Chemotherapy Services in the Community

A Guide for PCTs
Chemotherapy in the Community - A Guide for PCTs

The guide advises PCTs on the potential to develop chemotherapy services in the community.

Tracy Parker
Cancer Policy Team
402 Wellington House
SE1 8UG

t Tracy.parker@dh.gsi.gov.uk
Chemotherapy in the Community

A Guide for PCTs

Prepared by: DH Cancer Policy Team
Contents

Foreword by the Parliamentary Under Secretary of State for Heath Services……………………5

Executive Summary……………………………………………………………………………………..6

1. Introduction……………………………………………………………………………….8
   • purpose
   • background

2. What is chemotherapy in the community?…………………………………………………..10
   • models of delivery
   • pharmacy
   • current service provision

3. Why develop community chemotherapy services?……………………………………….13
   • benefits for patients and their carers
   • meeting increasing demand
   • potential efficiencies

4. Issues to consider when commissioning services………………………………………..16
   • network wide services
   • planning
   • workforce
   • training
   • acute oncology
   • models of contracting
   • regulation of service
   • protocols
   • leadership
   • monitoring

Key references ............................................................................................... …….….20
Foreword
by the Parliamentary Under Secretary of State for Health Services

We will all, at some time in our lives, be touched by cancer. The good news is that treatments are improving all the time and mortality rates continue to fall.

Many of the drugs that we now use to treat cancer can be safely delivered away from major cancer centres. This is good news for centres having difficulty meeting the increasing demand for chemotherapy treatment, because they are reaching their physical capacity and need to expand, and for patients facing difficult journeys to receive their treatment, who would prefer to have chemotherapy closer to home or even at home.

My experience working as a nurse in the community gave me first hand experience of how the place of treatment can impact on patients and their carers and families. Enabling patients to have treatment, where appropriate, closer to home or at home can greatly benefit the patient experience and can contribute to better outcomes. I am therefore very pleased that we are publishing this guide to help commissioners and providers in developing chemotherapy services in the community.

There is of course already good practice around the country in terms of delivering chemotherapy in the community, and we plan to evaluate the current models and disseminate the outcomes. In the meantime, I would like to encourage all PCTs, providers and Cancer Networks to work together to ensure that services delivered in the community are designed as part of their wider and fully integrated chemotherapy services. By doing this, we will ensure that they are safe, cost-effective and provide the quality services that will improve patients’ experience of treatment.

Professor Ann Keen
Executive summary

1. Community chemotherapy is described in Building Britain’s Future and NHS 2010-2015: From Good to Great as an area where potentially high-impact changes could be made for patients. The Operating Framework 2010-11 confirms the ongoing direction of travel towards having more services closer to home and therefore less investment and activity in the acute sector. The National Chemotherapy Advisory Group (NCAG) report, Chemotherapy Services in England: Ensuring quality and safety, which reported in August 2009, concluded that each cancer network should consider whether there were opportunities to deliver chemotherapy closer to patients’ homes.

2. Where most chemotherapy treatment has traditionally been delivered in the cancer centre, there has been a significant shift recently to move more services closer to patients’ homes and into cancer units at local District General Hospitals (DGHs). Community chemotherapy services go one step further and are those where patients receive their chemotherapy treatment outside of the accredited cancer centres and cancer units in facilities nearer to home such as a GP surgery or in their own homes.

3. The key drivers for delivering chemotherapy services in the community are improved patient choice and experience and managing the ongoing increasing demand for chemotherapy. Additionally, in some circumstances there is the potential for it to deliver efficiencies, particularly where physical expansion is required.

4. Evidence from overseas, and in particular, the schemes already operating in England demonstrates that appropriate chemotherapy regimens can be delivered as safely in community settings to selected patients as they can be in acute settings. There are different models for the delivery of chemotherapy in community settings including mobile units and in patients’ homes; they are described in this guidance. A number of pilot studies are currently underway.

5. The models have workforce implications, particularly where delivery is in the home, and work will be required to undertake thorough baseline assessments in developing local strategies. It is anticipated that services will only be expanded into the community where local business cases support such expansion and PCTs will need to consider such cases in the context of their overall budget.

