NHS England

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Chemotherapy CRG
Service	Acute Oncology - Adult
Commissioner Lead	Nathan Howes/Nicola Mcculloch
Provider Lead	Dr E Marshall
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Emergency admissions place an enormous burden on patients and the NHS. Over the last decade, emergency admissions have increased by 31% and attendances at Emergency departments have increased by more than 2 million to 16 million per annum[1] . Emergency presentation linked to cancer has doubled with 300,000 unplanned admissions per year[2] and often associated with poor patient experience, poor coordination of care, poor communication and fragmented patient pathways[3,4] . Following admission, there is wide variation in hospital length of stay for these patients with an average of 9.6 days[1]. It is estimated that the NHS could save in the region of 566,000 bed days, equating to £113million, if this variation was reduced to meet the best performing quartile.

A publication from a single Cancer network on over 3000 AO admissions reported that approximately, 50% of admissions are a consequence of cancer progression or associated comorbidity, 30% a consequence of cancer treatment and 20% represent an emergency presentation of a new cancer diagnosis[5] . In England, 24 per cent of all new cancers, around 58,400 cases a year, are diagnosed through an emergency presentation associated with reduced 1 and 5 year survival[6] Finally, emergency presentation following chemotherapy is increasing as a consequence of advances in new chemotherapy and the greater use of multiple lines of palliative chemotherapy.

Acute Oncology

Acute Oncology service provision was identified in 2009 as a key recommendation of the National Chemotherapy Advisory Group (NCAG) for improving quality and safety of emergency care for those patients with previously undiagnosed cancer and complications of cancer or treatment[7]. The report addressed concerns raised by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)[3], national peer review appraisals and the National Patient Safety Agency[8] The role of AOS has since been consolidated with the publication of NICE guidance concerning

CUP, Neutropenic Sepsis and MSCC[9]. Despite progress in recent years, both national peer review[10] (2013/14) and the 4th annual report of the Cancer Strategy[11] have highlighted particular concern in relation to AO and CUP with many areas of non-functioning and non-compliant services due to lack of staffing, lack of training and lack of robust emergency cancer pathways including MSCC.

Opportunities and 5 year view

Following the NCAG recommendations, AOS have largely focused on improving inpatient care. Despite many challenges, peer review has identified many areas of good practice highlighting improved quality of care and reduced Length of stay. Moving forward, AO represents a vehicle to deliver seamless emergency cancer care and admission avoidance in line with the Future Hospital commission[12] and Emergency Care strategy[1] and NHS 5 year view[13]. Acute Oncology represents one aspect of emergency care and Acute Oncology Services should connect to the whole urgent and emergency care system with the aims of supporting self-care, supporting admission avoidance and ensuring emergency cancer patients receive the right care in the right place with the necessary facilities and expertise, available 24 hours per day. Acute Oncology services should ensure that their expertise should extend to community services to facilitate the dialogue between primary and secondary care staff and to promote education, service redesign and the timely flow of patient information.

.

References

1.Transforming urgent and emergency care services in England: Urgent and Emergency care Review. End of Phase I Report. (2013).

2. Delivering the Cancer Reform Strategy – National Audit Office 2010.

3.The National Confidential Enquiry into Patient Outcome and Death report “For better For Worse” in 2008.

4. Cancer Patients in Crisis: A joint working party report from the Royal College of Physicians and Royal College of Radiologists (2013).

5. The impact of a new acute oncology service in acute hospitals: experience from the Clatterbridge Cancer Centre and Merseyside and Cheshire Cancer Network. Neville Webb H et al, Clinical Medicine 2013, 13, 565-9

6. Routes to diagnosis project. NCIN 2013

7. The National Chemotherapy Advisory Group (NCAG) report “Chemotherapy Services in England; Ensuring Quality and Safety (2009)

8.The National Patient Safety Agency (2008) Oral Chemotherapy alerts

9. The National Institute for Health and Care Excellence guidance in Cancer of Unknown Primary (CUP) , Metastatic Spinal Cord Compression (MSCC) and Neutropenic sepsis (NS)

10. National Peer review report: Acute Oncology 2012-2013

11. Improving outcomes: A Strategy for Cancer. Fourth Annual Report 2014

12. Future Hospital: Caring for medical patients (2013)

13. The NHS Five year forward view (October 2014):

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

An effective acute oncology service (AOS) will enhance patient experience and clinical effectiveness and ensure that equitable, safe, high quality emergency care is consistently provided for non-elective/emergency adult patients with known or suspected cancer.

