urgent oncology assessment service will only be available during weekdays as a minimum.
Acute Oncology Measures for Specialist Cancer Hospitals

Introduction
The responsibility for peer review purposes for measure 14-3Y-201 lies with the lead cancer clinician of the trust. The responsibility for the subsequent measures lies with the hospital acute oncology lead.

Key Theme
Structure and Function

Objective
Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

The Specialist Cancer Hospital Acute Oncology Team
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 AO problems in the course of their everyday practice. The team is organisational, dealing with AO policies, protocols and procedures for the hospital. Each hospital is separately reviewed, even if it shares an AOT with another hospital. Compliance against the hospital measures counts towards the hospital, not the AOT.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>14-3Y-201</td>
<td>The Specialist Cancer Hospital Acute Oncology Team</td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td><strong>There should be a single AOT, for the hospital, with a minimum membership, chair and terms of reference, as follows:</strong> Membership:</td>
<td></td>
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<tr>
<td></td>
<td>• one of the members listed below, should be the hospital acute oncology lead who should be chair of the group; (1)</td>
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<tr>
<td></td>
<td>• an oncologist who is a member of the acute oncology assessment service;</td>
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<td></td>
<td>• a haematologist, if the hospital has a haematology service, treating malignant disease; (2)</td>
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<tr>
<td></td>
<td>• a specialist oncology nurse;</td>
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</tr>
<tr>
<td></td>
<td>• a specialist haematology nurse, dealing with patients with haematological malignancy, if the hospital has a haematology service, dealing with malignancy;</td>
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<td></td>
<td>• if not included in the above and if the hospital has a chemotherapy service, the head of service of chemotherapy;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• if not included in the above and if the hospital has a radiotherapy department, the head of service of radiotherapy;</td>
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<tr>
<td></td>
<td>• a person agreed as representing management of acute oncology services;</td>
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<td></td>
<td>• a representative of a specialist palliative care team;</td>
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<tr>
<td></td>
<td>• a physiotherapist or occupational therapist who should be named as the rehab lead for MSCC.</td>
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</tr>
<tr>
<td></td>
<td><strong>There should be specified and timetabled time in the work plan(s) of named secretarial/administrative staff,</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) 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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) If haematologists take part in the hospital's AO assessment service, the haematologist should be one of those.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) The actual amount of time is not subject to review.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) The attendance rates of individual members are not subject to review.</td>
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</tbody>
</table>
for support for the work of the AOS for the hospital. There should be an agreed list of responsibilities for this role. (3)

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 (if applicable) lead for AO for the hospital;
- the team should have the delegated responsibility from the hospital's management to:
  - (i) act as the co-ordinating body for matters relating to AO between the hospital's clinical directorates (if applicable) and departments and between the hospital and other hospitals in the network;
  - (ii) ensure the implementation of the AO 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. (4)

Key Theme

**Co-ordination of Care / Patient Pathways**

**Objective**

All patients receive co-ordinated care.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-3Y-202 Agreement of Acute Oncology Treatments and Procedures</td>
<td>This measure should be read in conjunction with the relevant network measure in section 1E.</td>
<td>Operational Policy.</td>
</tr>
</tbody>
</table>

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 NAOG.

| 14-3Y-203 Acute Oncology Referral Acceptance Protocol | This measure should be read in conjunction with the relevant network measure in section 1E. | Operational Policy. |

The specialist hospital should have a protocol as follows:

- having agreed the particular range of AO treatment procedures that are provided by the specialist cancer hospital (14-3Y-202), the protocol should specify which types of AO 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 AO assessment team and any other staff who
decide on acceptance of AO 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.
General Acute Oncology Measures for Hospitals

**Introduction**

The responsibility for peer review purposes for the first measure lies with the lead cancer clinician of the trust. The responsibility for the subsequent measures lies with the hospital acute oncology lead. These measures should be read in conjunction with the relevant network measures where applicable.

