Acute Oncology Service
Expert Reference Group
Constitution

v0.17
1. Agreement

On behalf of the Joint Development Group
Position: Chief Medical Officer
Name: Prof Kathy Pritchard-Jones, Chief Medical Officer
Organisation: London Cancer, Integrated Cancer System
Date Agreed: 18 December 2012

Position: Director of Procurement Contracting and Performance
Name: Mr Will Huxter, Lead Commissioner
Organisation: NHS North East London & the City Commissioning Support Service
Date Agreed: 18 December 2012

Co-chairs of the Acute Oncology Expert Reference Group
Name: Dr Ekaterini Boleti
Organisation: London Cancer
Date Agreed: 8 January 2013

Name: Dr Adrian Tookman
Organisation: London Cancer
Date Agreed: 8 January 2013

Trust cancer lead clinicians (11-1A-301y)
Name: Dr Ian Grant
Position: Trust Lead Cancer Clinician
Organisation: Barking, Havering and Redbridge University Hospitals NHS Trust
Date Agreed: 19 December 2012

Name: Dr Marilyn Treacy
Position: Trust Lead Cancer Clinician
Organisation: Barnet & Chase Farm Hospitals NHS Trust
Date Agreed: 31 December 2012

Name: Dr Sarah Slater
Position: Lead Clinician for Solid Tumour
Organisation: Barts Health NHS Trust
Date Agreed: 14 December 2012

Name: Dr David Feuer
Position: Trust Lead Cancer Clinician
Organisation: Homerton University Hospital NHS Trust
Date Agreed: 14 December 2012
Name: Dr Sian Davies  
Position: Trust Lead Cancer Clinician  
Organisation: North Middlesex University Hospital NHS Trust  
Date Agreed: 19 December 2012

Name: Dr Gordon Read  
Position: Clinical Service Group Lead for Cancer  
Organisation: Princess Alexandra Hospital NHS Trust  
Date Agreed: 14 December 2012

Name: Dr Adrian Tookman  
Position: Trust Lead Cancer Clinician  
Organisation: Royal Free London NHS Trust  
Date Agreed: 8 January 2013

Name: Prof Jonathan Ledermann  
Position: Clinical Director of Cancer Services  
Organisation: University College London Hospital NHS Foundation Trust  
Date Agreed: 6 January 2013

Name: Dr Pauline Leonard  
Position: Trust Lead Cancer Clinician  
Organisation: Whittington Health  
Date Agreed: 14 December 2013

Constitution Review Date: January 2014
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2. Introduction

In April 2011, NHS London published an outline specification for an integrated cancer system (ICS) for the capital to deliver seamless cancer care. The North Central London & West Essex (NCLWE) Cancer Network and North East London (NEL) Cancer Network merged to become the London Cancer ICS.

Dr Adrian Tookman and Dr Ekaterini Boleti were appointed in July 2012 as Co-Chairs of the Acute Oncology Expert Reference Group (AOS ERG) for London Cancer. The AOS ERG was rapidly established, and the first meeting was held on 27th September 2012. The AOS ERG has met monthly since then. Details of the membership of the AOS ERG are provided in Section 4 and in Appendix 1 of this document.

One of the AOS ERG’s first priorities was to confirm the configuration of Acute Oncology Services across the ICS and to agree common working expectations and practices. These are outlined in this constitution, agreed by the AOS ERG at its meeting in January 2013.
3. Configuration

3.1 Review of acute oncology and related services (11-1A-302y)

Prior to the formation of London Cancer, both NCL&WE and NEL Cancer Networks undertook a review of acute oncology and related services (such as systemic anti-cancer chemotherapy services) across their geographical areas.

In accordance with measure 11 -1A – 302y, the purpose of the review was to review acute oncology and related services delivered within the network in order to establish:

- Current configuration of chemotherapy services (tumour types treated)
- Activity, capacity and projected growth
- Payment mechanisms
- Staffing establishment
- Distribution of electronic prescribing
- Pharmacy and compounding provision and capacity

The rest of this section outlines the details of the acute oncology and related services in all of the Trusts across the Integrated Cancer System.
### 3.2 Declaration of Acute Oncology and related services (11-1A-301y)

The AOS ERG has agreed the following configuration of acute oncology services in line with the classification of hospital groupings in the Peer Review measures.

