Delivering a systematic approach to dealing with Cancer related emergencies (Acute Oncology) across the Mount Vernon Cancer Network, which meets the recommendations set out in the National Chemotherapy Advisory Group report (NCAG 2009).

INTRODUCTION

This briefing paper is to support the required project management assignment and presentation as part of the YALE International Health Care Management Programme July 2011.

It outlines the role and responsibilities of the Mount Vernon Cancer Network (MVCN) in implementing the National Chemotherapy Advisory Group (NCAG) 2008 recommendations in reforming the way urgent care is provided to patients with Cancer. The NCAG report requires all trusts with an Accident & Emergency (A&E) department to have an established Acute Oncology Service (AOS) by April 2011.

PROBLEM

The NCAG report (2009) recommends reform to the way urgent care is provided for Cancer patients. The Mount Vernon Cancer Network current elective ‘hub and spoke’ oncology services model is unable to meet the NCAG report recommendations, thus resulting in delayed oncology assessment, inappropriate admissions, prolonged length of stay and poor patient experience.

OBJECTIVE

To establish an integrated Acute Oncology Service model within each of the 3 acute hospital trusts that:

- Has implemented the 5 agreed clinical pathways regardless of the patient’s point of entry into the hospital.
- Provides an AOS educational programme for the Medical and Accident & Emergency hospital workforce.
- Provides access to a 24 hour professional on-call telephone line
- Has established an information flagging system which alerts when known Cancer patients are seen in A&E.
- Has an established system for early oncology assessment / review (within 24 hours).
- Has a defined pathway for the recognition and management of Metastatic Spinal Cord Compression (MSCC).
- Demonstrates overall reduction Cancer in-patient length of stays.

**BACKGROUND**

The National Improving Outcomes: A strategy for Cancer was published in January in 2011. This was the first outcome strategy published on behalf of the new government and was developed by Mike Richards the National Cancer Director and National Cancer Action Team (NCAT). It builds upon the previous Cancer Reform Strategy of 2007, but with a stronger emphasis on identifying and improving clinical outcomes. It also reinforces the importance of the Quality, Innovation, and Productivity and Prevention (QIPP) agenda in suggesting the ways reform of Cancer services can contribute to the £20 billion savings that is required by the NHS over the next 3 years. The National Audit Office report highlights scope to reduce inpatient admissions and average length of stay, taken together this could save over £200 million per annum.

Under the auspices of the Cancer Reform strategy and subsequently referenced within the new strategy, the National Chemotherapy Advisory Group was established. This was in response to significant concerns that had been raised in the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report 2008 and from the findings from 2004 -7 National Cancer Peer Review of Chemotherapy services. The NCAG undertook a review on the provision of Chemotherapy services across England and published the report, **Chemotherapy Services in England: Ensuring Quality and Safety (Gateway reference 12208)** in August 2009. It acknowledged that a significant amount of Cancer patients are
admitted as emergencies. 40% of cancer inpatients stays are non-elective admissions and these admissions are often managed by the acute care medical teams. The reasons for the emergency admission is cancer patients who have developed complications from their treatment i.e. Neutropaenic sepsis due to their chemotherapy treatment. With increasing numbers of patients having their chemotherapy closer to home the local district general hospitals are baring the brunt of the acute oncology “unwell” patient. Also a number of patients are admitted as a consequence of their cancer disease i.e.: breathlessness due to a pleural effusion, spinal cord compression due to cancer metastasis. It is estimated that an average hospital will have 5-10 cancer patients admitted to A&E each week.

The report stated that in-patient cancer care accounts for around 50% of all Cancer expenditure and that in-patient cancer care accounts for 12% of all acute in-patient bed stays.

The NCAG report sets out clear actions for both commissioners and providers of both elective and emergency oncology services to ensure that all oncology patients receive high quality care.

The NCAG report highlights 3 key areas for improvements.