6. Discussions with patients have identified a number of perceived benefits to offering the choice of setting for chemotherapy treatment and existing services report positive patient feedback. However, some patients identified concerns that indicate that community delivery will not be for all. In all cases, it would only be offered where clinically appropriate.

7. PCTs will need to work with their local Cancer Network Teams to undertake baseline assessments and develop local strategies for the delivery of chemotherapy services that address all of the NCAG recommendations and to examine the potential for the delivery of some of those services in the community as part of a fully integrated chemotherapy service.

8. Best practice guidance for commissioning of chemotherapy services is described in
detail in the NCAG report. The report addresses key issues including the use of e-prescribing systems, commissioning agreed pathways and specifications, clinical governance and leadership, all of which will be incorporated into peer review measures that will apply equally to community based services. Offering the choice of community chemotherapy can form a part of a quality chemotherapy service where that service fulfils the criteria set out in the NCAG 2009 report.

9. To further support local teams considering community chemotherapy, the National Chemotherapy Implementation Group (NCIG) will monitor the existing pilot schemes with a view to developing more detailed guidance, including a service specification, outline business case and costing models.
1. Introduction

Purpose

1.1 This document provides a guide to PCTs on the potential to develop chemotherapy services in the community. Community chemotherapy is described in Building Britain’s Future and NHS 2010-2015: From Good to Great as an area where potentially high-impact changes could be made for patients. Quality community care has the potential to reduce the impact of disease and improve the experience for patients and their carers, whilst some models of delivery also have the potential to reduce costs to the NHS. The Operating Framework 2010-11 confirms the ongoing direction of travel towards having more services closer to home and therefore less investment and activity in the acute sector.

1.2 The National Chemotherapy Advisory Group (NCAG) report, Chemotherapy Services in England: Ensuring quality and safety, published in August 2009, highlighted the significant increase in chemotherapy utilisation over the past decade. The report recognised that chemotherapy should be delivered as conveniently as possible for patients and that nurse-led or pharmacist-led chemotherapy within agreed working protocols offers great opportunities for increasing capacity and flexibility to reduce waiting times and to move at least part of the care closer to the home of the patient. This guide should be read in conjunction with the NCAG report and will help each PCT, together with their Cancer Network, to consider whether there are further opportunities to devolve chemotherapy from cancer centres and cancer units to community settings while maintaining safety and quality and delivering an efficient service.

1.3 The National Chemotherapy Implementation Group (NCIG) has been established to provide an oversight role as clinical teams and commissioning bodies develop local responses to the NCAG report. The group will commission and develop national work in support of local teams. It will monitor the existing pilot schemes with a view to developing more detailed guidance, including a service specification, outline business case and costing models for the delivery of chemotherapy services in the community.

Background

1.4 The NCAG report provided best practice guidance, setting out a framework for planning, implementing and monitoring services based on a care pathway model and the proposed actions that need to be taken by commissioners and providers to ensure high quality care. It recognised that Primary Care Trusts (PCTs) should work together across a Cancer Network to plan, procure and monitor service delivery. They should ensure that Acute Oncology Services (AOS) are available in all hospitals with A&E departments. If chemotherapy is delivered elsewhere, PCTs should ensure that there are appropriate arrangements in place for patients to access telephone advice and emergency care. The report stated that PCTs will wish to achieve an appropriate balance between centralisation, cancer units and community services and to ensure that all services are safe and effective in line with the NCAG guidance.

1.5 The NCAG reported highlighted that improving patients’ experiences when they receive chemotherapy should clearly be a high priority. Treatment should be delivered in a pleasant environment, as conveniently as possible for patients and without any
avoidable delays. The report added that whatever the setting, chemotherapy needs to be given by staff that are appropriately trained so that safety is maximised and noted that, in this country, chemotherapy nurses deliver almost all chemotherapy.

1.6 Development of community chemotherapy services may offer PCTs an opportunity to meet local needs with high quality care and a patient-centred approach especially when the capacity of the day chemotherapy unit has been reached. Under some circumstances, this may involve significant service reconfiguration and this could affect workforce planning, training, estates and the service provision at the oncology day unit.