*Table 1: Acute oncology and related services within the London Cancer ICS.*

<table>
<thead>
<tr>
<th>Trust Name</th>
<th>Type of hospital</th>
<th>Chemotherapy service</th>
<th>Dedicated oncology and haemato-oncology inpatient beds?</th>
<th>Definitively treat MSCC with surgery?</th>
<th>Definitively treat MSCC with radiotherapy?</th>
<th>Oncology pharmacy service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking Havering and Redbridge University Hospitals NHS Trusts</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Single service based at Queens Hospital which also covers King George Hospital</td>
</tr>
<tr>
<td>Queens Hospital, Romford</td>
<td>Group 1 A&amp;E department</td>
<td>Outpatient and inpatient chemotherapy for solid tumours &amp; haemato-oncology</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>King George Hospital</td>
<td>Group 1 A&amp;E department</td>
<td>Outpatient chemotherapy for solid tumours</td>
<td>No Patients to be transferred to Queens Hospital</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Trust Name</td>
<td>Type of hospital</td>
<td>Chemotherapy service</td>
<td>Dedicated oncology and haemato-oncology inpatient beds?</td>
<td>Definitively treat MSCC with surgery?</td>
<td>Definitively treat MSCC with radiotherapy?</td>
<td>Oncology pharmacy service?</td>
</tr>
<tr>
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<td>--------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Barts Health NHS Trust</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Bartholomew’s Hospital</td>
<td>Group 2</td>
<td>Outpatient and inpatient chemotherapy for solid tumours &amp; haemato-oncology</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Single service based at St Bartholomew’s which covers The Royal London Hospital, and provides IV chemotherapy to Newham Hospital</td>
</tr>
<tr>
<td>The Royal London</td>
<td>Group 1</td>
<td>None</td>
<td>No - Patients to be transferred to St Bartholomew’s pending on their fitness to transfer. The decision is made by the consultant oncologist on-call.</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>Group 1</td>
<td>Outpatient chemotherapy for solid tumours (lung cancer only) &amp; haemato-oncology</td>
<td>No - Patients are admitted to medical wards</td>
<td>No</td>
<td>No</td>
<td>One service</td>
</tr>
<tr>
<td>Trust Name</td>
<td>Type of hospital</td>
<td>Chemotherapy service</td>
<td>Dedicated oncology and haemato-oncology inpatient beds?</td>
<td>Definitively treat MSCC with surgery?</td>
<td>Definitively treat MSCC with radiotherapy?</td>
<td>Oncology pharmacy service?</td>
</tr>
<tr>
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<td>---------------------------</td>
</tr>
<tr>
<td>Newham Hospital</td>
<td>Group 1 A&amp;E department</td>
<td>No inpatient beds for chemotherapy. Chemotherapy is provided to inpatients in the hospital’s day case facilities. The pharmacy provides oral chemotherapy on site.</td>
<td>No – Patients are admitted under the on-take medical team</td>
<td>No</td>
<td>No</td>
<td>One service. IV chemotherapy from St Bartholomew’s Hospital</td>
</tr>
<tr>
<td>Homerton University Hospital Foundation NHS Trust</td>
<td>Group 1 A&amp;E department</td>
<td>Very limited oral chemotherapy service</td>
<td>No – Patients admitted to the Acute Care Unit</td>
<td>No</td>
<td>No</td>
<td>One service – only oral chemotherapy is prescribed onsite</td>
</tr>
<tr>
<td>Barnet and Chase Farm Hospitals NHS Trust</td>
<td>Group 1 A&amp;E department Group 1 A&amp;E department</td>
<td>Outpatient chemotherapy (12 chairs, no beds) Outpatient chemotherapy (10 chairs, 1 bed)</td>
<td>15 inpatient beds on Mulberry ward No - Patients admitted to Acute Assessment Unit</td>
<td>No</td>
<td>No</td>
<td>One service Barnet No</td>
</tr>
<tr>
<td>North Middlesex University Hospital NHS Trust</td>
<td>Group 1 A&amp;E department</td>
<td>Outpatient chemotherapy (10 chairs, 5 beds)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>One oncology pharmacy service – non licensed unit</td>
</tr>
<tr>
<td>Trust Name</td>
<td>Type of hospital</td>
<td>Chemotherapy service</td>
<td>Dedicated oncology and haemato-oncology inpatient beds?</td>
<td>Definitively treat MSCC with surgery?</td>
<td>Definitively treat MSCC with radiotherapy?</td>
<td>Oncology pharmacy service?</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>----------------------------</td>
</tr>
<tr>
<td>Royal Free London NHS Foundation Trust</td>
<td>Group 1</td>
<td>Outpatient chemotherapy (15 chairs, 8 beds)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>One oncology pharmacy service – licensed unit</td>
</tr>
<tr>
<td>University College London Hospital NHS Foundation Trust</td>
<td>Group 1</td>
<td>Outpatient chemotherapy: 22 chairs and 10 beds; Ambulatory care: 5 chairs and 6 beds; Inpatient chemotherapy: 2 beds, plus 2 in ACU)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>One oncology pharmacy service – licensed unit</td>
</tr>
<tr>
<td>Whittington Health</td>
<td>Group 1</td>
<td>Outpatient chemotherapy (6 chairs, 2 beds)</td>
<td>No – Patients are prioritized to Mercers Medical ward</td>
<td>No</td>
<td>No</td>
<td>One oncology pharmacy service – non licensed unit</td>
</tr>
<tr>
<td>Princess Alexandra Hospital</td>
<td>Group 1</td>
<td>Outpatient chemotherapy (18 chairs)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>One oncology pharmacy service – non licensed unit</td>
</tr>
</tbody>
</table>
St Bartholomew’s Hospital is the only hospital within the ICS that is classified as a ‘Group 2’ hospital. The range of treatments and procedures for acute oncology patients are the same for patients attending St Bartholomew’s as for patients attending the remaining Group 1 Hospitals within London Cancer. Where possible, patients presenting at the Royal London Hospital, are transferred to an inpatient bed at St Bartholomew’s Hospital. Similarly, where possible, patients presenting at King George Hospital, Ilford, are transferred to an inpatient bed at Queens Hospital, Romford.

