Independent Sector Cancer Network (ISCN)

Cancer Service Guidelines

'Putting Patients First, Transforming Cancer Care Together'

Version 1.0

4th October 2024

Contents

Introduction

The Independent Sector Cancer Network (ISCN) is a strategic quality governance and safety group which aims to improve independent sector cancer provision though effective collaboration and sharing of best practice across the Independent Sector Cancer Services within the UK.

This document sets out the quality guidelines that patients can expect from Cancer Care within the Independent Sector. The guidelines reflect the key elements of the cancer patient pathway that impacts upon physical, social and psychological wellbeing. The guidelines are based on National and International Guidelines, NHS Professional cancer bodies and Cancer Charities, gathering in one document based upon the CQC regulatory framework.

Purpose

This document is intended for use within the Independent Sector Cancer Services, to guide safe, quality assured patient care from diagnosis through to recovery or End of Life.

This document provides guidance on a standardised approach to service design and review. Organisations can use this document to develop an objective measuring tool to demonstrate service improvement in preparation for internal and external audits.

Although this document covers most of the Cancer Treatment Pathway, further development is underway to capture areas of practice not extensively covered. For example: Prehabilitation, Screening and Cancer Rehabilitation.

Set up of the document

The ISCN Cancer Service Guidelines are set out according to eight key criteria of cancer care:

	1. Environment, Services and Governance
	2. Multi-disciplinary treatment teams
	3. Diagnosis
	4. Surgery
	5. Systemic Anti-cancer Therapy (SACT)
	6. Radiotherapy
	7. End of Life Care (EOL) and Care of the Deceased and Family
	8. Cancer Clinical Nurse Specialists

Whilst there is more than one way to demonstrate achievement of each guideline (including accreditation by recognised external bodies), this document sets out the evidence required to help demonstrate that achievement.

- **Criteria 1 and 2** reflect guidelines associated with the organisation / facility and arrangements for multidisciplinary team (MDT) discussion, review and planning.

- **Criteria 3, 4, 5, 6, 7 and 8** relate to the various possible stages of the cancer patient pathway. An individual patients' care may involve a number of different service providers, across both community and hospital settings. It is vital that there be a seamless transition of care

between cancer service provider (both Independent Sector and NHS) in order to ensure that care is never compromised.

Each of the guidelines within the 8 criterias are mapped to the Care Quality Commission Five Key Domains:

SAFE

EFFECTIVE

CARING

RESPONSIVE

WELL LED

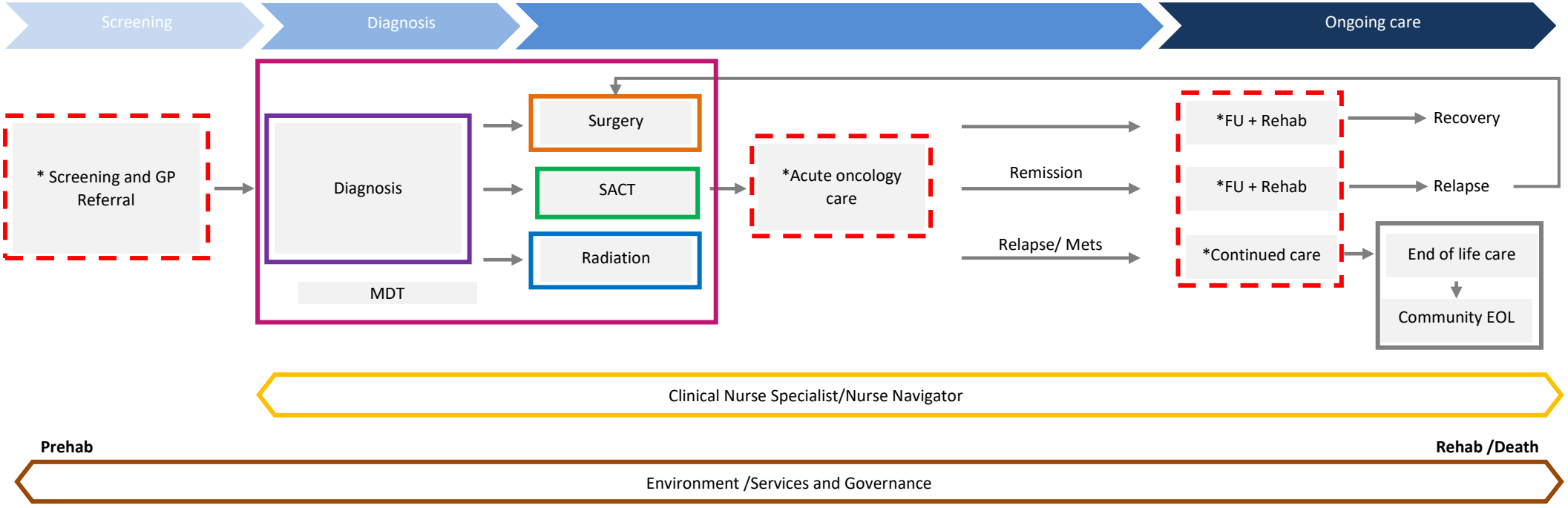
This will allow consistent monitoring of services across the network of hospitals based on the Key Lines of Enquiry (Care Quality Commission, 2022).