1.7 Community chemotherapy services should therefore be developed as an integrated part of an overall network strategy for chemotherapy in order to maintain service quality and meet waiting times. Reconfiguration needs to be driven by individual business case disciplines and PCTs will need to consider such cases in the context of their overall budget. Community chemotherapy services are likely to be extensions to existing models of chemotherapy delivery. They provide opportunities for clinicians to develop skills in different settings and some centres/units may offer the option of working in both the community and oncology day unit.

1.8 Moving chemotherapy services into community settings will have an impact on the local workforce, as the number of patients a nurse can treat during the course of the shift may be lower than at a cancer centre or unit. Baseline assessments will need to be undertaken in order to allow local services to plan for the appropriate changes in workforce requirements and to assess any potential impact on other services.

1.9 Guidance for commissioning of chemotherapy services is included in the NCAG 2009 report, Chemotherapy Services in England: Ensuring quality and safety. The report addresses key issues including the use of e-prescribing systems, commissioning agreed pathways and specifications, clinical governance and leadership, all of which will be incorporated into peer review measures that will apply equally to community based services. Offering the choice of community chemotherapy can form a part of a quality chemotherapy service provided the service fulfils the criteria set out in the NCAG report.

**Approach to the development of the guidance**

1.10 This guide has been developed following discussions with a number of key stakeholders including clinicians, specialist nurses, patients, third sector representatives, private providers, commissioners, and international healthcare providers, Cancer Network teams and draws heavily on the NCAG report.
2 What is chemotherapy in the community?

2.1 Treatment for cancer has traditionally been delivered to patients in oncology units. Chemotherapy in the community is the delivery of chemotherapy services outside the main cancer centres and cancer units, and closer to patients’ homes. The vast majority of all intravenous chemotherapy treatments are delivered in dedicated day case units. A much smaller proportion of doses are delivered to inpatients, either because the patient is too unwell to be at home or because of the complexity of the regimen. As new drugs have been introduced and the demand for chemotherapy has increased, models of service delivery for chemotherapy have evolved.

2.2 The advent of oral chemotherapy, bolus drugs and shorter infusions has allowed most patients to be treated as day cases at oncology day units in District General Hospitals (DGHs) rather than requiring overnight hospital admission. In the last decade, a number of services have been developed that deliver chemotherapy in patients’ homes, in mobile units, in GP surgeries, community hospitals, within polyclinics and in nursing homes. Some of the most pioneering NHS centres/units have delivered services in the community for 8 years.

Models of delivery

2.3 Across a network, decisions need to be made on the configuration of services for patients undergoing chemotherapy; it is for PCTs working with providers and Cancer Network teams to determine the appropriate balance of services across a Network, whether it is at the traditional Cancer Centre, a DGH, a Community Hospital, polyclinic or in the patients’ home. They will also need to ensure high quality care for cancer patients who may present through A&E departments anywhere within the network.

2.4 Each of the service models set out below need to be established as part of an integrated network chemotherapy service and will be a part of the existing service pathway. The chemotherapy care pathway starts with access to and referral to an oncologist (clinical, medical or haematological). It also includes assessment and decision to treat; formal patient consent; prescribing, prescription verification and dispensing; delivery; information, education, advice and support for patients and carers; urgent assessment and management of complications and the use of all relevant information along this pathway to determine the prescribing or otherwise of a subsequent cycle of chemotherapy. At the end of the pathway, a record of treatment delivered and a subsequent care plan should be made.

2.5 Wherever the treatment is delivered, decisions on the initiation of a course of chemotherapy should, unless in exceptional circumstances, be made at consultant level with the patient and carer fully involved on an informed choice basis. Chemotherapy treatment should only be delivered in the community if it is clinically appropriate.

2.6 It is at the “delivery” point in the chemotherapy care pathway that the following models might be considered. The models of community delivery described in the following paragraphs, have generally been developed in the NHS following pilot studies.

Delivery at a community facility
2.7 This includes delivery of chemotherapy at a non-oncology hospital unit such as a GP surgery, community hospital, polyclinic or nursing home. This is currently the most common model used in the NHS. Typically, a team of two nurses will undertake a reduced chemotherapy workload than they would in an oncology day centre or unit. Some time will also be taken up in collecting the chemotherapy, travel and setting-up equipment at the community facility.