3.3 Treatments and procedures offered by each acute oncology team
Each acute oncology team is equipped to deal appropriately with the following conditions:

<table>
<thead>
<tr>
<th>Conditions caused by the systemic treatment of cancer</th>
<th>Conditions arising as a result of radiotherapy</th>
<th>Conditions caused directly by malignant disease and presenting as an urgent acute problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neutropenic sepsis</td>
<td>• Acute skin reactions</td>
<td>• Uncontrolled pain</td>
</tr>
<tr>
<td>• Uncontrolled nausea and vomiting</td>
<td>• Uncontrolled nausea and vomiting</td>
<td>• Pleural effusion.</td>
</tr>
<tr>
<td>• Extravasation injury (not provided at Homerton Hospital)</td>
<td>• Uncontrolled diarrhoea</td>
<td>• Pericardial effusion.</td>
</tr>
<tr>
<td>• Acute hypersensitivity reactions including anaphylactic shock</td>
<td>• Uncontrolled mucositis</td>
<td>• Lymphangitiscarcinomatosa.</td>
</tr>
<tr>
<td>• Complications associated with venous access devices</td>
<td>• Acute radiation pneumonitis</td>
<td>• Superior mediastinal obstruction syndrome, including superior vena caval obstruction.</td>
</tr>
<tr>
<td>• Uncontrolled diarrhoea</td>
<td>• Acute cerebral/other CNS, oedema</td>
<td>• Abdominal ascites.</td>
</tr>
<tr>
<td>• Uncontrolled mucositis</td>
<td></td>
<td>• Hypercalcaemia</td>
</tr>
<tr>
<td>• Hypomagnesaemia</td>
<td></td>
<td>• Spinal cord compression including MSCC + Cerebral space occupying lesion(s)</td>
</tr>
</tbody>
</table>

Acute oncology teams also deal with cases in which the A&E staff or acute medical firm decide an urgent oncology assessment is needed.

3.4 New diagnoses
All hospital trusts provide an in-patient consultation service for all new patients with suspected (i.e. based on radiological tests) but as yet undiagnosed cancer, and advice on the most appropriate investigations and management pathway.

3.5 Chemotherapy
The need for chemotherapy is likely to continue to increase, with the main increase being in chemotherapy being given to solid tumours such as lung, as reflected in NCEPOD data. There is likely to be a need for some additional chemotherapy capacity in the future, although we recognise that many of the new types of drugs will be dispensed in outpatient settings rather than the chemotherapy unit. Further development and service planning of chemotherapy services will need to be informed by

- Patient choice and safety
- Configuration of acute oncology services
- National recommendations e.g. NCAG, National Cancer Peer Review Measures
- Affordability versus desirability

NCAG (2009) recommends that in order to provide patient centred care, inpatient delivery of systemic anti-cancer therapy should be minimised. Furthermore, as long as it is safe, and clinically appropriate to do so, satellite services should be established that are linked to a central unit in the provider network, and chemotherapy should be delivered in the outpatient setting.
The AOS ERG is committed to working closely with the Chemotherapy ERG and their chair is a member of the AOS ERG.

Currently, chemotherapy is administered in all the acute trusts within the network. Not all sites deliver outpatient/day case, and inpatient chemotherapy (See Table 2 below).

**Table 2: Chemotherapy delivery within London Cancer**

<table>
<thead>
<tr>
<th>Trust</th>
<th>Hospital</th>
<th>In-patient chemotherapy?</th>
<th>Outpatient chemotherapy?</th>
<th>Intrathecal chemotherapy?</th>
<th>Chemotherapy production?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet and Chase Farm Hospital NHS Trust</td>
<td>Barnet Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Chase Farm Hospital</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Middlesex University Hospital NHS Trust</td>
<td>North Middlesex University Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Royal Free Hampstead NHS Trust</td>
<td>Royal Free Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University College London Hospital NHS Foundation Trust</td>
<td>University College London Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whittington Health</td>
<td>Whittington Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Princess Alexandra Hospital</td>
<td>Princess Alexandra Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homerton University Hospital Foundation NHS Trust</td>
<td>Homerton University Hospital</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>Barts Health</td>
<td>St Bartholomew’s Hospital</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>The Royal London</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Whipps Cross Hospital</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Newham Hospital</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
3.6 The Network Acute Oncology Group (11-1A-304y)

London Cancer’s Network Acute Oncology Group is constituted as an Expert Reference Group (ERG). The Acute Oncology group sits alongside, and is closely connected to, ERGs for chemotherapy, radiotherapy and nursing.

The Terms of Reference for the Acute Oncology Expert Reference Group can be found in Appendix 1.

**Table 3: List of roles within the AOS ERG**

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary role</th>
<th>Additional role</th>
</tr>
</thead>
</table>
| 1    | Dr Ekaterini Boleti, RFH | Clinical Lead for Acute Oncology (Co-Chair) | • Medical oncologist who is a member of an acute oncology assessment service  
• MSCC lead
| 2    | Dr Adrian Tookman, RFH | Clinical Lead for Acute Oncology (Co-Chair) | • A member of a specialist palliative care team who is also a member of a hospital acute oncology team  
• MSCC lead
| 3    | Dr David Feuer, HUH  
Dr Gordon Read, PAH  
Dr Pauline Leonard, WH  
Dr Sarah Slater, BH  
Dr Tanya Ahmad, UCLH*  
Dr Ursula McGovern, BCFH | Hospital acute oncology leads from across the network | |
| 4    | Dr Chris Gallagher, BH | Chair of the Chemotherapy ERG | |
| 5    | Dr Chris Cottrill, RFH  
Dr Katharine Pigott, RFH/UCLH | Chair of the Radiotherapy ERG | |
| 6    | Dr Girija Anand, NMUH  
Dr Chris Cottrill, BH (WXUH) | Clinical oncologist who is a member of an acute oncology assessment service | |
| 7    | Dr Jane Stevens, BHRUT | Haemato-oncologist who is a member of an acute oncology assessment service | |
| 8    | Dr Emma Young, BH (NUH) | A & E consultant who is a member of a hospital acute oncology team | |
| 9    | Philip Lodge, RFH (palliative medicine doctor) | Consultant physician who is a member of a hospital acute | |