AOS Outcome Measures

Inpatient Care

An effective AOS will:

- Provide emergency cancer intelligence delivered by an agreed minimum dataset
- Ensure AO review within 24hrs of admission, 7 days a week
- Improve safety and quality of emergency care with development of AO pathways, protocols and training
- Support the Neutropenic Sepsis pathway in line with published NICE guidance and continuously reduce mortality in neutropenic sepsis,
- Improve patient experience
- reduce Hospital length of stay (LOS)
- reduced 30 day readmission
- support the Metastatic spinal cord compression (MSCC) pathway in line with published

NICE guidance

Admission Avoidance

An effective AOS will:

Deliver services to promote Admission avoidance & reduction in Emergency department admissions by:

- Leading on patient information, education and self-help concerning emergency contingency planning
- Supporting 24/7 Cancer help lines for health professionals and cancer patients
- Developing Options for rapid access and ambulatory care
- Supporting Carcinoma of unknown primary (CUP) services in line with published NICE guidance & including options for fast track review in cases of suspected cancer that require urgent oncology review
- Developing community/outreach AO services

Data and Information Management:

An AOS will maintain an agreed minimum dataset and have an explicit data and information strategy in place that covers: types of data, quality of data, data protection and confidentiality, accessibility, transparency, analysis of data and information, use of data and information, dissemination of data and information, risks.

- Number of emergency admissions for cancer-related problems by patient and tumour type;
- **Type I**: All Patients in whom a first diagnosis of cancer is made in the emergency setting
- **Type II**: Complications of non- surgical therapies
- **Type III** Patients with known cancer
- Time of referral and time of review by member of the Acute Oncology Service
- Number of patients reviewed by the AOS
- Number of patients discussed at AO review meeting
- Inpatient length of stay for all medical emergency cancer patients
- Readmission rates within 30 days
- Mortality in neutropenic sepsis according to risk stratification group (MASCC)
- Time to first antibiotic in suspected neutropenic sepsis
- Compliance with Trust antibiotic protocol in neutropenic sepsis
- Compliance with Metastatic Spinal Cord Compression measures;
- Audit of MSCC management and outcomes including surgical interventions, functional outcome and survival
- Deaths within 30 days of receiving chemotherapy

- Annual acute oncology patient experience survey
- Annual professional experience survey
- % of patients with a complete mandatory minimum dataset
- Triage and assessment outcomes:
- Numbers of patients/professionals contacting 24 hour advice line services
- Numbers of patients managed with advice and/or referral to primary care services
- Numbers of patients managed with telephone follow up or planned outpatient review
- Number of patients asked to attend an ambulatory or assessment unit.
- Numbers of patients asked to attend A&E for assessment
- Numbers of patients admitted for on-going care.
- Clinical incidents involving advice lines
- Patient and professional advice line experience including complements and complaints

3. Scope

3.1 Aims and objectives of service

Acute Oncology and Haemato-oncology

This Acute Oncology (AO) specification covers Haemato-oncology as well as solid tumour oncology. All Haemato-oncology services and patients are considered to be subject to this service specification. In many services, established Haemato –Oncology pathways already fulfill the core principles set out within the service specification for AO. The differing work patterns of haematologists and oncologists are recognised, and local differences in the delivery of AO by haematologists and oncologists are acceptable as long as the principles set down in this document are adhered to. It is expected that haematologists and oncologists will work together as closely as possible to ensure efficient use of AO resources and for this reason, the membership local AO teams must include both haematology and oncology representatives.