**Delivery at a mobile unit**

2.8 Chemotherapy can also be delivered in a mobile unit or chemotherapy bus that will drive to community locations. There are currently chemotherapy bus services operating in Gloucestershire and Wales. The workforce requirements are similar to services in community facilities.

**Delivery in patients’ homes**

2.9 Chemotherapy in the home is being delivered by the NHS in West Anglia as part of a randomised controlled trial, in Dorset and in Sunderland. A single nurse will typically collect the day’s chemotherapy and then treat up to approximately one half to one third of the number of patients that the nurse could treat at an oncology day centre or unit depending on the length of treatments and time required to drive between patients’ homes. The two largest private homecare providers are also delivering chemotherapy to a small percentage of NHS patients in their own homes at locations throughout England. This tends to be for the less complex cases.

**Pharmacy**

2.10 The oncology pharmacy will prepare the chemotherapy in the same way that they would at the main oncology centre. The chemotherapy is then transported safely to the patient. Where private pharmacies are used, they may deliver the chemotherapy directly to the community setting. In some systems, this will involve the nurse collecting the chemotherapy from a central dispensary/store and with other models, the chemotherapy may be delivered by courier, scheduled to arrive at the planned administration time. All NCAG recommendations relating to the recording and delivery of chemotherapy prescriptions apply whatever the delivery setting. It should be noted that where pharmacy services are outsourced, prescribing, clinical checks and record keeping aspects of the services remain within the NHS.

**Current service provision**

**NHS services**

2.11 There are a number of NHS providers of community chemotherapy and pilot studies are underway. These typically involve a limited number of patients being offered one or a small number of regimens within a particular geographical area in a cancer network. The trend has been for these services to expand as integrated parts of the cancer networks, both in the number of different treatments undertaken by the services and number of patients treated. The development of the services has reflected the needs of the patients served. Many of the centres or units have only commenced community
chemotherapy for subsequent cycles, patients receiving their first one or two cycles in the hospital setting. Exemplars of community chemotherapy services are in Sunderland, Dorset, West Anglia, East Anglia and East Kent. NCIG will develop commissioning guidance/ supporting material drawing on the outcomes of these pilot schemes as they begin to report a year from now.

Private providers

2.12 There are currently 4 main private healthcare companies who undertake chemotherapy in the community offering services to both private and NHS providers:
- Gem Healthcare
- Careology
- BUPA Home Healthcare
- Healthcare at Home.

Overseas experience

2.13 Chemotherapy at home is widely practiced in other countries such as France and the USA. In Alberta, Canada, a pilot home oncology service has been set up and this includes home chemotherapy. Studies of home chemotherapy have been published from Australia and Spain. There are a number of small studies that have examined patient care outside the main hospital and three are of particular relevance. These have demonstrated that, in these countries chemotherapy delivery in the home is in general preferred by patients and carers, and is similar (or marginally higher) in cost to chemotherapy delivered in hospital.
3. **Why develop community chemotherapy services?**

3.1 Capacity issues in chemotherapy suites and pharmacy services together with the need to offer choice and better experience to patients has led NCAG to recommend that each Cancer Network should consider whether there are further opportunities to devolve chemotherapy delivery from cancer centres to cancer units (or closer to home) while still maintaining safety and quality. The key benefits are explored further in the following paragraphs.

**Benefits for Patients and their Carers**

3.2 Studies from abroad and reports from the centres and units undertaking community chemotherapy suggest that patients are enthusiastic about receiving treatment in the community. Discussions with patients revealed that some also have concerns, this demonstrates that community chemotherapy or delivery in the home is not right for all patients or appropriate for all types of chemotherapy. It has also been reported that initial patient support has sometimes been slow.