1 “One of these individuals should be chair of the network MSCC group if the network chooses to have a separate MSCC group (this individual would then be considered to be the network lead for MSCC. If there is no separate MSCC group, one of the two should be nominated as the network lead for MSCC).” NCAT, Manual for cancer services: Acute oncology – including MSCC measures, version 1.0, April 2011, p.18.
<table>
<thead>
<tr>
<th>Name</th>
<th>Primary role</th>
<th>Additional role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blessing Kamudyariwa, NMUH</td>
<td>oncology team</td>
<td></td>
</tr>
<tr>
<td>Karen Phillips, BH (NUH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kate Earwicker, BH (WXUH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kate Fitzgerald, RFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kellie O’Riordan, BCFH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist nurse who is a member of an acute oncology assessment service</td>
<td>Patient advocate</td>
</tr>
<tr>
<td>Mr John Brecknall, BHRUT</td>
<td>Senior clinical advisor for MSCC (spinal surgical)</td>
<td></td>
</tr>
<tr>
<td>Mr David Choi, UCLH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Mat Shaw, RNOH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Arun Ranganathan, BH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Girija Anand, NMUH</td>
<td>Senior clinical advisor for MSCC (clinical oncology)</td>
<td></td>
</tr>
<tr>
<td>Raj Nijar, BH</td>
<td>Designated oncology pharmacist</td>
<td></td>
</tr>
<tr>
<td>Abby Livingston, RNOH</td>
<td>Physiotherapist</td>
<td></td>
</tr>
<tr>
<td>Sharon Cavanagh, LC</td>
<td>Patient advocate</td>
<td></td>
</tr>
<tr>
<td>Annette O’Gorman</td>
<td>Patient representative x 2</td>
<td></td>
</tr>
<tr>
<td>Barry Wood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lucy Gladman, BHRUT</td>
<td>Cancer Manager</td>
<td></td>
</tr>
<tr>
<td>Ashi Naveed, HUH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr John Bridgewater</td>
<td>Cancer of Unknown Primary (CUP) Lead Research representative</td>
<td></td>
</tr>
</tbody>
</table>

*Dr Tanya Ahmed’s lead responsibilities are joint with Prof Jonathan Ledermann at UCLH, however Dr Ahmed represents UCLH on the ERG.*
4. Acute oncology guidelines

4.1 Clinical guidelines
During the current transition period, the London Cancer AOS ERG has formally adopted the previous North East London Cancer Network (NELCN) Network Acute Oncology Group referral guidelines (formally recorded in the minutes of the AOS ERG meeting on 30th October 2012). The guidelines were produced in consultation with the NELCN chemotherapy heads of service, radiotherapy heads of service and hospital acute oncology leads. These reflect NICE guidance on the prevention and management of neutropenic sepsis in cancer patients.\(^2\)

Please refer to the separate AOS guideline document. This is available on the London Cancer website and has also been uploaded on the CQuINS website as a separate document.

The AOS ERG has agreed that it will consider adopting the new UK Oncology Nursing Society (UKONS) AOS guidelines when they are published in 2013.

4.2 Referral guidelines (11-1E-104y)
The AOS ERG is in the process of updating its clinical guidelines – which will include referral guidelines in line with the Peer Review measures – in line with the UKONS national guidance.

These are in development and will be available in hard copy for review and consideration by the Peer Review visit team on 28th February 2013.

4.3 Consultant oncologist telephone on call service (11-1E-103y)
The AOS ERG, in consultation with the hospital acute oncology leads has agreed the minimum specification of the 24/7 consultant oncologist telephone on call service, which stipulates 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.

The service is divided across the ICS as follows:

- For NEL, 24 hour consultant on call service is provided by Barts (BLT) and Queens Hospital to other hospitals within North East London (Barts Heath NHS Trust, Homerton Hospital and Barking, Havering & Redbridge University Hospitals NHS Trust).
- For NCLWE, three 24/7 consultant oncology helplines exist:
  - North Middlesex Hospital – also provides a service for Princess Alexandra Hospital
  - Royal Free Hospital
  - University College London Hospital (UCLH) – provides a 24/7 helpline service for UCLH, Barnet and Chase Farm Hospitals, and Whittington Health.

Further details will be provided as hard evidence for review and consideration by the Peer Review visit team on 28th February 2013.

5. Metastatic Spinal Cord Compression (MSCC)

A critical concern for the AOS ERG is the management of Metastatic Spinal Cord Compression (MSCC) across the London Cancer ICS.