1. The Provision of elective Chemotherapy services, to be based around care pathways.
2. The leadership, information systems, governance, monitoring and commissioning of chemotherapy services.
3. The provision of emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer and those patients who present and are suspected to have a cancer. It recommends that all hospitals with an Accident and Emergency (A&E) department establish an “acute oncology service”, bringing relevant staff from A&E, general medicine, haematology and clinical/ medical oncology, oncology nursing and oncology pharmacy.

The Cancer clinical managed networks are tasked to support commissioners and providers to deliver upon the NCAG recommendations. Mount Vernon
Cancer Network is one of the 28 clinical managed networks across England. Its dual aim is to both prevent the incidence of Cancer for its population by helping people lead healthier lives and ensuring Cancer patients have prompt access to high quality safe treatment and care. The delivery of Acute Oncology services has been identified as a priority within the MVCN 2011/12 work plan.

AIMS OF THE ACUTE ONCOLOGY SERVICE:

- Faster and better care of patients with complications of cancer (early recognition, better treatment, rapid referral back to specialist hematology/oncology team, palliative care team)
- Faster and better care of patients with complications of chemotherapy (early recognition, better treatment, early discharge)
- Appropriate investigation of patients who might benefit from treatment for unknown primary cancers (targeted investigations, rapid triage of patients into specialist oncology or palliative care).

SCOPE:
Mount Vernon Cancer Network serves a population of 1.3 million of who live in Hertfordshire, Luton and South Bedfordshire locality. The network management team ensures a governed partnership approach in delivery of required national guidance and quality standards in being delivered between:

- The Cancer centre (A specialist hospital without an A&E department)
- 3 NHS district general hospitals, (4 A&E departments)
- 3 NHS Primary Care Trusts,
- 3 NHS community services,
- A number of hospices and other specialist palliative care providers.

ROOT CAUSE ANALYSIS

The Mount Vernon Cancer Network Oncology Services are provided through a ‘hub and spoke’ model from the Mount Vernon Cancer Centre Hospital
which provides outreach sessional oncology consultant support to the established acute Trusts Cancer units, and the tumour site specific multidisciplinary teams. This current service model is suitable for the provision of elective oncology care and does provide “acute oncology” intervention on an individual patient basis; however this current model does not provide a systematic approach to managing all cancer patients being admitted through the local A&E departments. The reasons for this are.

- Lack of capacity in the Outreach oncologists work plans to provide rapid access, / fast track clinic and unplanned assessments of Cancer patients admitted as an emergency.
- There are no localised clear defined care pathways from A&E to the oncology services.
- Acute trust general medical and A&E teams are not aware that they are able to access 24 hour Oncology telephone advice line.
- There are no flagging systems in place notifying trust and cancer teams that a cancer patient has been admitted.
- There are no network wide protocols in the management of acute oncology care that local trusts can endorse and be referenced to in the emergency setting.
- A&E and acute medical and nursing workforce have no continual professional development in the management of the Acute Oncology patient
- The NCAG report concludes that the delivery of the service changes required should not require additional resources and that potential cost savings from reducing emergency bed days could make the service redesign requirements cost neutral overall.
- The potential destabilisation of the cancer centre Oncologist workforce.

**The AGREED MVCN AOS CARE PATHWAYS.**

The NCAG report recommends that each trust should have 5 defined Clinical pathways for the management and onward referral for those patients who present with Acute Oncology emergencies into the A&E department.
1. Patients who are known to have Cancer and a recent history of having Chemotherapy, Radiotherapy and are admitted with a complication of their recent treatment i.e.: Neutropaenic sepsis.

2. Patients who are known to have Cancer and admitted due to a complication of their disease i.e.: Malignant spinal cord compression, hypercalcemia.

3. Patients who are known to have a diagnosis of Cancer which is stable/cured, and who presents with a non related acute event.

4. Patients in the Palliative/End of Life Care stages of their disease.

5. Patients who are suspected to have a diagnosis of Cancer.

The pathway below has been adopted by each of the trusts.