3.3 Discussions with patients identified a number of benefits of being offered the choice of delivery setting for their treatment, many of which have also been reported where these services are in operation. Some of the key perceived benefits and concerns that patients reported on being offered the choice to receive their treatment in the community are as follows:

<table>
<thead>
<tr>
<th>Patient reported benefits and concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td>Increased freedom to “get on with life”/less disruption to life.</td>
</tr>
<tr>
<td>Reduced travel/total treatment time.</td>
</tr>
<tr>
<td>Reduced waiting time.</td>
</tr>
<tr>
<td>Greater comfort and convenience, for patients and carers.</td>
</tr>
<tr>
<td>One-to-one treatment and more one-to-one time with the nurse during chemotherapy delivery.</td>
</tr>
<tr>
<td>Easier parking and/or no parking cost</td>
</tr>
<tr>
<td>More personalised care</td>
</tr>
<tr>
<td>Choice</td>
</tr>
</tbody>
</table>
| Lower direct costs to patients and their families/carers | }
Increasing demand for chemotherapy

3.4 There is a year-on-year increase in the number of programmes of chemotherapy (a planned period of repeated cycles of treatment) by around 15% per annum. In order to meet this increasing demand, PCTs will need to work with their networks and providers to ensure that capacity is increased. The most significant issue in meeting the increased demand is the lack of chemotherapy nurses.

3.5 The NCAG report recognised that while some chemotherapy facilities are well designed, and many physical environments continue to improve, many are overcrowded due to the very rapid increases in workloads over recent years. It concluded that some patients are being treated at cancer centres when they could receive treatment closer to home. Nurse-led or pharmacist-led chemotherapy within agreed working protocols offers great opportunities for increasing capacity and providing the flexibility to reduce waiting times and to move at least part of the care closer to the home of the patient. Both space and workforce constraints will need to be considered in meeting increasing demands.

3.6 When the oncology day centre or unit’s physical capacity cannot be extended or extension requires significant capital spend. Providers may wish to examine a business case to invest in and develop community chemotherapy services within their networks where there is sufficient workforce capacity.

3.7 Many new drugs can be given orally or have short infusion times and nearly all of the new chemotherapy treatments expected to come into clinical practice in the future will not involve inpatient delivery. Some also have low side effect profiles and are well tolerated meaning that patients do not require frequent hospital checks, such as Trastuzumab (Herceptin). The combination of the increase in demand for this drug, relatively short infusion time and favourable side effect profile have made it an excellent treatment around which community and home chemotherapy services have been built. Other examples include Capecitabine, Gemcitabine and Irinotecan.

Potential efficiencies

Costs

3.8 Chemotherapy currently remains outside of the scope of Payment by Results, although work is progressing to change this. As such, there is little standardisation in how the delivery of chemotherapy is currently costed, to compare costs with delivering in community settings is therefore difficult. Initial modelling, making a series of assumptions, together with experience elsewhere suggests that delivering chemotherapy in the community can be at a lower cost than providing treatment in a hospital setting. Savings are likely to be delivered through provision of increased physical capacity and by avoiding capital costs of expanding physical capacity in acute settings. There are already pilot studies underway and when they have completed we will be in a much better position to provide more accurate details on costs. NCIG will work with the pilot schemes to develop accurate cost models and provide outline business cases as part of a package of detailed guidance to commissioners to enable them to examine the cost effectiveness of the different models of chemotherapy delivery. This work will be done alongside the existing work being undertaken by the
National Cancer Action Team (NCAT) and the Information Centre to improve the costing of chemotherapy delivery services generally.

3.9 There would be lower overheads for running home chemotherapy services while services in community settings would have to factor the costs of using the facilities into their financial model. These efficiencies must be balanced locally against the cost of employing additional nurses to deliver chemotherapy at home and in the community, as it is unlikely that the services could be provided within existing staffing levels. Costs will also vary locally, depending on the existing skills base of the nurses.

3.10 Both Healthcare at Home and BUPA Home Healthcare state that they are able to deliver home chemotherapy cost-effectively despite the lower nurse productivity. This is in part due to third parties being able to liberate savings on VAT for procurement of drugs for “personal use”.