The principal role of the Acute Oncology Service in emergency cancer care is advisory and lies in:

- Defining the most clinically appropriate care pathway
- Improving patient experience,
- Communication with and signposting to appropriate specialist advice and services.
- Training and education

The overarching aim of the AO service is to:

- Ensure timely and equitable access to specialist oncology review and advice for all cancer patients who present with a cancer-related emergency
- Develop standard, evidence based management protocols and pathways to ensure safe,

high quality and effective treatment for emergency cancer care
- Conform to national standards and guidance and ensure local audit is conducted to ensure these standards are met
- To support a standard training and education programme in emergency cancer care to staff involved in the care of acute oncology patients to ensure safe high quality care is available 24/7
- To develop alternative pathways to hospital admission and reduce variation in hospital length of stay following emergency presentation
- To develop effective communication pathways and record keeping to ensure that all those involved in the patients care are informed regarding emergency presentations and actions taken

3.2 Service description/care pathway

3.2.1 The Acute Oncology Patient Pathway The acute oncology pathway requires a whole system approach towards prevention and contingency planning. There should be regular assessment of risks and systematic adoption of emergency contingency planning for individual patients with cancer. AOS should hold cancer site specific teams to account according to the quality of patient information and contingency planning.

The acute oncology patient episode begins at the same point for all patient groups at the first contact with a health professional during this acute episode and ends at the point that responsibility for care is transferred to site specific, Specialist palliative or primary care team

3.2.2 Community presentation & cancer patient triage:

For known cancer patients, with urgent care needs,, access for both patients and health care professionals to urgent telephone advice is essential and may direct patients to appropriate emergency care such as direct admission or A&E attendance or offer admission avoidance strategies including patient self-management, advice or community review by one of the following: General Practitioner, specialist palliative care team, district nursing services, ambulance service , access to ambulatory care or day-case facility, or urgent OPD review.

- 24 hour cancer advice lines should be available for healthcare professionals and should have links with the on call oncology team.

- All Cancer patients should be provided with clear information on emergency contact numbers, recognising that these may change during a patient cancer journey.

- 24 hour dedicated specialist cancer advice lines should be available to all Patients with known cancer who are receiving Systemic Anti-Cancer Therapy (SACT) or radiotherapy..

Healthcare professionals manning advice lines should be trained to: -
- Assess and triage patients contacting advice lines
- Provide advice and guidance that is underpinned by national algorithms (e.g. UKONS triage tool) and provide timely access to senior clinician advice when required.
- Direct and link patients to associated services, such as specialist palliative care, general practitioners, and district nursing services or ambulance teams.
- Ensure that the patient episode is recorded and communicated to the oncology team responsible for the patients' management.
- Provide timely specialist emergency care advice for cancer related problems for healthcare professionals

Advice line providers should have clear protocols for: -

- The provision of patient and professional information regarding the advice line contact numbers and what to lookout for and when to contact the advice lines
- Admission and assessment pathways
- Continued monitoring and review process for patients who have contacted the advice line
- Pathway for rapid review as an outpatient

3.2.3 Patient Information:

Health care professionals should have access to key patient information and treatment details 24/7.This information should be made available through hospital-wide electronic medical record systems, which should link, to cancer-specific systems (e.g. Somerset) and community electronic records.

3.2.4 Emergency Department (ED):

ED attendance is for acutely unwell patients where there is no established diagnosis or pathway and that require emergency review and management (within 24hours). ED staff should have training and 24-hour access to agreed emergency cancer treatment protocols, appropriate intra venous antibiotics, emergency cancer management pathway algorithms and advice from an AOS service. ED should develop pathways to ensure patients with suspected cancers are referred urgently to the appropriate cancer site specific multidisciplinary team (MDT) according to nationally agreed 2 week rule pathways. AOS services should facilitate responsive 2 week referral pathways for patients with suspected new cancers that do not fit existing 2 week referral criteria. The AOS should be informed of all known cancer-related emergency presentations within 24 hours of presentation.

3.2.5 Acute Medical Units (AMU):

The AOS should develop collaborative working with AMU to provide seamless care for all cancer patients admitted to AMU with the aim of delivering expert care and options for early hospital discharge. This integration should include daily access to AOS team, pathways and protocols. Integration may be facilitated and enhanced by joint posts, link nursing roles, training and AMU core membership of the weekly AO meeting and Trust AO steering group.

3.2.6 Inpatient Care:

The AOS should be made aware of all inpatient episodes that fall into the category of AO presentations, with timely referral and review. The AOS should be made aware within 24hrs of admission for Type II/III patients or within 24 hours of a suspected diagnosis for Type I patients.

The AOS should provide advice and/or review within 24hours of referral and should ensure transfer of responsibility to site-specific team at the earliest time point.