**IMPLEMENTATION STRATEGY**

In developing the agreed AOS service model across MVCN, an AOS implementation group was established with agreed Terms of reference (appendix 1) and MVCN AOS implementation work plan (appendix 2).
group consisted of senior clinicians – medical, nursing, pharmacy and a physiotherapist, from Oncology, Palliative care, Emergency care and Acute medicine, Cancer service managers, an indentified lead commissioner, and the Network representative. Each of the trusts also established local implementation groups. It was therefore important that there was clarity on the roles and responsibilities between the two groups. The network AOS group acknowledged the limitations of the current ‘hub and spoke’ oncology model and in principle supported the recommendations of the NCAG report. There were a number of challenges identified mainly due to the individual trusts processes and competing agenda’s. There have also been sensitivities on the provision of local oncologist posts and the potential risk of destabilising the Cancer centre consultant workforce if trusts were to appoint their own consultant oncologists. The greatest challenge for the group was implementing a whole system service change with no identified set up costs.

The MVCN AOS implementation plan was presented and ratified by the MVCN board. The key milestones were to undertake a Network wide chemotherapy / Acute Oncology services review and produce an AOS commissioner agreed service specification with quality outcomes monitoring schedule. The service specification outlines the key features that the 3 trusts AOS need to implement:

- Adoption of network agreed A&E protocols for the management of oncology emergencies and implement the induction to AOS network wide training for A&E and medical staff.
- Implement the agreed AOS nurse practitioner model, with a triage process to the Oncologist that ensures that an early review by oncology team within 24 hours 7 days a week is in place.
- To localise the defined clinical pathways for the management and referral onwards of people with oncological emergencies from A&E through to oncology services.
- To work in collaboration with the Cancer centre to provide a 24/7 Acute Consultant Oncology Telephone Service – which provides a single point of contact for emergency advice for professionals.
• Provide fast track clinic access from A&E to an oncologist for those patients suspected with a cancer or not requiring hospital admission.
• Establish a flagging system in A&E that alerts Oncology/Cancer services that a patient with Cancer has been admitted.
• Implementation of the agreed defined pathway for the recognition and management of MSCC.

The MVCN NAOG Implementation Plan incorporates the actions, milestone dates to support the group to deliver the agreed Acute Oncology services within the expected national timescale of April 2011. It also steers the group in preparing for the National Cancer Peer Programme Acute Oncology quality measures review which requires the network group and individual trusts AOS to be internally validated and upload evidence and an assessment report to the national team by September 2011.

PROGRESS TO DATE:
The MVCN Acute Oncology group has met frequently with regular attendance from the key stakeholders. The AOS implementation plan has met the agreed time scales, and the MVCN network group undertook the required internal validation panel review to demonstrate compliance against the AOS peer review measures in June 2011. The following has been developed and implemented.

1. A Acute Oncology Service specification has been agreed by the MVCN board and is part of commissioners acute trusts contracts
2. A Chemotherapy service review has been undertaken and the report and recommendation for service redesign to be presented in September 2011.
3. Network Policies and protocols have been up dated and will be circulated to all acute trusts governance structures which will be required to be endorsed and disseminated network wide.
4. A one day AOS induction training model was delivered in June with 25 A&E staff attending.
5. Agreement of a network wide oncology telephone on call service- a nurse triage to consultant on-call service to be hosted and audited by the Cancer centre.