5.1 MSCC group (11-1A-108y)

The London Cancer AOS ERG does not currently have a separate group focusing on MSCC. Instead, it considers MSCC within its central remit and the co-chairs for AOS, Dr Adrian Tookman and Dr Katia Boleti, lead all work on MSCC. The AOS ERG is attended by senior clinical advisors on MSCC, including spinal surgery representatives. The leads for MSCC are Dr Adrian Tookman and Dr Katia Boleti as co-chairs of the AOS ERG.

Collaborative arrangements are in place with the London Cancer site-specific Pathway Board for Brain and Spine. The AOS ERG co-chair, Dr Katia Boleti, attends the Brain and Spine Pathway Board.

5.2 Patient information on early detection of MSCC (11-1E-105y)

The first priority is to ensure that patients at high risk of MSCC are provided with information to facilitate its early detection. This has been developed separately by the two separate legacy AOS NAOGs before the ERG was formed.

North east London trusts

The legacy NAOG in consultation with the MSCC senior clinical advisors for the group and hospital acute leads have agreed patient information for patients with spinal metastases, or at high risk of developing spinal metastases. The information describes the signs and symptoms of MSCC, enabling patients to detect impending MSCC so that they can be investigated, diagnosed and treated early.

Within the trusts of the former NELCN, two forms have been developed that contain patient-facing information on MSCC. Barts and The London, Whipps Cross, Newham and Homerton patients are provided with a patient information card and Barking, Havering & Redbridge patients are given a patient information leaflet. Both card and leaflet provide the same level of information. Those cancer patients provided with MSCC information include; Breast, Lung, Urology and Myeloma and any patient with bone metastases. (Please see Appendix 2 for the NELCN MSCC patient information card and leaflet).

The NAOG in consultation with the MSCC senior clinical advisors has also produced an MSCC poster, targeted at health professionals. The poster explains the symptoms of MSCC and advises teams to contact the MSCC coordinator urgently if a patient presents with any of the symptoms listed. All Trusts in the Network have posters displayed in their A&E departments. Some trusts are also aiming to display copies in outpatient consulting rooms. (Please see Appendix 2 for an example of the MSCC poster).

North central London and west Essex trusts

The Patient Information Group developed a patient information leaflet that is offered to patients and/or carers of patients with spinal metastases or at high risk of developing spinal metastases. The information describes the signs and symptoms to enable the detection of MSCC at an early stage. (Please see Appendix 2 for the NCL&WE MSCC patient information leaflet).
5.3 MSCC pathway of care
The AOS ERG has developed a pathway which describes the expected pathway and management of MSCC cases across London Cancer. Its aim is to ensure safe and effective management of every patient with suspected or confirmed MSCC.

The pathway has been discussed and agreed by the ERG during its first meetings and is now in the early stages of implementation. The pathway is included in Appendix 3.
<table>
<thead>
<tr>
<th>Name of Trust</th>
<th>On site?</th>
<th>MRI 24/7?</th>
<th>Routine access outside normal working hours?</th>
<th>Details of MRI access</th>
<th>MRI weekend list?</th>
<th>MRI weekend comments</th>
<th>Does Trust use IEP?</th>
<th>If not what does system is used?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet and Chase Farm</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>9am – 7pm Monday to Friday</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Bartholomew’s</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Royal London is 24/7. Barts is 8am-9pm Monday to Friday</td>
<td>Y</td>
<td></td>
<td>Y</td>
<td></td>
<td>BLT has a video conferencing link and can receive images via the Imaging Exchange Portal [IEP] with Whippets Cross, Newham and Homerton.</td>
</tr>
<tr>
<td>Royal London Hospital</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>9am - 5pm Monday to Friday - no on call or out of hours at present</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whippets Cross</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>8am – 7.30pm Monday to Friday</td>
<td>Y</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newham</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>8am – 7.30pm Monday to Friday</td>
<td>Y</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHRUT</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>8.30am - 5pm Monday – Friday</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td>PACS used and accessible to partner trusts and images are sent via IEP.</td>
</tr>
<tr>
<td>Homerton University Hospital</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>8.30am - 5pm Monday – Friday</td>
<td>N</td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Free Hospital</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>9am – 5pm Monday – Friday</td>
<td>Y</td>
<td>Saturday only. 09:00 – 17:00hrs</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Trust</td>
<td>On site?</td>
<td>MRI 24/7?</td>
<td>Routine access outside normal working hours?</td>
<td>Details of MRI access</td>
<td>MRI weekend list?</td>
<td>MRI weekend comments</td>
<td>Does Trust use IEP?</td>
<td>If not what does system is used?</td>
<td>Comments</td>
</tr>
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<td>----------</td>
</tr>
<tr>
<td>North Middlesex University Hospital</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>9am – 5pm Monday – Friday</td>
<td>Y</td>
<td>MRI is available but there is no radiologist on site. The on call radiologist is available if needed</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNOH</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>MRI is available but there is no radiologist on site. The on call radiologist is available if needed</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCLH</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>9am – 5pm Monday – Friday Emergency slot for suspected MSCC at 2pm each day.</td>
<td>Y</td>
<td>If patients present after hours during week, need to wait until following day for 2pm slot. On weekends must be transferred to NHNN for MRI; however, this is dependent on bed availability.</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whittington Health</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>9am – 5pm Monday – Friday</td>
<td>Y</td>
<td>MRI is available but there is no radiologist on site. The on call radiologist is available if needed</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.4 MSCC senior clinical advisor service (11-1A-109y)

A critical element of the pathway of care is to ensure appropriate and timely senior clinical advice in the diagnostic and management planning process for patients with suspected and/ or confirmed MSCC. Arrangements are different across the ICS.