**Key Theme**

**Structure and Function**

**Objective**

Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
<tbody>
<tr>
<td>14-3Y-301</td>
<td><strong>Core Membership</strong></td>
<td>Operational Policy.</td>
</tr>
<tr>
<td></td>
<td>There should be a single named AO lead for the hospital, agreed by the trust lead cancer clinician. (1)</td>
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<tr>
<td></td>
<td>The hospital AO lead should have agreed a list of responsibilities for the post with the trust cancer lead clinician.</td>
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<td></td>
<td>The AO 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. (2)</td>
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<tr>
<td></td>
<td>(1) The post holder could be from any of the three clinical professional groups (nursing, medical, pharmacy) but should be of consultant status.</td>
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<tr>
<td></td>
<td>(2) The trust may include the duties of hospital lead for MSCC in those of this post or in addition, name a separate individual who fulfils this measure independently for a minimum single session and against a list of responsibilities for the MSCC lead only.</td>
<td></td>
</tr>
<tr>
<td>14-3Y-302</td>
<td><strong>Patient Flagging System</strong></td>
<td>Operational Policy.</td>
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<tr>
<td></td>
<td>The hospital should have implemented a system for immediate essential patient information retrieval which includes at least the following specifications: (1)</td>
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<tr>
<td></td>
<td>• it should be intended for the management of patients presenting acutely with the complications of systemic chemotherapy for malignant disease and of radiotherapy; (2)</td>
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<tr>
<td></td>
<td>• it should identify patients who have received systemic chemotherapy for malignant disease or radiotherapy within the previous six weeks;</td>
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<td></td>
<td>• the information should include, as well as their standard demographic parameters, the following:</td>
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<td></td>
<td>• their current cancer diagnosis;</td>
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<td></td>
<td>• their most recent systemic treatment regimen and date of most recent administration;</td>
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<td></td>
<td>• the treatment intention.</td>
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<td></td>
<td>• the patient population for a given system should include at least all those patients being treated by the hospital under review;</td>
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<tr>
<td></td>
<td>• the information should be viewable electronically</td>
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<tr>
<td></td>
<td>(1) The hospital may choose a more comprehensive system than specified in this measure, with a wider range of patient types or larger patient population.</td>
<td></td>
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<td></td>
<td>(2) These are defined as in the relevant parts of appendix 3.</td>
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ACUTE ONCOLOGY MEASURES

GATEWAY No. 15843 - APR 2014

26
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.

<table>
<thead>
<tr>
<th>14-3Y-303</th>
<th>Consultant Oncologist Telephone On Call Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital should agree the network specification for the consultant telephone on call service and provide its agreed contribution of staff on the rota.</td>
<td>It may agree with the NAOG that it need not provide any contribution to the service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14-3Y-304</th>
<th>The MSCC Coordinator Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable only to hospitals agreed by the network as definitively treating cases of MSCC with surgery and/or radiotherapy. The hospital should have a MSCC co-ordinator service which fulfils the following:</td>
<td></td>
</tr>
<tr>
<td>• there should be a single contact number for the hospital's service;</td>
<td></td>
</tr>
<tr>
<td>• 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;</td>
<td></td>
</tr>
<tr>
<td>• the staff on the rota should agree a list of responsibilities for the co-ordinator role with the hospital acute oncology lead; (1)</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
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</tr>
<tr>
<td>(1) See appendix 2 for a list of responsibilities for illustrative purposes only.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>14-3Y-305</th>
<th>Acute Oncology Induction Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 AO service.</td>
<td></td>
</tr>
</tbody>
</table>

ACUTE ONCOLOGY MEASURES

GATEWAY No. 15843 - APR 2014
### Key Theme

#### Co-ordination of Care / Patient Pathways

**Objective**

*All patients receive agreed treatment that is consistent and equitable.*

### 14-3Y-306 The Acute Oncology Treatment Protocols

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

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. (1)

The protocols for the acute management of MSCC should also be available on orthopaedic wards where patients with acute spinal cord compression are admitted as part of the ward's agreed policy.

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

### 14-3Y-307 The One Hour to Antibiotic Pathway

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 hospital AO treatment protocols.

### Objective

*All patients receive co-ordinated care.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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</thead>
</table>

The hospital should agree:

- the network MSCC senior clinical advisor service specification and provide its agreed staff members for the MSCC advisors' rota;
Key Theme

Patient Experience

Objective

All patients receive patient centred care with respect and dignity which takes account of their holistic needs.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-3Y-309 Patient Information on Early Detection of MSCC</td>
<td></td>
<td>Operational Policy. Examples should be available for PR visit.</td>
</tr>
</tbody>
</table>

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.

Key Theme

Clinical Outcomes / Indicators

Objective

All patients receive treatment intended to provide the best possible outcomes that is consistent across the network.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-3Y-310 The One Hour to Antibiotic Audit</td>
<td></td>
<td>Annual Report.</td>
</tr>
</tbody>
</table>

There should be a hospital audit of 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 include all settings which deal with the assessment and initial management of patients with neutropaenic sepsis.

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. (1)

(1) The results themselves are not subject to the peer review. They are used here as evidence that the audit has been performed.
Introduction
The responsibility for peer review purposes for these measures lies with the hospital acute oncology lead. These measures should be read in conjunction with the relevant network measures where applicable.