6. The 3 trusts have secured project management funding from the Macmillan Cancer Support charity for a 18 month post to support the implementation of the;
   a. local 5 agreed care pathways
   b. development of flagging systems
   c. establishing fast track process’s

7. An agreed MSCC pathway to a designated tertiary MSCC coordination centre for surgery with radiotherapy and palliative care being delivered within the network. A network wide MSCC audit is currently being undertaken and will be reported to the Network AOG

**CONCLUSION**

The past year has required close collaborative working from the 3 acute trusts, Cancer centre as well as the lead commissioner in agreeing the AOS model for the MVCN. It was important there was engagement from all the key stakeholders, to ensure a whole system network wide approach was adopted. The network role has been essential in i, leading on the development of the agreed model, ii, providing an infrastructure to support the trusts to implement the AOS service pathways and process’s, iii, to provide a conduit to support sensitive discussions on the preferred way forward.

During this next year, the network will be required to concentrate on the implementation of the AOS model within each of the trusts. This will require performance monitoring against the following outcomes.
<table>
<thead>
<tr>
<th>OUTCOMES (what we want to achieve)</th>
<th>MEASUREMENT (information we need to collect to see the level of achievement of the outcome)</th>
<th>TARGET (specific level of achievement to reach)</th>
<th>DELIVERABLES (activities to do in order to achieve outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reduced SACT deaths</td>
<td>No. patients presenting with neutropenic sepsis who don’t die as a consequence of SACT.</td>
<td>100%</td>
<td>Neutropenic sepsis pathway AOS induction training programme Acute oncology treatment policies</td>
</tr>
<tr>
<td>2 Reduced door to needle time for people with suspected Neutropenic sepsis.</td>
<td>Average door to needle time per patient.</td>
<td>100% within 60 minutes of presentation</td>
<td>Neutropenic sepsis pathway AOS induction training programme Acute oncology treatment policies</td>
</tr>
<tr>
<td>3 Defined appropriate referral to clinical services in line with pathways.</td>
<td>Percentage of patients presenting at A&amp;E with suspected oncological emergency Percentage of admissions related to acute oncology episodes that are appropriate to the case.</td>
<td>20% reduction year on year 100%</td>
<td>Neutropenic sepsis pathway AOS induction training programme MSCC Pathway</td>
</tr>
<tr>
<td>4</td>
<td>Reduced patient’s length of stay in hospital</td>
<td>Average of days in hospital per acute episode</td>
<td>X days - TBC</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>5</td>
<td>Reduced excess bed day usage</td>
<td>Average excess bed day usage per episode of acute oncology patient</td>
<td>X days - TBC</td>
</tr>
<tr>
<td>6</td>
<td>Patients satisfied with the service received</td>
<td>Results of ‘customer satisfaction’ survey/consultation.</td>
<td>95% Satisfaction levels.</td>
</tr>
<tr>
<td>7</td>
<td>Improved clinical outcomes in general</td>
<td>Management of Neutropaenic sepsis – number of cases managed and door to antibiotic time No of suspected MSCC patients referred for surgical opinion</td>
<td>% of cases / % of achieving targets</td>
</tr>
</tbody>
</table>
REFERENCES:


4. **National Confidential Enquiry into Patient Outcomes and Death (NCEPOD).** For better or Worse- A report on care of patients who died within 30 days of receiving systemic anticancer therapy. November 2008.

5. **Cancer Peer Review- National overview report.** 2004-7 National Cancer Peer Review of Chemotherapy services.


**Appendices**

Appendix 1: Terms of reference of the MVCN Acute Oncology Group 2010/11.

Appendix 2: MVCN AOS Implementation plan 2010/11.
Appendix 1:

TERMS OF REFERENCE

FOR

MOUNT VERNON CANCER NETWORK

Acute Oncology Group
General Information

1. Title | Network Acute Oncology Group

2. Accountable to: | MVCN Board

3. How is accountability demonstrated? | Clinical Chair and MVCN Nurse Director will provide regular updates and progress reports to the Board

4. Purpose of Group | The Network Acute Oncology Group will offer expert opinion to the Mount Vernon Cancer Network (MVCN) Board regarding the delivery of Acute Oncology Services, and be the primary source of clinical opinion relating to Acute oncology for the network. The underpinning responsibility is to ensure the highest quality of care available to patients within the MVCN, to ensure equality of access, achieving excellent care in all settings and to attain the best possible outcomes. The NAOG is responsible for advising and informing the MVCN of all aspects of cancer care, ensuring its safe delivery and working with commissioners to accomplish strategic objectives. Working with the MVCN, the NAOG will have responsibility for meeting Peer Review standards and to be an expert resource in response to national and local initiatives.