**North east London trusts**

There are two MSCC senior clinical advisor services within the north east London part of the ICS: one at St Bartholomew’s Hospital, part of Barts Health NHS Trust, and one at Queens Hospital, part of Barking, Havering and Redbridge University Hospitals NHS Trust. These clinical advisors provide 24/7 advice to secondary care clinicians and MSCC coordinators managing or referring patients with MSCC, who have been judged suitable for active definitive treatment.

There is a direct mobile number for the MSCC co-ordinator. At night, the mobile may be held by medical oncology SPRs, as there is a joint rota. However, these colleagues are all on the FRCR course, so they comply with the relevant criteria.

MSCC services have a rota made up of consultants known as senior clinical advisors from the following three disciplines:

- Surgery (of orthopaedic or neurosurgical disciplines)
- Clinical oncologists who treat MSCC
- Radiology.

The MSCC senior clinical advisor service at St Bartholomew’s Hospital also covers patients from the Royal London Hospital, Newham University Hospital, Whipps Cross University Hospital and Homerton University Hospital. The service also covers Inner North East London (INEL) primary care clusters, NHS City and Hackney, NHS Tower Hamlets, NHS Newham and Outer North East London (ONEL) primary care cluster, NHS Waltham Forest. The service can be accessed by contacting the radiotherapy on call registrar or by bleeping hospital switchboard.

The MSCC senior clinical advisor service at Queen’s Hospital also covers patients from King George Hospital, along with Outer North East London (ONEL) primary care clusters, Barking and Dagenham PCT, Redbridge PCT and Havering PCT.

The oncology opinion is accessed via the NELCN 24 hour Consultant on call telephone service. Both Barts (BLT) and Queens will provide this rota to other hospital AOTs (Acute Oncology Teams) on a weekly/fortnightly/monthly/six-weekly basis.

Please see Table 5 below for more details about arrangements in North East London.

**North central London and west Essex trusts**

Within North Central London and West Essex, current arrangements are limited to oncology consultant input, which exists through three 24/7 consultant oncology helplines as follows:

- North Middlesex Hospital – also provides a service for Princess Alexandra Hospital.
- Royal Free Hospital
- UCLH – provides a 24/7 helpline service for UCLH, Barnet and Chase Farm and the Whittington

Professionals from primary and secondary care can access these helplines for advice.
There is not currently an agreed senior consultant advisor service available 24/7 for surgical opinion for MSCC cases. Work is underway to ensure a rota is in place for all North Central London and West Essex Trusts, and this focus is reflected in the AOS ERG work programme.
<table>
<thead>
<tr>
<th></th>
<th>Barts Health</th>
<th>BHRUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>MSCC Service description</strong>&lt;br&gt;Radiotherapy provided at Barts site&lt;br&gt;Surgery done at Royal London site&lt;br&gt;A&amp;E at Royal London site</td>
<td>Radiotherapy, Surgery and A&amp;E all at Queen’s site&lt;br&gt;Additional A&amp;E at King George’s site</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Contact details for patients to contact MSCC services 24x7</strong>&lt;br&gt;On call Radiotherapy Registrar: 07786 118349. Mobile contact for MSCC coordinator (currently no bleep facility)</td>
<td>MSCC Coordinator: 01708 435000 Ext: 6177</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Patient Information given as</strong>&lt;br&gt;MSCC alert card for patients not yet given out routinely</td>
<td>MSCC Leaflets (last modified 2010)</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Types of patients receiving leaflets and information</strong>&lt;br&gt;Commonly lung, prostate, breast and myeloma patients</td>
<td>Any patients who have cancer in their bones or are at risk of developing MSCC</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Registrar rota</strong>&lt;br&gt;The neuro-surgery SpRs are on call 24/7&lt;br&gt;The oncology SpRs are on call 24/7 with 24/7 consultant oncology on call cover</td>
<td>The neuro-surgery SpRs are on call 24/7&lt;br&gt;The oncology SpRs cover 7 days a week 9am – 5pm with 24/7 consultant oncology on call cover</td>
</tr>
<tr>
<td>7.</td>
<td><strong>Induction Training programme for MSCC coordinators</strong>&lt;br&gt;Prerequisite for a staff member to be on the MSCC hospital co-ordinator rota:&lt;br&gt;• Gained MRCP&lt;br&gt;• On clinical oncology training programme for FRCR&lt;br&gt;• Completed in house training programme for MSCC&lt;br&gt;• Undertaken induction training in the use of the acute oncology service</td>
<td>No separate for MSCC coordinators, local induction with FY2’s</td>
</tr>
</tbody>
</table>
5.5 The MSCC case discussion policy (11-1E-110y)

In the agreed pathway, the AOS ERG specifies that following confirmation by MRI scanning and prior to definitive treatment, all cases of MSCC should be subject to a case discussion between the senior clinical advisors for MSCC, ensuring appropriate clinical oncology, radiology (where necessary) and spinal surgery input.

Initial review should be carried out by the local oncology consultant who will initiate the case discussion. This discussion does not require an MDT, can happen by phone, and should be carried out urgently, to enable treatment to commence within 24 hours of the patient presenting with neurological symptoms and minimise the risks of long term damage. The only time when a case discussion does not need to take place is when no active definitive treatment is appropriate and this decision can be made by the local team. Equally if a discussion of the options would be helpful, then a case discussion may still be appropriate.