3.11 It should be noted that patients being treated in the community will continue to need to be seen by the oncologist, indeed there may be increased demands on the time of oncologists in supervising these services, and will continue to require monitoring or review in the centre or unit.
4. **Issues to consider when commissioning services.**

**Network wide services**

4.1 In considering whether to move some chemotherapy services into the community, PCTs will need to work with their Cancer Network Teams, including the Network Chemotherapy Groups. As chemotherapy services are necessarily organised at a Network level with some aspects being delivered centrally and others closer to home, it is also logical for PCTs to work together across a Network to commission these services, through a lead PCT arrangement. It is well recognised that chemotherapy is a complex and specialised area of healthcare, as well as an area of high spend. PCTs will therefore want to draw on the expertise that cancer Network teams can provide, particularly the Network lead pharmacist and Network lead nurse.

4.2 PCTs will wish to achieve an appropriate balance between centralisation, cancer units and community services. It should be recognised that financial flows can mitigate against centres devolving care to cancer units. It should also be recognised that the consultant staff in clinical and medical oncology are largely based in cancer centres and provide outreach services to other hospitals. This is less the case with haematology. PCTs will need to be assured that there are formal provider to provider agreements in place across the Network about the supervision and support that each provider in the Network is expected to give patients, wherever they are treated.

**Planning**

4.3 The first step will be the need to undertake a baseline assessment of current chemotherapy services across the Cancer Network. This would include an analysis of what and how much chemotherapy is being provided where, as well as the governance arrangements and agreements about the safe supervision of the service that are in place between providers.

4.4 Commissioners working with service providers will need to look ahead each year to plan which drugs will be introduced and where they should be provided. The Cancer Commissioning Toolkit (CCT) has a ‘horizon scanning module’, which identifies where drugs are in the pipeline. This is updated regularly by the Network Pharmacist Group. The CCT also provides an activity-planning module, which can help commissioners assess the overall chemotherapy activity required each year.

4.5 C-PORT, the chemotherapy capacity-planning on line resource tool that is currently being rolled out across networks, enables providers to model the impact of new demand on their services and help plan for the safe, but cost effective introduction of new drugs and to model the impact of changing resources in chemotherapy departments. C-PORT allows planning for change to happen rapidly and to ensure the safe and most effective use of resources and can help to build the business case for the reconfiguration of services.

4.6 In moving these services into the community, registered providers will want to assure themselves that the premises / settings they use are appropriate in the light of the Care Quality Commission’s registration requirements.
Workforce

4.7 PCTs will need to ensure that numbers of appropriately trained staff are in place to deliver all models of chemotherapy delivery planned.

4.8 Generally, the specialist senior nurses have delivered chemotherapy in the community. This is a reflection on their experience and confidence in caring for patients and the need to be able to assess patients’ suitability for treatment. There are examples of current services where staff are rotated through the different settings to ensure that all have experience of the different ways of working.

4.9 Frequently it will be the more complex chemotherapy regimens that are delivered at the oncology day units. Therefore, the requirement for senior specialist chemotherapy nurses to deliver both acute and community services will increase pressure on the existing workforce resulting in the likelihood of more nurses being required and trained if quality service measures are to be maintained. This should be factored into planning locally as it is unlikely that the services could be provided within the existing staffing levels.

4.10 The development of community chemotherapy services outsourced to non-NHS providers could result in senior nurses being recruited from the main oncology units to undertake the community chemotherapy and could result in problems with staffing in the main oncology units.

4.11 A community based nurse specialist delivering chemotherapy at different locations during the course of a shift will not be able to treat as many patients as one working at a single unit. For example when the chemotherapy infusion has been commenced this is a time when the chemotherapy nurse at an oncology day unit could leave the patient and undertake other tasks such as treating other patients or administration. Therefore when planning services it is likely that the most efficient model for the home chemotherapy will be that where the chemotherapy consists of bolus drugs or short infusions and when transport time between patients is shortest.

4.12 Workforce planning and commissioning of post-registration training is undertaken at local level and PCTs would wish to involve their workforce leads in planning changes to service models at the earliest opportunity.