5. Terms of Reference

- The NAOG should have agreed a work programme with the board for the contracting year in which the peer review/assessment takes place.
- The NAOG should have produced an annual report for the board for the complete calendar or contacting year prior to the peer review visit/assessment.
- The NAOG should meet regularly and record attendance.
- The NAOG should agree, the range of treatments and procedures for acute oncology patients which should be offered on site at the specialist cancer hospital.
- The NAOG should carry out a review of the provision of chemotherapy, oncology pharmacy services and acute oncology services across the network ensuring:
  - there is agreement for planning purposes over the intended sites of chemotherapy delivery and the case mix, with respect to intensity of treatment and potential degree of acute complications, at each service site;
  - there is agreement for planning purposes over the intended configuration of acute oncology services;
  - the issue has been addressed, of co-ordination between the sites / case-mixes of chemotherapy provision and the configuration of acute oncology services;
  - the issue has been addressed, of a balance between (a), consolidation and co-siting of services for different tumour types (for viability and efficiency), and (b), provision of services local to the patient;
  - the time limit for planning purposes for implementation of the review's agreements should be by 2011.
- The NAOG should declare all the hospitals in the network catchment area and categorise them with regards to their current status, according to the Cancer Peer Review
The NAOG should specify which and only which hospitals should definitively treat MSCC (with radiotherapy and/or surgery).

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

The NAOG should be the network's primary source of advice on issues relating to acute oncology in the network;

The NAOG will have with corporate responsibility, delegated by the Network Board for ensuring co-ordination and consistency across the network for implementing the acute oncology measures and for ensuring co-ordination and consistency across the network for the acute oncology practice in hospitals;

The NAOG will be the group for consulting with the NSSGs and the network chemotherapy and radiotherapy groups on the acute oncology treatment and referral guidelines.

The NAOG will be responsible for maintaining the document security of the acute oncological emergency policies, ensuring that they meet the network policy on document control.

The NAOG, in consultation with the hospital acute oncology leads, should agree network induction training in the use of the acute oncology service.

The NAOG in consultation with the chemotherapy heads of service, the radiotherapy heads of service and the hospital acute oncology leads should produce guidelines which should cover:

• when patients with acute oncology presentations consult primary care or hospitals/services outside the acute oncology system,
• the contact points for the hospital MSCC co-ordinators across the network;
• the symptoms and signs suggestive of MSCC

The NAOG, in consultation with the hospital acute oncology leads should agree the minimum specification of the 24/7 consultant oncologist telephone on call service, which should stipulate that:

• 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;
• each contact number should give telephone access during the time of the call to a consultant oncologist, making up a 24/7 duty rota

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);

The NAOG should, in consultation with the hospital acute oncology leads, produce a minimum service specification for a network MSCC, senior clinical advisor service.
## 6. Membership (names, titles and organisations)