Each senior clinical advisor should be able to view that patient’s imaging as per the imaging links outlined in Table 4. The referring clinician or caller should provide the clinical case details as below:

1. Clinical history of cancer, location of primary (if known) and metastatic disease.
2. Details of current or planned anti-cancer treatment.
3. History of symptoms resulting in suspicions of MSCC.
4. Results of full neurology assessment of whole spine.
5. Performance status.
6. Any co-morbidities and associated surgical risks.
7. Patient preferences about potential future care, if these have been expressed at this stage.

Following the case discussion with the senior clinical advisors, the local team will discuss the treatment options with the patient and family.

This has been agreed by the AOS ERG.

5.6 MSCC audits

In order to assess the ongoing improvements to the MSCC pathway across London Cancer, all Trusts have agreed to participate in audits as follows:

- Audit of Timeliness of the investigation of MSCC (11-1E-111y)
- Audit of timeliness of definitive treatment of MSCC (11-1E-112y)
- Audit of the outcome of definitive treatment of MSCC (11-1E-113y)

A number of audits have been conducted and presented either to the legacy NAOGs, or, more recently, to the new AOS ERG, and this process is ongoing. Actions for improvement are noted from these audits, agreed and monitored at the AOS ERG meetings.

Audit activity for the coming year is being discussed and agreed at the moment and there is support to transition to a ‘live’ audit through a system of Root Cause Analysis which will be implemented in 2013.
6. Training

6.1 Network induction training in the use of the acute oncology service (11-1E-106y)

Both the NCL&WE and NEL NAOGs have developed an induction programme for nursing and medical staff working within A&E, MAU, Acute Medicine, those on the Consultant Oncologist 24/7 on call rota and the 24/7 chemotherapy advice line service rota. The purpose of this induction programme is to orientate staff in the organisation of the local acute Oncology services and the Network configuration, protocols and referral pathways.

The subjects covered include those required by the acute oncology measures:

- The network configuration of the acute oncology service
- The acute oncology referral guidelines
- The protocols associated with the acute oncology service
- The roles and responsibilities and relevant contact points associated with, the NAOG, the hospital AOTs, the acute oncology assessment service, the 24/7 chemotherapy patient advice service, the MSCC hospital coordinators and the MSCC senior clinical advisors;
- Contains locally specific information
- Each staff member is provided with written confirmation of completion.

During the transition period, the AOS ERG is reviewing the induction training materials across the ICS. The trusts are responsible for conducting and maintaining local AOS training and providing the ICS with training registers. The ERG is also seeking to develop an e-learning module to address learning and development needs across the ICS.

6.2 Training for MSCC Coordinators (11-1E-107y)

The NAOG in collaboration with the MSCC senior clinical advisors have agreed professional qualifications and training for Metastatic spinal cord compression coordinators in order for staff to be on a hospital co-ordinator rota. This training is additional to the induction training of acute oncology services.

Prerequisite for a staff member to be on the MSCC hospital coordinator rota (based on NICE Clinical Guidelines CG75 – Metastatic Spinal Cord Compression):

- A qualified health professional. During formal working hours, the role may be delivered by one or more individuals, but this role could be taken on by healthcare professionals involved in an existing on call rota out of hours.
- Competent in performing an initial telephone triage by assessing requirement for, and urgency of, investigations, transfer and treatment, advise on the immediate care of the spinal cord and spine and seek senior clinical advice, as necessary
- Competent in gathering baseline information to aid decision-making and collate data for audit purposes
- Ability to identify the appropriate place for timely investigations and admission if required
- Good communication skills in order to liaise with the acute receiving team and organise admission and mode of transport
Network list of authorised assessors of competence for the training of MSCC coordinators:
Assessors are authorised to assess competency for a MSCC coordinator. Each assessor has been trained and assessed as competent by another authorised assessor or one of the MSCC clinical advisors. Network assessors are responsible for entry and maintenance of MSCC training for the Network. For 2011 the list of assessors are identified in table 5. Assessors will be reviewed yearly.

Table 6: Authorised assessors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Trust</th>
<th>Entry onto list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Virginia Wolstenholme</td>
<td>Consultant Clinical Oncologist</td>
<td>Barts Health NHS Trust</td>
<td>July 2011</td>
</tr>
<tr>
<td>Mr John Brecknell</td>
<td>Consultant Neurosurgeon</td>
<td>Barking, Havering and Redbridge University Hospitals NHS Trust</td>
<td>July 2011</td>
</tr>
<tr>
<td>Dr Emma Staples</td>
<td>Consultant Clinical Oncologist</td>
<td>Barking, Havering and Redbridge University Hospitals NHS Trust</td>
<td>July 2011</td>
</tr>
</tbody>
</table>
Appendix 1

Terms of Reference of Acute Oncology Expert Reference Group

London Cancer Board

London Cancer is an Integrated Cancer System covering a resident population of approximately 3.2 million people in North Central London, North East London and West Essex.

The London Cancer Board is independent of the London Cancer providers and is supported by high quality information and recommendations from cancer Pathway Boards. The London Cancer Board takes account of clinical evidence, population, value and potential impacts in other pathways and treatments when making decisions. It has a focus on bringing about real change that delivers significant benefits for patients.