How to use the document

The Guideline has colour coded sections relating to the cancer patient treatment journey and some of the support mechanisms in place to run safe quality assured services that put the patient at the centre of this care.

Each section can be used to design new services or review existing provision in a systematic evidence-based way, guiding audit and preparation for internal and external reviews. A gap analysis tool can be developed depending on the extent of the services delivered and each section can be used to do so independently of the others. This should allow organisations providing cancer care in only parts of the patient pathway to use the relevant sections.

Further development is ongoing in the sections highlighted*



1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
1.1 **CQC** **Safe** **Well-Led**	Appropriate Health and Safety measures for the cancer service provided are in place.	Please see specific measure relating to this in: a) Surgery: Section 4 b) SACT: Section 5(5.9) c) Radiotherapy: Section 6 d) EOL: Section 7	Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Health and Safety Executive (2013). *Safe handling of cytotoxic drugs in the workplace - Health and Social Care*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm Health and Safety Executive (2013). *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 - RIDDOR - HSE*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/riddor/ Health and Safety Executive, H. (2013b). *L5 Control of Substances Hazardous to Health : the Control of Substances Hazardous to Health Regulations 2002. Approved Code of Practice and Guidance, L5*. Norwich: The Stationery Office Ltd.	• Appropriate national and local Policy/SOP and guidelines dependant on the area of review. • Individual organisation HSE audits • Individual organisations waste management audit and policy
1.2 **CQC** **Safe** **Well-Led**	Appropriate environmental safeguards are in place to deliver Quality Assured Cancer Services	Any environment where SACT is stored and handled should designed to control occupational exposure in line with national and international law and guidance. These environments include wards, day unit, pharmacies, outpatients, radiology areas and all other areas where SACT is handled (including Home Care). Hierarchic order of protection measures need to be put in place. If elimination and substitution of the hazard is not possible then the following order should be followed: 1) Isolate people from the hazard through engineering and ventilation controls 2) Change the way people work to control the risk by minimising exposure duration, minimising	Health and Safety Executive (2013). *Safe handling of cytotoxic drugs in the workplace - Health and Social Care*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm International Society of Oncology Pharmacy Practitioners (2022). ISOPP Standards for the Safe Handling of Cytotoxics. *Journal of Oncology Pharmacy Practice*, 28(3_suppl), pp.S1–S126. doi: https://doi.org/10.1177/10781552211070933	• SOPs • Report of enviornments where SACT is transported, stored or handled • Individual organisations SACT policy and waste management policy • Organisational safe handling and spillage protocols and procedures with associated training plan • Report following review of training records for safe handing and spillage • Risk assessments • Environmental audits and action plans • Individual organisations HSE audits

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		the number of workers and ensuring adequate SOPs and training 3) Protect workers with PPE. This is last line of protection and must be proceeded by the 2 above. These environments should be designed in such a way to ensure that: a) exposure is controlled at source, for example, by using adequate extraction systems and appropriate organisational measures; b) staff are issued personal protective equipment where adequate control cannot be achieved by other measures alone. c) the quantities of drugs used are kept to a minimum d) the number of employees and patients potentially exposed and their duration of exposure are kept to a minimum e.g. by limiting the areas that SACT is handled and limiting the distances that SACT is transported. e) there can be safe handling, storage and transport of SACT and waste material containing or contaminated by them. Larger quantities of SACT should be transported in original packaging on wheeled trollies with sides. Smaller quantities can be transported in an unbreakable, leak tight container. They should contain moulded foam or another material capable of protecting the product. All containers should be labelled that the contents are cytotoxic or hazardous. f) totally enclosed systems can be used where reasonably practicable g) good hygiene practices can be followed and that they can provide suitable welfare facilities, e.g. prohibiting eating, drinking and smoking in		• Review of process of SACT from delivery to administration and disposal • Results of SACT Wipe Testing • Identify risks; presented in local and organisational risk register with evidence of regular review