<table>
<thead>
<tr>
<th>ROLE</th>
<th>CURRENT REP</th>
<th>TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Clinical Lead / Chair</td>
<td>Pete Ostler</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>Network Co Chair</td>
<td>Jackie Tritton</td>
<td>MVCN</td>
</tr>
<tr>
<td>Trust AOS Lead</td>
<td>Liz Lees</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>Trust AOS Lead</td>
<td>Jan Chalkley</td>
<td>L&amp;D</td>
</tr>
<tr>
<td>Trust AOS Lead</td>
<td>Michelle Sorley</td>
<td>W HERTS</td>
</tr>
<tr>
<td>Nominated representative from the SACT</td>
<td>1 Jeanette Dickson, 2 Andy Polychronis</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>Nominated representative from the network radiotherapy Group</td>
<td>1 Jeanette Dickson, 2 Pete Ostler</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>Clinical Oncologist who is a member of an acute oncology assessment service</td>
<td>1 Jeanette Dickson, 2 Pete Ostler</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>A medical Oncologist who is a member of an acute oncology assessment service</td>
<td>1 Jeanette Dickson, 2 Andy Polychronis</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>A Haemato-oncologist who is a member of an acute oncology assessment service</td>
<td>Judith Hanslip</td>
<td>E&amp;N HERTS</td>
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<tr>
<td>An A&amp;E Cons who is a member of an acute oncology assessment service</td>
<td>TBC</td>
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<tr>
<td>A palliative care Cons who is a member of an acute oncology assessment service</td>
<td>1 Maria Ribiero, 2 Clare Hearnshaw</td>
<td>W HERTS</td>
</tr>
<tr>
<td>A consultant Physician who is a member of an acute oncology assessment service</td>
<td>Andy Barlow</td>
<td>W HERTS</td>
</tr>
<tr>
<td>A Senior clinical advisor for MSCC from both the spinal surgical and clinical oncology disciplines.</td>
<td>1 Jeanette Dickson, 2 Maria Ribero</td>
<td>E&amp;N HERTS</td>
</tr>
<tr>
<td>A Specialist Nurse who is a member of an acute oncology assessment service</td>
<td>Liz Lees, Michelle Sorley, Jan Chalkley</td>
<td>ALL</td>
</tr>
<tr>
<td>A designated oncology pharmacist</td>
<td>Dermot Ball</td>
<td>MVCN</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Sarah Crickmore</td>
<td>E&amp;N HERTS</td>
</tr>
</tbody>
</table>

### Wider Group membership

| Education Lead | Carolyn Fowler | E&N HERTS |
7. Chair of Group | Jackie Tritton  
8. Secretary | Amy Launders  
9. Quorum | 1 Representative from Each Trust + Cancer Centre  
10. Frequency of meetings | Bi Monthly in preparation of AOS panel then quarterly  
11. Reports from and to | MVCN Network Board  
14. Amendments to Terms of Reference |  
15. Lifespan of Group |  

Terms of Reference Agreed …………………………………………………………….
Date: ………………………………………………………………………………………
Review Date: …………………………………………………………………………..
Appendix 2

Mount Vernon Cancer Network

Acute Oncology Implementation Documents

1. RAG MVCN Progress against plan

2. MVCN Work Plan
<table>
<thead>
<tr>
<th>Key Milestone</th>
<th>Specific Action Required</th>
<th>Due Date</th>
<th>MVCN Lead</th>
<th>Progress to date 21/03/11</th>
<th>RAG</th>
<th>Outputs</th>
</tr>
</thead>
</table>
| 1. Set up advisory group on delivering AOS in each Trust                       | *Membership from A&E/Cancer Palliative & Spinal Cord Group.  
  *TOR of group.                                                                                                                                   | March 2010 | JT         | Work plan agreed          | Comp.     | Development of working party                                         |
| 2. Undertake a baseline mapping of current cancer pathways from A&E/AAU         | *Draft mapping, questionnaire circulated to group.                                                                                                          | June 2010 | AG         | *Early mapping results presented at workshop meeting | Comp.     | Set up of working groups at each trust                                |
| 3. Set up working parties at each trust                                        | *Identification of key staff within each trust and each clinical area involved                                                                         | July      | AG         | *Working parties established within each locality. | Comp.     | Trust working parties / implementation groups                          |
| 4. AOS Workshop                                                               | *Workshop – 22nd June                                                                                                                                                                                                    | June 2010 | JT         | *Workshop held – Presentations – MVCN website  | Comp.     | Raising awareness of AOS to support development of working groups      |
| 5. Merge with network MSCC group to develop service and pathways.             | *Integrate existing group into AOS working party                                                                                                           | Jan 2011  | AG         | *MSCC groups and NAOG merged  
  *MSCC requirements reflected in service specification                      | Comp.     | Service Spec signed off                                                        |
| 6. Produce Service specification for Acute Oncology                           | *Agreed Service Specification to be submitted to MVCN Board for approval.                                                                                     | Jan 2011  | AG         | Spec finalised, signed off and circulated | Comp.     | Service Spec updated following Final measures                         |