Constitution of the Acute Oncology Expert Reference Group

The London Cancer Acute Oncology Expert Reference Group (AOS ERG) is an expert advisory forum that sits as part of the London Cancer Integrated Cancer System (ICS) governance structure. It reports to the London Cancer Board.

The group brings together acute oncology experts from all relevant clinical disciplines and offers a strategic overview of clinical acute oncology services provision and education. In this way, the AOS ERG will contribute to improved cancer outcomes and patient experience for local people within London Cancer.

Aims and Purpose of the AOS ERG

The AOS ERG supports the overall aims of London Cancer by facilitating collaboration of providers of acute oncology services and commissioners within the system to provide seamless care based on best practice. Primarily, it provides a forum for colleagues to take a strategic overview of acute oncology services, and to develop collaborative working practices that will drive and maintain improvements in patient outcomes and experiences.

Operating within the London Cancer ICS, the AOS ERG:

- Is the primary source of advice on issues relating to acute oncology within the system for Pathway Boards and other groups.
• Has corporate responsibility, delegated by the *London Cancer* Board, for ensuring co-ordination and consistency across the system for implementing the NCAT measures for acute oncology and metastatic spinal cord compression; and for acute oncology practice in hospitals.
• Is responsible for consulting with Pathway Boards and the ICS Chemotherapy and Radiotherapy Expert Reference Groups on the acute oncology treatment and referral guidelines.

**The role and functions of the AOS ERG**

The AOS ERG has five key functions:

**A. Service planning and service improvement**

- Review acute oncology services across the ICS and advise *London Cancer* and commissioners on the distribution of such services, reflections on current challenges and opportunities for improvement.
- Work with hospital acute oncology leads to agree the minimum specification of the 24/7 consultant telephone on-call service.
- Produce referral guidelines in consultation with chemotherapy heads of service, radiotherapy heads of service, and hospital acute oncology leads.
- Ensure that all approved guidelines, treatment and care protocols, work procedures and related information are maintained, distributed appropriately and reviewed regularly.
- Agree with MSCC senior clinical advisors and hospital acute oncology leads the information that may be offered to patients with spinal metastases or who are at risk of developing spinal metastases.

**B. Service quality monitoring and evaluation**

- Promote and oversee work to monitor the effectiveness of acute oncology services.
- Undertake work to achieve compliance with the acute oncology and MSCC measures in the *Manual of Cancer Services* (2011). The AOS ERG will work with the London Cancer Chemotherapy and Radiotherapy ERGs, with the Brain and Spine Pathway Board, with other bodies, and with individual trusts to ensure compliance with the measures.
- Liaise closely with other providers, commissioners, and organisations – including non-NHS suppliers – as appropriate.

**C. Workforce development**

- Identify all clinicians, nurses and support services involved in the planning, management and delivery of acute oncology services in each of the providers within the system, and ensure their involvement, as appropriate.
- Develop, in consultation with hospital acute oncology leads, system-wide induction training in the use of the acute oncology service.
- Agree with the MSCC senior clinical advisors the professional qualifications and training necessary for a staff member to be on the hospital co-ordinator rota.

**D. Research and development**

- Participate in the mechanism for all new NCRN clinical trials and research. At each meeting an update on research, and – where relevant – new trials and trial uptake within the system will be reviewed and considered.
- Promote the capture and sharing of lessons learned from the service through audits and engagement events.
E. Annual work planning and reporting

- Produce a work programme and a retrospective annual report for ratification by the London Cancer Board.

Core Membership (11-1A-304y)
The Group will aim to be representative of all trusts in London Cancer and will include the following core members:

- the hospital acute oncology leads from the network;
- if not included in the above and if they exist as part of the network’s arrangements:
  - the Chair of the Chemotherapy Expert Reference Group;
  - the Chair of the Radiotherapy Expert Reference 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 haematology 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 specialist nurse who is a member of an acute oncology assessment service;
- a designated oncology pharmacist;
- a physiotherapist
- two user representatives. (If the local user group is unable to nominate user representatives, a Clinical Nurse Specialist and/or allied health professionals will be responsible to obtain user advice.)

Frequency of meetings (11-1E-101y)
The AOS ERG will meet every two months for at least its first six months of operation. Following this, the group must meet at least quarterly. Members will be expected to attend the meetings in person. A register of attendance will be kept. Membership will be reviewed annually.

Quorum
The Group’s minimum attendance will be at least six members of the core membership.

Dissemination of the group’s work
The AOS ERG will be required to design, organise and host at least one open engagement event per year to communicate to the London Cancer community and local patients and the public the progress of the Group against its work programme and objectives, and to access additional input and advice. The invitees to these meetings must represent all sections of the London Cancer professional body and geography, as well as patients and voluntary sector partners. Events can be supported through access to central enablement funds.

The minutes, agendas and work programmes of the Expert Reference Group, as well as copies of papers from educational and engagement events will be made available for viewing by the local community through the London Cancer website.

Administrative support
Administrative support for the meetings is provided through the Senior Coordinator, London Cancer.
Appendix 2

Patient information materials for MSCC

These will be available in hard copy for review and consideration by the Peer Review visit team on 28th February 2013.
Appendix 3

MSCC pathway

The finalised pathway schematic will be available in hard copy for review and consideration by the Peer Review visit team on 28th February 2013.