Training

4.13 There is currently no nationally accredited training programme specifically for chemotherapy and higher education institution providers have worked with trusts to develop their own curricula with courses varying in length. The Department of Health and the National Cancer Action Team will start work with Skills for Health to review and develop current competences for chemotherapy that will include competences to reflect the changing delivery and settings for chemotherapy. The goal of this is to develop a national training curriculum for chemotherapy nurse training which will allow nurses who have trained against this standard to have their training recognised and the opportunity to move jobs more easily through a ‘skills passport’. This will also identify best practice for those wishing to review current training and those wishing to set up training.
Acute Oncology

4.14 Whatever the configuration of elective chemotherapy services, commissioners and the Network team will need to ensure that appropriate arrangements are in place for acute oncology in all hospitals with Accident and Emergency (A&E) services. In those chemotherapy services that deliver treatment on a site without the provision of acute admissions, arrangements for patients to be treated and transferred should be put in place. Arrangements should also be made to ensure that patients have appropriate information and access to 24 hour support.

Models of contracting

4.15 Different models of contracting for chemotherapy services operate in different parts of the country. In many places, PCTs contract directly with individual hospitals, but this arrangement does not help support integrated chemotherapy service provision across providers and may actively work to fragment patient care. PCTs in the Cancer Networks will need to consider how they can collectively commission an integrated network of chemotherapy/Acute Oncology Service (AOS) provision, supported by integrated chemotherapy (e-prescribing) information systems.

4.16 One solution is to commission through a ‘lead provider’ and this model has been adopted in some Networks, with service level agreements ensuring that appropriate work is devolved to hospitals closer to a patients’ homes. Another model might be to contract with a formalised consortium/network of providers. This may include NHS, independent or third sector providers. Again commissioners will want to specify what services are provided where; to which patients in the Network; and assure themselves that the provider consortium has sound governance arrangements in place to ensure patients get the right care, from the right person in the right place and in the right way from all its constituent organisations.

4.17 A standard service specification template for adult systemic cancer therapy services incorporating these actions and measures is being developed by the National Cancer Action Team (NCAT) to help commissioners formalise their requirements with providers and this will reflect services in the community.

Regulation of service

4.18 In developing these services the PCT and the potential providers will need to consider the need to register the proposed services with the Care Quality Commission. Providers will need to register with the Care Quality Commission to provide any regulated activities, including the provision of treatment for a disease, disorder or injury by or under the supervision of a healthcare professional or multi-disciplinary team involving a healthcare professional. NHS bodies will need to register from 1 April 2010, private and voluntary sector providers from 1 October 2010. To register the provider will need to demonstrate ongoing compliance with 16 essential safety and quality registration requirements.
Protocols

4.19 Protocols should be agreed across a Cancer Network, incorporated into a protocol “book” (actual or web-based) and updated at least annually. The protocol book should also include treatment guidelines for the management of common chemotherapy toxicities (e.g. neutropenic sepsis) and extravasation. The current protocol book should be available wherever chemotherapy is prescribed, dispensed or delivered and where chemotherapy patients are assessed and treated (e.g. emergency departments, acute admission wards etc.). Handwritten prescribing of parenteral chemotherapy should be replaced as soon as possible by pre-printed forms or preferably by electronic prescribing systems.

Leadership

4.20 The NCAG report said that effective leadership is needed at Network and Trust levels for both elective chemotherapy services, in whatever setting and acute oncology. Chemotherapy and Acute Oncology Teams (AOTs) should be responsible for overseeing capacity planning, clinical governance, workforce and training, patient information and support, financial management, facilities and IT support.

Monitoring

4.21 In developing these services PCTs will want to ensure that patients’ views on the experience of receiving chemotherapy are sought and acted upon and they will want to monitor the proportion of treatments delivered in different settings as well as the expansion of nurse and pharmacist led chemotherapy.
Key references:

_Chemotherapy Services in England: Ensuring quality and safety_, DH, August 2009


The Cancer Commissioning Tool kit can be found at: [https://www.cancertoolkit.co.uk/PublicPages/Login.aspx?ReturnUrl=%2fDefault.aspx&AspxAutoDetectCookieSupport=1](https://www.cancertoolkit.co.uk/PublicPages/Login.aspx?ReturnUrl=%2fDefault.aspx&AspxAutoDetectCookieSupport=1)

References to International Studies:

Northern Ireland Health Economic Group (NIHEG) Report 2008 Home healthcare – an economic choice for the health service