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		areas where drugs are handled and providing washing facilities h) all staff who could come into contact with SACT are trained on how to deal with contaminated waste, spillages and the risk and precautions to take i) staff can be provided with the freedom of choice not to work in an area where SACT is handled j) adequate cleaning procedures are in place to ensure reduced contamination as well as providing protection for those cleaning		
1.3 **CQC** **Safe** **Effective**	All risks associated with the cancer service are identified, assessed and managed appropriately.	a) There is a mechanism for managing NPSA, MHRA and Rapid Response Alerts relating to cancer services b) There is evidence of compliance with current International and National Guidance relating to cancer services c) There is evidence of reviewing trends from key performance measures including clinical audit, adverse events and complaints. Key areas of risk are identified, and outcomes are addressed with evidence of changes in practice. d) Specific risks associated with oncology / haematology are monitored & data collated to drive best practice in these areas e.g. neutropenia, VTE incidents 90 days post care, sepsis, anaphylaxis, death within 30 days of systemic anti-cancer therapy and 60 days of radiotherapy treatment. e) There are robust procedures in place for the review of healthcare technologies and introduction of new procedures / treatments for cancer services prior to implementation.	Regulation 15 and 17 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Risk Assessments & Risk Register for clinical areas. • Policy & tracking system. • Action taken to address alerts • Minutes from local Expert advisory group, Infection Prevention, Governance Committees & MAC, Quality & Governance Reports. Cascade of information from central groups & Committees. • Communications reflecting audit findings, adverse incidents, feedback from service users, staff, consultants, 3rd parties • Evidence of shared learning & actions taken. • IS organisational Quality Assurance Framework for cancer and/or dedicated Policy • Quality Improvement action plans. • Internal Quality Assurance Reviews. • Systems in place for concerns to be raised & appropriately addressed.

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		f) Clinical areas identified as falling below standard are appropriately risk assessed.		• Corporate Policy; evidence of local adherence
1.4 **CQC Safe** **Effective** **Responsive**	Meet NHS Cancer Waiting Times Standard	Current Cancer Waiting Times standards: a) Maximum two weeks from receipt of urgent referral for suspected cancer to first outpatient attendance. b) Maximum 28 days from receipt of two week wait referral for suspected cancer, receipt of urgent referral (regardless of referral route) to the date the patient is informed of a diagnosis or ruling out of cancer c) Maximum one month (31 days) from decision to treat to first definitive treatment d) Maximum one month (31 days) from decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is surgery, drug treatment or radiotherapy. e) Maximum two months (62 days) from urgent referral for suspected cancer to first treatment (62-day classic)	NHS England Publications (2020). *National Cancer Waiting Times Monitoring Dataset Guidance -Version 11.0*. [online] Available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/national-cancer-waiting-times-monitoring-dataset-guidance-v11-sep2020.pdf	• Data from clinical waiting times audits • Patient and doctor complaints • ePrescribing data
1.5 **CQC** **Safe** **Effective**	Infection prevention and control measures are in place to protect patients with cancer & those caring for them.	There is evidence of:- a) Cleaning schedules in all clinical areas & easy clean equipment within Oncology units. b) Appropriate hand hygiene facilities and compliance. Taps within Oncology Units must be mixer taps, elbow operated (ideally not sensors) & flushed as a minimum daily for 2 mins with hot water @ 60° C c) Universal infection control precautions in line with local IPC policy d) Training in line with local IPC policy	Regulation 11, 12 and 16 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations NHS England (2022). *NHS England» National Infection Prevention and Control Manual (NIPCM) for England*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/	• National and local policy followed • Awareness of DIPC/ Local microbiologist and Infection Prevention. • Standardised PPE with evidence base for optimal provision • Environmental Audits. • Training and competency records. • Water safety records • Clinical audits, benchmarking, learning & quality improvement