3.2.7 Discharge planning:

The AOS should provide advice and guidance to clinicians and patients on treatment aims, prognosis and care planning. Working with the Specialist palliative care team, AOS should support timely discharge planning and communication with primary care and community services.

Patients must be given appropriate after treatment care and follow-up including information on contingency planning for subsequent emergency events, and advice on self-management.

3.2.8 Clinical Trials

As is the standard for all areas of health care the importance of evidence based care must be emphasized. Providers should endeavor to participate in any appropriate AO clinical trials and contribute to the development of an evidence base for practice.

3.2.9 AO and Carcinoma of Unknown Primary

All patients presenting with malignancy of undefined primary origin (MUO) should be assessed and managed according to NICE Carcinoma of unknown primary Guidance (CUP). In some instances, CUP assessment arrangements may be offered as part of AOS if appropriate, or to be a separate entity. In either case, there should be a single service for each Hospital Trust and details governing this pathway should be agreed locally and should be made explicit to all referring disciplines.

3.2.10 AO and Metastatic Spinal Cord Compression (MSCC)

MSCC assessment and management requires multi professional and multi-agency collaboration and often spanning several organisations. Service provision and individual patient management should be delivered in line with NICE guidance and national cancer peer review. Against this background, the AOS is responsible for delivering peer review measures and has an important role to play in raising awareness, promoting education, supporting seamless care, audit and service development. The metastatic spinal cord coordinator function should link seamlessly with 24/7 emergency cancer triage services.

3.2.11 Service model

SACT and radiotherapy treatment centres (Tertiary Cancer Referral Centres)

AOS within specialist cancer centres should have a role in the clinical assessment and immediate management of emergency presentations as well as ongoing advice and support of acutely unwell inpatients. In such centres, Oncologists and/or Haematologists will retain chief responsibility for the patient. Tertiary Cancer Referral centres should develop clear management protocols for inpatient care and a single point of access for cancer-related emergency presentation ensuring appropriate levels of expertise, timely review by consultant staff in line with national guidance, competencies and treat and transfer policies. Service development should be supported by acute medicine expertise to ensure networked emergency care pathways and joint working.

Acute Hospitals without dedicated specialist oncology beds

Acute medicine and/or, according to local agreement, Haematology, supported by site-specific cancer teams, designated key workers and Specialist palliative care should retain chief responsibility for the patient.

AOS have a key role providing advice and coordinating care for specific cancer presentations, clearly described in the Manual for cancer standards measures for acute oncology and MSCC. In these circumstances, the AOS would not have direct responsibility for care or defined inpatient bed resource.

Acute Hospitals with dedicated specialist oncology beds

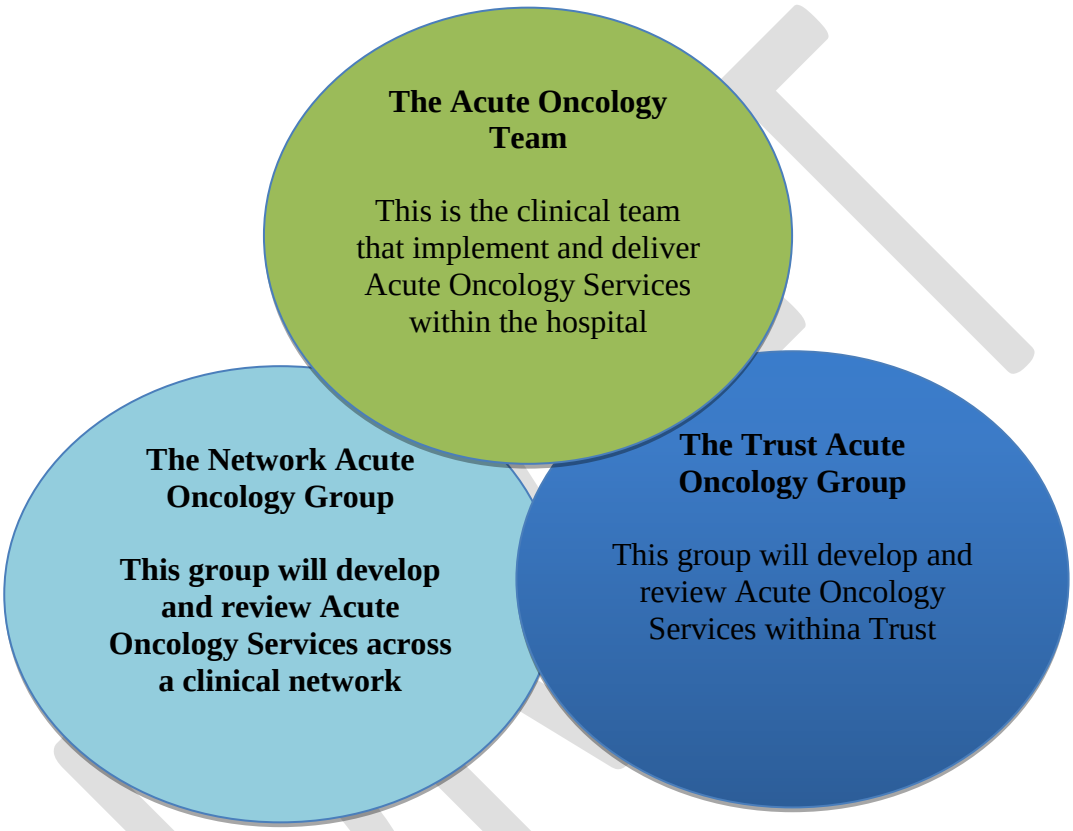
In Acute Hospital Trusts where resident oncology is available, Oncology may retain chief responsibility if there are designated oncology beds and an explicit protocol defining the patient