Key Theme
Structure and Function

Objective
*Patients receive treatment from specialists that have the skills and expertise to ensure the best possible outcomes.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>14-3Y-401</td>
<td>Staffing of Acute Oncology Assessment Service by Oncologists</td>
<td>(1) Providing the specifications are fulfilled, the oncologist may be available for other duties during the specified time. (2) The definition of acute oncology presentations for the purpose of this measure is as found in appendix 3. (3) 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. This is not subject to review.</td>
</tr>
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</table>
**Acute Oncology Assessment by Specialist Nurses**

**Introduction**
The measure below is not applicable to specialist cancer hospitals without an A&E or acute general medical on take.

It has been decided that a mandatory specialist nurse AO 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.

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 AO assessment by a specialist cancer nurse may be applicable in this instance and this is left to the discretion of the peer review.

<table>
<thead>
<tr>
<th>14-3Y-402</th>
<th>Staffing of Acute Oncology Assessment Service by Specialist Nurses</th>
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<tbody>
<tr>
<td><strong>Not applicable to specialist cancer hospitals without an A&amp;E or acute general medical on take.</strong></td>
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<tr>
<td>There should be sessions, worked in the hospital, in the job descriptions of specialist nurses, which fulfil the following specifications:</td>
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<tr>
<td>• there should be a minimum of two nurses involved;</td>
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<tr>
<td>• there should be a minimum of one nurse's session for each morning and each afternoon of the 5 weekdays;</td>
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<tr>
<td>• during the sessions, the nurse should be available for consultations with and/or ward visits to patients presenting with AO problems, admitted during the previous 24 hrs, (or over the weekend, for a Monday PA). (1,2)</td>
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<tr>
<td>There should be a rota of named staff, for the 'acute assessment by specialist nurse' sessions.</td>
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<table>
<thead>
<tr>
<th>14-3Y-403</th>
<th>Induction Training for Acute Oncology Assessment Service</th>
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<tbody>
<tr>
<td>The consultant oncologists and NCCG oncology staff in the hospital who take part in the hospital's AO assessment rota should be trained according to the network training in the use of the AO service.</td>
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</table>

**Key Theme**

**Co-ordination of Care / Patient Pathways**

**Objective**

*All patients receive co-ordinated care.*

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<thead>
<tr>
<th>Measure</th>
<th>Notes</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>14-3Y-404</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

**Operational Policy.**

To be confirmed at PR visit.
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;

<table>
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<tr>
<th>2. for specialist cancer hospitals;</th>
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<tbody>
<tr>
<td>• 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;</td>
</tr>
<tr>
<td>• for patients admitted during the weekend, they should be seen and assessed by a consultant oncologist during Monday morning.</td>
</tr>
</tbody>
</table>

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 and secondly by the MSCC audit measures which address the timeliness of the stages in the patients’ pathway.
**Section 2 Clinical Indicators/Lines of Enquiry**

**Introduction**

The clinical indicators identified in this section have been identified by clinicians within the service as key aspects that reflect the quality of treatment and care provided. These indicators should form the basis of discussion by teams enabling them to identify areas for improvement. The team should comment on these indicators in their self assessment report and any plans for improvement should be included in their work programme.

<table>
<thead>
<tr>
<th>Clinical Indicators</th>
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<td>TBA</td>
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Appendix 1 Ground Rules for Networking

Ground Rules for Networking

Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarised as follows:

- They prevent destructive competition between MDTs for their catchment populations.
- They prevent destructive competition between network groups for their associated MDTs.
- They allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients’ best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

The Network Groups

- The network group should be the only such network group for the MDTs which are associated with it.
- For cancer sites where there is only one level of MDT, the network group should be associated with more than one MDT.
- For cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the network group need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.
  Notes: The network group need only be associated with one specialist/supranetwork type MDT but may be associated with more than one.

Cross Cutting Groups

These currently include network groups for:

- Chemotherapy
- Radiotherapy
- Acute Oncology

These services are required to have local multiprofessional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with.

- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.
  Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and delineate their boundaries in terms of staff and facilities. Sometimes a declared ‘service’ may cross more than one hospital.

MDTs

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e. no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.
  Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning
purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances.

This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.

- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.

  Note:
  
  This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site.
  
  This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust.
  
  This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.

- The MDT should be associated with a single named network group for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

  Note:
  
  MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one network group, but should have only one per cancer site. E.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate network group for each of its specialty sites.

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the ‘local’ type MDTs.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area.

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site.

- The specialist MDT should act as the ‘local’ type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.

  Note:
  
  This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site.

- The specialist MDT should be associated with a single named network group, (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.
Appendix 2 Roles and Responsibilities

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.
Appendix 3

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.