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		e) Surveillance monitoring, review and action in line with local IPC policy f) IPC Audit in line with local IPC policy	NHS England (2022b). *NHS England» National Infection Prevention and Control Manual (NIPCM) for England*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/. NHS Scotland (2022). *National Infection Prevention and Control Manual: Home*. [online] www.nipcm.scot.nhs.uk. Available at: https://www.nipcm.scot.nhs.uk/. NHS Wales (2012). *NIPCM*. [online] Public Health Wales. Available at: https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/nipcm/. HSC (n.d.). *PHA Infection Control |*. [online] www.niinfectioncontrolmanual.net. Available at: https://www.niinfectioncontrolmanual.net/. NHS (2022). *NHS England» National Infection Prevention and Control*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/national-infection-prevention-and-control/. NHS England (2022). *Classification: Official Publication approval reference: C1632 A rapid review of aerosol generating procedures (AGPs)*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2022/04/C1632_rapid-review-of-aerosol-generating-procedures.pdf	action plans. Evidence of improvement activity as a result. Standardised consumables, suitable storage & stock management. • Equipment cleaning records
1.6 **CQC** **Caring** **Responsive**	Patient privacy and dignity is maintained at all times.	a) The reception areas are welcoming and readily accessible. b) Privacy is maintained at reception areas, Consulting and treatment rooms – voices not overheard, access not permitted whilst in use, private documents not visible in public spaces. c) Shared treatment areas are large enough for patients not to feel space is invaded or overlooked.	Regulation 11, 12 and 16 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• PLACE Audit results & action plans. • Service user feedback • Observational / qualitative audit.

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		d) Quiet rooms are available for patients / relatives e) Appropriate quite spaces for staff to have conversations with patients/relatives/clinicians		
1.7 **CQC** **Caring** **Responsive**	The environment contributes to the comfort and well-being of patients accessing cancer services.	a) The facility has dedicated space which is attractive and well maintained. b) Patient treatment areas have access to natural light (except for radiotherapy planning and treatment rooms). c) Furniture, fixtures, fittings and decor have been selected with input from people using the facility. d) Sourced art is used in the facility and dominant rather than medical / information posters. e) Flexible visiting times, accessible facilities and a culture that welcomes visitors and attends to their wellbeing – e.g. provision of food and beverages if required.	Macmillan Cancer Support (2024). *Macmillan Quality Environment Mark*. [online] Macmillan.org.uk. Available at: https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/mqem [Accessed 29 Sep. 2024]. NHS England (2024). *Patient-Led Assessments of the Care Environment (PLACE)*. [online] NHS Digital. Available at: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place.	• Environmental Audits & action plans. • PLACE Audit & action plan. • Review process for procurement of furniture, soft furnishings & equipment • Service user feedback.

1.8
 	
CQC
Safe
Responsive
	People who use cancer service are protected from abuse.	a) Policies and procedures are in place for the protection of vulnerable adults.
		b) There are robust recruitment policies and procedures in place - including full DBS disclosure for all staff, verification of professional qualifications & experience. Professional registration is maintained and checked on a regular basis.
		c) All staff undergo training re. safeguarding vulnerable adults and Mental Capacity Act
		d) Diversity, beliefs and values of people using the service are identified and respected.
		e) Deprivation of Liberty safeguards are applicable only when in the best interests of the person using the service and in accordance with the Mental Capacity Act 2005.
			Regulation 13 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations
			
			Health & Care Professions Council (HCPC) register www.hpc-uk.org/check
			
			Mental Capacity Act (2005). *Mental Capacity Act 2005*. [online] Legislation.gov.uk. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents.
			
			Social Care Institute for Excellence (SCIE) (2022). *Deprivation of Liberty Safeguards (DoLS) at a glance*. [online] SCIE. Available at: https://www.scie.org.uk/mca/dols/at-a-glance/
				• Review access to Policies & accessibility of relevant flowcharts & local contacts.
				• Assess staff understanding of safeguarding, MCA & DoL's.
				• Review records to evidence referrals & / or application of Policy.
				• There are arrangements in place to screen;
				  ○ consultants before granting practising privileges.
				  ○ 3rd party arrangements e.g. External visitors.
				  ○ recruiting volunteers / approving work experience.