group. In this instance, policies should clearly define responsibilities and operational arrangements required to ensure seamless care at all times to ensure optimal patient safety, clinical effectiveness, and patient experience.

3.2.12. Core Minimum Requirements for the AOS

The AOS and Staffing:

The diagram below describes the basic structure, links and responsibilities that will need to be developed and demonstrated by those providing Acute Oncology Services.



The Acute Oncology Team (AOT):

The AOT is the core clinical team that is responsible for delivering AOS within the Trust on a daily basis.

Membership: the core membership of the acute oncology team is as a minimum;

- Consultant Oncologist/deputy
- Consultant Haematologist/deputy
- Palliative Care Consultant/deputy
- Acute Oncology, specialist palliative care and Haematology Nursing team
- Administrative support

The core team should include an identified individual (s) with appropriate competencies (Clinical Oncologist or Therapy Radiographer) who is available for advice on radiotherapy and is able to coordinate urgent assessment for palliative radiotherapy treatment.

An AOS requires strong leadership and engagement with non-surgical oncology services to

ensure optimal service development and communication with Tertiary, secondary and primary care. Providers must ensure adequate time for this leadership. The overall lead of the AOS should be a team member who is directly responsible for the development, management and ultimate clinical accountability and responsibility of the service

Acute Oncology teams will ensure that:

- Health care professionals are fully informed of 24 hour access to senior decision making by Consultant Oncology, Haematology and Specialist Palliative Physicians.
- A minimum of 5 day availability for clinical review by a senior physician member of the AOT with 7 day availability for treat and transfer policy
- A fully competent acute oncology team member will assess all patients with a known cancer diagnosis who are admitted as an emergency/unplanned within 24 hours of admission.
- A fully competent acute oncology team member should review all patients who are admitted as an emergency/unplanned and have a new diagnosis or high suspicion of cancer within 24 hours of referral.

Competency must be assessed and agreed by the trust Acute Oncology Lead Clinician.

Staffing levels for AO nursing should support 7 day working and ensure availability to provide direct clinical care within 24hours of referral, timely communication, clinical information capture and their key role in education and service development. Furthermore, coordination of care, communication and outcome measures are dependent on appropriate levels of administrative support.

Weekly review meeting

The acute oncology team should meet weekly at an agreed time to ensure a high level of team working, multiprofessional review of care, good communication, coordinated patient follow up and collection of a minimum dataset The weekly meeting should not delay daily decision making but rather provides multi professional oversight, supporting decision making. All emergency haemato-oncology admissions should be discussed in a weekly meeting either as part of the AOT meeting (with Haematology representation) or as a separate haematology MDT. The weekly meeting should develop links to facilitate communication with community services.