**Designing the AOS – NETWORK RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>Key Milestone</th>
<th>Specific Action Required</th>
<th>Due Date</th>
<th>MVCN Lead</th>
<th>Progress to date 21/03/11</th>
<th>RAG</th>
<th>Outputs</th>
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</table>
## Designing the AOS – NETWORK RESPONSIBILITIES

### 7. To develop agreed network-wide/local A & E protocols
- **To agree what protocols are required and what is currently covered by existing policies and protocols**
- **Oversee development of outstanding documents**
- **Protocols to be agreed by all relevant Trust/Network Group and ratified by MVCN Board.**

- **March 2011 AG**
- **MVCC Onc Spec Reg to identify current policies and protocols in existence and where gaps exist develop drafts**
- **Drafts to be circulated to appropriate NSSG’s for approval then to each trust to be ratified and adoption**

<table>
<thead>
<tr>
<th>Development of protocols and policies to meet AOS requirements</th>
</tr>
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<tbody>
<tr>
<td>Protocol_Status180411v2.docx</td>
</tr>
</tbody>
</table>

### 8. To develop an agreed AOS Network-wide Induction programme
- **To agree core programme.**

- **Jan 2011 CF**
- **Training needs changed following publication of final measures**
- **Induction programme to be drafted**
- **Education Forum 21th April**

<table>
<thead>
<tr>
<th>Training course syllabus that will meet the skills and competencies required</th>
</tr>
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</table>

### 9. MSCC Management
- **Agreed pathway and service for the management of MSCC**

- **April 2011 JT**
- **Define and agree network pathway**
- **MSCC mtg 13th May**

<table>
<thead>
<tr>
<th>Agreed pathway Draft</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSCC_Pat2_departmentUAL</td>
</tr>
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</table>

### 10. Prepare for NCPR
- **Ensure MVCN AOS documentation ready for SA / IV in Sept 2011**

- **May 2011 AG**
- **Develop constitution, work plan and Annual Report**

<table>
<thead>
<tr>
<th>Documents to be drafted for 3rd May</th>
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<tr>
<td>Green</td>
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### Key Milestone
<table>
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<tr>
<th>Specific Action Required</th>
<th>Due Date</th>
<th>MVCN Lead</th>
<th>Progress to date 21/03/11</th>
<th>RAG</th>
<th>Outputs</th>
</tr>
</thead>
</table>

### 11. To audit current 24/7 telephone advice services within MVCN
- **To audit current advice line usage within the network looking across oncology and palliative care services to ensure good quality safe practice**

- **May 2011 Trust**
- **Network group convened.**

<table>
<thead>
<tr>
<th>Audit proforma developed. To audit all call received on the 6.6.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amber</td>
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**Note:**
- **This is no longer a requirement of the AOS but is staying in the work plan as ensuring good safe practice**

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**Designing the AOS – NETWORK RESPONSIBILITIES**

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### 22
## Designing the AOS – NETWORK RESPONSIBILITIES

<table>
<thead>
<tr>
<th>12. Develop clinical pathways as per AOS measures:</th>
<th>Map and agree MSCC pathway from referral to MRI to North London Coordination Centre</th>
<th>May 2011</th>
<th>CH AG</th>
<th>Project resource identified to spend time per trust mapping the agreed pathways</th>
<th>Green</th>
<th>MSCC Clinical pathway</th>
</tr>
</thead>
<tbody>
<tr>
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