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
1.9 **CQC** **Effective** **Safe**	Patients with cancer and other cancer service providers are assured of appropriately completed health records and information governance.	a) Contemporaneous medical records are maintained - accessible to all disciplines in both primary and secondary care settings. b) Patients should be provided with a personalised patient held record for cancer treatment. c) All Health records (electronic and paper) are stored securely and confidentially maintained in line with GDPR guidelines. d) Staff undergo Information Governance & Security training	Regulation 17 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations GOV.UK (2018). *Data Protection Act*. [online] GOV.UK. Available at: https://www.gov.uk/data-protection.	• Medical Records; content, completeness & accessibility. • Patient held records. • Review suitability of storage arrangements. • Staff training records. • Observe practice • GDPR compliance measures are all in place • Staff are able to articulate how to escalate possible GDPR concerns
1.10 **CQC** **Caring** **Responsive**	The cancer services provider considers service user and patient views.	a) There are feedback mechanisms in place to ascertain patient and service user views which lead to quality improvements.	Regulation 10 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Macmillan Cancer Support (2024). *Macmillan Quality Environment Mark*. [online] Macmillan.org.uk. Available at: https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/mqem [Accessed 29 Sep. 2024]. NHS England (2024). *Patient-Led Assessments of the Care Environment (PLACE)*. [online] NHS Digital. Available at: https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place.	• PLACE Audit report & action plan. • Patient surveys, shared learning & action plans • Complaints handling, shared learning & action plans. • Evidence of change as a result of feedback.
1.11 **CQC** **Safe**	Procedures are in place to manage patients in emergency situations.	There is evidence of:- a) Emergency protocols and procedures: i. Cytotoxic spillage ii. Anaphylaxis/hypersensitivity iii. Extravasation	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Review Policy provision • Review compliance to patient assessment tools (NEWS2), triggers & clinical response. • Mechanisms for communication – use of SBAR.

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Effective		iv. Acute oncology admission v. Major haemorrhage vi. Cardiac arrest b) Staff training and scenarios related to above occur (minimally) annually which includes all appropriate departments e.g. porters, housekeepers etc c) Emergency equipment is checked and fully maintained with records as per organisational policy	UKONS (2023). *Acute Oncology Initial Management Guidelines - latest version* -. [online] UKONS Oncology Nursing Society. Available at: https://ukons.org/news-events/acute-oncology-initial-management-guidelines-latest-version/.	• Emergency notification (alarm) process. • Type & frequency of scenarios – feedback mechanisms, evidence of shared learning & improvements. • Check emergency equipment – Is it standardised / consistent? Review equipment service records. • Review equipment checks. • Type & frequency of training provision. • Staff training records. Review arrangements – local Resuscitation committee. • Review arrangements for central overview & Quality Governance. • UKONS Triage in place and regular outcome audit and action planning
1.12 **CQC** **Safe** **Effective**	Co-operation with other health and social care service providers	a) There are written agreements with 3rd party health care service providers where required. b) There is evidence of collaborative working to optimise patient care and streamline the service between different health care providers both during treatment and at point of discharge from the service. c) A treatment summary is provided at point of referral following each treatment episode and at the point of discharge.	Regulation 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations GOV.UK (2019). *Health and Social Care Act 2008*. [online] Legislation.gov.uk. Available at: http://www.legislation.gov.uk/ukpga/2008/14/contents.	• Review Policy for managing 3rd Party Arrangements & local contracts / Service Level Agreements (SLA's). • Review mechanisms for on-going contract reviews with quality focus and action plans. • Review referral processes & information provision for other services & providers. • Review networking arrangements.
1.13 **CQC**	Governance, policy and procedures in relation to medicines are in place. (see section 5 SACT)	a) Policies must be in place to ensure safe procurement, storage, prescribing, dispensing, administration and disposal of medicines.	Regulation 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available	• Local Intelligence Network (LIN) Assessment. • Waste Management Audit • Home Office Statement of Compliance

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe		b) CD Licence relevant to the service must be in place	at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Review of medicine management policy and review of SACT administration policy to ensure safe procurement, storage, prescribing, dispensing, administration and disposal of SACT are included (see section 5) • Review CD licence. Ensure in date and covers all aspects of service required.
1.14 **CQC** **Safe** **Responsive**	Equipment to meet the needs of patients with cancer is available	a) Equipment is readily available, fully serviced and maintained to meet the individual needs of patients with cancer. E.g. Cold cap systems, electric profiling beds / treatment couches, static and ambulatory infusion pumps. b) Quality assurance on Linear Accelerators and planning CT scanners in line with national guidelines. c) There is evidence of staff training in the use of all relevant equipment prior to commencement of use and regular updates.	Regulation 15 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Compliance evidenced by external/internal H&S Inspection. • Staff competency assessments • Staff & Consultant surveys, shared learning & action plans. • Mechanisms for 3rd party feedback – shared learning & action plans. Evidence of change because of feedback. • Review policies & mechanisms for raising concerns relating to equipment e.g. Whistleblowing Policy, Safe Call • Assess equipment provision & suitability. • Review of evidence of service records, cleaning records and staff training/competency records. • Observe use of equipment and assess staff knowledge. • Review procurement process – consider due diligence, standardisation, service user input etc.