The AO review meeting may act as the CUP MDT in some instances. If this is the case then the group membership should fully comply with peer review measures.

The Trust Acute Oncology Group:

- Responsibilities: this is an overarching multidisciplinary strategic group responsible for governance, service development and monitoring of the AOS across a hospital trust in line with national guidelines and recommendations. .

- Membership: This group should have representation from the AOT, cancer services management and all disciplines/departments involved with the emergency care pathway for cancer patients.

The Network Acute Oncology Group:

- Responsibilities: this group will develop and review acute Oncology services across a defined clinical network and will support, cross boundary working and equitable service

delivery according to national guidelines and recommendations. . This group will offer expert opinion and guidance and will lead on AO performance monitoring on behalf of commissioning groups. The group will lead on education and training for AOTs.

. .

- Membership: this group will be formed and led by representatives from each trust/organisation that provides an acute oncology service in total or a component of acute oncology services within a clinical network. For example an organisation may provide advice line services or deliver a component of MSCC management as part of an acute oncology service and as such should provide representation of their service to this group. This network AO group should ensure appropriate representation from all AOSs and including Oncology, Haematology, Specialist palliative care, primary care, acute medicine and commissioning. The group should have appropriate levels of administrative and data management support to fulfil its role.

3.2.13 Acute Oncology Training and Education

Acute Oncology Induction training in referral criteria, contact details, 24/7 triage and 24/7 consultant oncology availability should be the responsibility of every NHS hospital Trust and CCG education and training department working with Local education and Training Boards (LETBs) to ensure maximum awareness of local service configuration. The induction training package should be produced by each AOS.

The Network AO group should be responsible for training and education of AOTs and ensuring appropriate competencies. All nursing members of the AOT should have completed specific training and competencies in AO presentations delivered as part of a certified AO module and should participate in regular updates, at least on an annual basis.

3.2.14 AO and Specialist Palliative Care

Specialist palliative care has a key role in the delivery of an effective acute oncology service and should provide representation within the AOT. In many instances, Specialist palliative care services may lead the AOS on many aspects of care with specific expertise in symptom control, patient and family support, advance care planning, care in the last days of life and service development. A close working relationship between the acute oncology service and specialist palliative care team is necessary to ensure that patients and families receive appropriate specialist input as part of a cohesive and timely care pathway.

3.2.15 AO and Pharmacy

Providers should ensure full engagement of pharmacy staff with the AOS to support the AOT with 24/7 access to specialist pharmacist advice for chemotherapy regimens prescribed and/or recently administered for a presenting patient, supportive medication needed, advice on and access to palliative care medicines,..
Confirmation of a thorough medication history for newly admitted patients, particularly focussing on identifying oral chemotherapy, chemotherapy adjunctive treatments and chemotherapy supportive medications.
Education and training of general medical and nursing staff to raise awareness of oral chemotherapy drugs and supportive medications to understand fully when to refer patients to specialist services.

3.3 Population covered

This service specification relates to the treatment of adults requiring emergency medical care as part of their treatment for cancer, whether curative or palliative and including treatment for solid tumours and haematological cancers. The service outlined in this specification is for patients ordinarily resident in England*; or otherwise within the commissioning responsibility of the NHS in

England (as defined in Who Pays?; Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purpose of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

An Acute Oncology Service should cover at least the following patient groups:

Type I: All Patients in whom a first diagnosis of cancer is suspected in the emergency setting Acute Oncology Teams (AOT) have a key role in Malignancy of unknown Origin (MUO) and Carcinoma Unknown Primary (CUP) services but also generic skills and competencies for all new emergency cancer presentations when defining aims and objectives for inpatient care (early access to Specialist palliative care, appropriate investigation, treatment options and discharge planning)

Type II: Patients with known cancer who present as an emergency with acute complications of non-surgical treatment – including Systemic Anti-Cancer Therapy (SACT) or radiotherapy.

Type III a. Patients with known cancer who are acutely ill because of the disease itself: This group represent the largest proportion of emergency patients and often present with complex issues including comorbidity, progressive cancer and end of life care (EOL) needs. AOS has a leading role in the assessment of specific complications as outlined in national peer review. For many patients, the AOT should outline the care pathway and discharge to appropriate services (eg Specialist palliative care, cancer site-specific teams, primary care) to ensure optimal efficiency and effectiveness of the service.