1. Environment, Services and Governance

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
1.15 **CQC** **Effective** **Responsive**	Adequate and reliable IT Infrastructure and digital equipment are in place within all services to facilitate patient care delivery	a) Business continuity plans for IT infrastructre b) Maintenance and upgrades of systems evidenced through contracts. c) Evidence of adequate version control over systems and hardware upgrades	UK SACT Board (2022). *Standards for the safer use of electronic Prescribing and Medicines Administration (ePMA) systems for use in Systemic Anti-Cancer Therapy (SACT) Services*. [online] Available at: https://www.uksactboard.org/_files/ugd/638ee8_5613776913e5415f81f31610e4a4a862.pdf [Accessed 29 Sep. 2024].	• Audit of equipment and usage • Audit of Wi-Fi down time • Clinical incidents related to equipment or Wi-Fi • 24hr access to IT support • BCP planned down time and audit of the scenario • BCP regular review and risk assessment • Review against Standards for the safer use of ePMA systems for use in SACT Services

2. Multi-disciplinary treatment teams

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
2.1 **CQC** **Safe** **Effective**	Each patient treatment pathway has been approved by the relevant multidisciplinary team	All patients with a diagnosis of cancer within the organisation have evidence that their treatment plan was discussed by an appropriate MDT when following a pathway of care within the organisation The MDT must follow the national minimum standards a) The organisation should monitor the quality of the MDT against these national minimum standards. b) An SLA agreeing the process for accessing the MDT, transfer of information to and from the MDT	Regulation 4 and 7 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations NHS England (2020). *NHS England» Streamlining Multi-Disciplinary Team Meetings – Guidance for Cancer Alliances*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/streamlining-mdt-meetings-guidance-cancer-alliances/ Brown, G.T.F., Bekker, H.L. and Young, A.L. (2022). Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a systematic review. *BMC Cancer*, [online] 22(1). doi: https://doi.org/10.1186/s12885-022-09369-8.	• Patients treatment plan is available within individual patient medical record • Review processes of organisational monitoring of MDT compliance. • Audit of MDT of compliance and quality of documentation against national minimum standards • Service level agreement
'Independent Provider' Cancer Services with their own MDT:				
2.2 **CQC** **Safe** **Effective**	The MDT/ Treatment team considers the MDT standards referred to in the Department of Health's Manual for Cancer services 2004	a) There is a named lead clinician, who is a member of the core team within the local cancer network b) The lead clinician has written responsibilities agreed with the organisation c) The core members of the team include a minimum of 2 Surgeons, 2 Oncologist, 2 Histopathologist, 2 Radiologist, Other healthcare professionals as appropriate to site of primary tumour	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations NHS England (2020). *NHS England» Streamlining Multi-Disciplinary Team Meetings – Guidance for Cancer Alliances*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/streamlining-mdt-meetings-guidance-cancer-alliances/ Brown, G.T.F., Bekker, H.L. and Young, A.L. (2022). Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a	• An operational policy for the MDT detailing Core Membership evidencing appropriate membership • Lead Clinician on MAC • Operational policy detailing roles and responsibility of core membership • A standard agenda outlining governance requirements I.e. audit, training, complaints and incidents • Quorum detailed in each meeting minutes in order to be justified as MDT • Audit of the effectiveness of the MDT

2. Multi-disciplinary treatment teams

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			systematic review. *BMC Cancer*, [online] 22(1). doi: https://doi.org/10.1186/s12885-022-09369-8.	
2.3 **CQC** **Safe** **Effective**	Any MDT/ Treatment team meetings held consider the MDT standards referred to in the Department of Health's Manual for Cancer services (2004)	a) If there is a separate pre op/diagnostic meeting in addition to treatment planning MDT, membership should be named and agreed b) Core members or cover should attend the majority of meetings c) MDT to agree cover arrangements for all core members d) If there is a separate pre op/diagnostic meeting in addition to treatment planning MDT, membership should be named, agreed and quorate e) Core members or cover should attend the majority of meetings (75%) f) MDT to agree cover arrangements for all core members	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Brown, G.T.F., Bekker, H.L. and Young, A.L. (2022). Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a systematic review. *BMC Cancer*, [online] 22(1). doi: https://doi.org/10.1186/s12885-022-09369-8.	• MDT minutes detailing attendance is quorate • Core membership cover is detailed in operational policy • Monitored by annual internal clinical review and included in annual MDT governance report and external review every 3 years • An agreed MDT proforma that has minimum data set and clear treatment plan agreement
2.4 **CQC** **Safe** **Effective**	The MDT/ Treatment team Operational Policies consider the MDT standards referred to in the Department of Health's Manual for Cancer services (2004)	a) In addition to regular meetings, the MDT should meet at least once a year to review and agree operational policies (Annual MDT Governance meeting) b) It must be agreed policy that all new patients are reviewed by the MDT c) There must be an agreed policy on the communication of the diagnosis with the GP d) The GP should be informed of the diagnosis by the end of the following day (from the patient being told) e) Information is provided to GPs on the appropriateness and timeliness of referral of suspected cancer patients	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Brown, G.T.F., Bekker, H.L. and Young, A.L. (2022). Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a systematic review. *BMC Cancer*, [online] 22(1). doi: https://doi.org/10.1186/s12885-022-09369-8.	• Evidence of a minimum of annual meeting minutes with quorate membership and appropriate governance agenda • Monitored by annual clinical review and included in annual MDT governance report • Compliance with National Cancer Peer Review Programme NHS England

2. Multi-disciplinary treatment teams

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
2.5 **CQC** **Safe** **Effective**	The MDT/ Treatment The Function of the team providing patient centred care mirrors the components of an MDT as set out in the Manual for Cancer services (2004)	a) Written arrangements on how patients gain access to the members of the MDT are available b) The MDT carries out a survey of patients views on the service. Action points agreed as a result of the survey, are implemented c) Written materials are available on the tumour site, local services, and support and self help d) The MDT agrees and records individual patient's treatment plans at the regular meeting. e) The MDT has written clinical guidelines, agreed by the local NHS trust Tumour Site Specific Group (TSSG) f) The MDT has agreed guidelines for referral between primary, secondary and tertiary care, agreed with the local NHS trust TSSG g) The MDT has the same agreed minimum dataset (MDS) as the other MDTs of the cancer site in the local NHS. h) Cancer Deaths within 30 days of SACT are monitored and discussed at hospital governance and presented to MAC and trends and learning discussed at the annual MDT governance meeting	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations National Quality Board (2017). *National Guidance on Learning from Deaths National Guidance on Learning from Deaths Contents*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf. Brown, G.T.F., Bekker, H.L. and Young, A.L. (2022). Quality and efficacy of Multidisciplinary Team (MDT) quality assessment tools and discussion checklists: a systematic review. *BMC Cancer*, [online] 22(1). doi: https://doi.org/10.1186/s12885-022-09369-8.	• Monitored by annual clinical review and included in annual MDT governance report • Learning from Deaths Dashboard • Cancer Data set collection figures available in annual MDT report • Minutes of Annual MDT governance meeting if conducting own organisational MDT • Learning from Cancer and SACT death detailed in the MDT governance meeting annual report • Compliance with National Cancer Peer Review Programme NHS England

3. Diagnosis

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
3.1 **Consultation** **CQC** **Safe** **Effective**	Patients with cancer are seen by a Cancer Specialist in current practice.	All clinicians managing cancer patients must be:- a) A cancer specialist – Consultant who is a core member of at least one MDT for the speciality in which they are practising. b) Fully registered and Licensed with the GMC on the specialist register	The medical register: https://www.gmc-uk.org/registration-and-licensing/our-registers Regulation 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Meets the standards within the PP processes– i.e. evidence CPD, activity data, Annual Appraisal • Obtain scope of practice • Listed on the specialist register with the GMC
3.2 **Consultation** **CQC** **Effective** **Responsive**	Patients with cancer are not delayed awaiting Consultation.	a) Appointments must be offered as quickly as possible and at the patient's convenience. b) GP's must be informed by the end of the following day when a patient is given a diagnosis of cancer. c) There needs to be a robust process for the management of unexpected suspicious findings within radiology	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Audit data of time of request to appointment • Audit of time of letter provided from date of Consultation
3.3 **Patient Information and support** **CQC** **Caring** **Responsive**	Patients with cancer have ready access to relevant information and support.	Patients have ready access to: - a) Key worker- Clinical Nurse Specialist (CNS) with qualifications for the speciality or specialist radiographer or specialist SACT nurse. b) Holistic Needs Assessments at Key Points in the patients pathway (HNA) c) End of treatment summaries at the end of each treatment modality d) Access to Health and Wellbeing events or appointments e) Relevant and current approved patient information. f) Counselling, Psychology, Psychiatry, Dietetic, Occupational Therapy, Physiotherapy,	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Macmillan Cancer Support (2024). *Macmillan Quality Environment Mark*. [online] Macmillan.org.uk. Available at: https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/mqem [Accessed 29 Sep. 2024]. Macmillan Learning Hub: https://macmillan.fuseuniversal.com/users/sign_in	• Audit of CNS contact with the patient at key points in the pathway • HNA – audit against diagnosis data • End of Treatment summary audit data • Examples of patient information • Examples of Health and Wellbeing programmes and evaluations • Service details for Allied Healthcare Professionals. • Evidence of patient information for therapies and support groups. • Evidence of sign posting to charities