Type III b. Patients with known cancer who are acutely ill because of comorbidity. This group of patients will be managed by admitting physicians but may require AOS input where a cancer diagnosis might impact on the medical management and to support care planning, prognosis and ceiling of care.

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Acceptance Criteria

Referrals to the AOS should sent electronically and be triaged daily to ensure timely review by the most appropriate team member. To ensure that all appropriate type II and type III patients are able to access AO services, Trusts should implement electronic recognition and alert systems that would automatically inform the AOS at the point of a patients unplanned attendance.. Patients who attend hospital, as an emergency/unplanned event when receiving SACT or radiotherapy should trigger an electronic alert in the admitting area that will inform the acute care team of their special circumstances.

3.4.3 Exclusion Criteria

Management of cancer in children and young adults treated within the children's services (see separate service specification B15/S/B).

Elective admission of known cancer patients

Emergency admission requiring primarily surgical input

Type III cancer patients managed by site specific teams or specialist palliative care:

3.5 Interdependencies with other services/providers

AOS is a multi-professional service that integrates existing expertise in acute medicine, specialist palliative care, haematology and oncology and community services. The AOS provides outlet for community management, admission avoidance as well as inpatient care across all cancer care providers

3.5.1 Co Located services
The service should be part of a clinical managed network and there should be significant representation from the local service on the network AO group.
This service should work closely with its local, regional and national colleagues to ensure continuous service improvement

3.5.2 Inter dependent services
The AOS will be required to set up and maintain formal links across the Tertiary Referral cancer centre, local district general hospitals and community services and to include governance, training and development and networked solutions for patient information and triage purposes. Cross cover arrangements for core AO members should be organised by the AOT and agreed by the AO lead

3.5.3 Additional key relationships include:

- Pathology Services (including histopathology, haematology, and microbiology)
- Ambulatory and day care facilities
- Inpatient Facilities
- Radiology
- Pharmacy
- Biomedical and clinical research
- Clinical Psychology
- Counselling service and PALS
- Specialist Nursing teams including community nurses
- Macmillan nurses,
- Social workers
- Community services
- Hospice services
- Ambulance service

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

- NICE Improving Outcomes Guidance (IOG) – (http://guidance.nice.org.uk/CSG)
- NICE Guidance CG104: Metastatic malignant disease of unknown primary origin
- NICE Guidance: CG75: Metastatic Spinal Cord Compression
- NICE Guidance CG151: Prevention and management of neutropenic sepsis in cancer
- National Cancer Peer Review “The Manual for Cancer Services” Measures relating to chemotherapy services, acute oncology services and CUP services
- Chemotherapy Reference Group :Chemotherapy Service Specification
- Department of Health (2011) Improving Outcomes: A strategy for Cancer 2011
- National Chemotherapy Advisory Group (2009) Chemotherapy Services in England:

Ensuring Safety and Quality

- NCEPOD (2008) "For Better, for worse? A review of the care of patients who died within 30 days of receiving systematic anti-cancer therapy"

Department of Health (2011) Innovation Health and Wealth, Accelerating Adoption and Diffusion in NHS weblink

All NICE Technology appraisal recommendations should be incorporated automatically into relevant local NHS formularies in a planned way that supports safe and clinically appropriate practice.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- *Cancer Patients in Crisis : responding to urgent needs. A joint report by Royal College of Physicians &Royal College of Radiologists*

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

The reference numbers for quality requirements and the CQUIN goals which apply to the service should be listed here. This allows clarity about the requirements relating to specific services.
Please note any contractual levers relating to quality, KPIs, CQUINs will need to be included in the relevant schedules of the contracts.

6. Location of Provider Premises

The Provider's Premises are located at:

ONLY LIST PROVIDERS IF THERE HAS BEEN A FORMAL DESIGNATION PROCESS.

7. Individual Service User Placement

Insert details including price where appropriate of any individual service user placement e.g. mental health. This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.

Appendix Two

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
Insert text			
Domain 2: Enhancing the quality of life of people with long-term conditions			
Insert text			
Domain 3: Helping people to recover from episodes of ill-health or following injury			
Insert text			
Domain 4: Ensuring that people have a positive experience of care			
Insert text			
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Insert text			