3. Diagnosis

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		Lymphoedema Practitioners and Speech and Language therapists. g) Information regarding complementary and holistic therapies as an adjunct to conventional treatments. h) Signposting to Support groups and / or websites e.g. Penny Brohn Cancer Care, site-specific cancer charities.	National Cancer Action Team (n.d.). *Holistic Needs Assessment for people with cancer A practical guide for healthcare professionals National Cancer Action Team Part of the National Cancer Programme Living with and beyond cancer*. [online] Available at: https://www.rcplondon.ac.uk/file/3041/download.	
3.4 Patient Information and support	Patients with cancer feel involved and empowered regarding treatment pathway	There is: - a) evidence of discussion and informed consent b) Patients and carers have choice, voice and control over what happens to then at each step of their care. c) Consideration should be made to the use of digit information to be sustainable.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Written Patient pathways • Patient experience surveys to include whether they have a choice and voice
3.5 Patient Consent to treatment	All patients have appropriate consent taken prior to receiving treatment for Cancer related procedures and treatment	Patients are consented for the following cancer related treatment areas: • SACT • Surgery • Radiotherapy a) Patients recieving SACT are consented by a consultant using the CRUK consent forms b) Consultants give patients time to ask questions to enable informed consent c) Patients are given approriate information to enable informed consent d) Patients have time following diagnosis and treatment planning to decide on treatment ready to consent e) Patients are involved with treatment decisions	Regulation 11 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Care Quality Commission (2019). *Inspection framework: Acute and independent healthcare*. [online] Available at: https://www.cqc.org.uk/sites/default/files/NHS_and_IH_Outpatients_service_framework.pdf [Accessed 29 Sep. 2024]. Cancer Research UK (2016). *Consent forms for SACT (Systemic Anti-Cancer Therapy)*. [online] Cancer Research UK. Available at: https://www.cancerresearchuk.org/health-professional/treatment-and-other-post-diagnosis-	• Audit results • Patient satisfaction surveys

3. Diagnosis

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		f) Patients have been supported by CNS's to enable patients to ask questions to allow informed consent g) Staff understand their requriements in relation to capacity to consent and have processes in place to assess capacity h) Patients are offered copies of consent documenation i) Are patients offered translation services when English is not their first language	issues/consent-forms-for-sact-systemic-anti-cancer-therapy. General Medical Council (n.d.). *Decision making and consent*. [online] Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/decision-making-and-consent [Accessed 9 Nov. 2020]. Department of Health (2009). *Reference guide to consent for examination or treatment (second edition)*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition. Public Health England (2021). *Language interpretation: migrant health guide*. [online] GOV.UK. Available at: https://www.gov.uk/guidance/language-interpretation-migrant-health-guide. Department of Health (2009b). *Reference guide to consent for examination or treatment Second edition*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf.	
3.6 **Pathology Services** **CQC** **Safe**	Pathology services for patients with cancer are provided by suitably qualified staff within an accredited facility.	The laboratory must demonstrate: - a) CPA / ISO Accreditation – at a minimum of conditional level. b) UKAS accreditation c) MHRA compliance for blood transfusion d) NBS – Arrangements for obtaining specialist products.	UKAS (2022). *Medical Laboratory accreditation*. [online] UKAS. Available at: https://www.ukas.com/accreditation/standards/medical-laboratory-accreditation/.	• Evidence of CPA/ISO Accreditation • Evidence of policy to demonstrate MHRA compliance for blood transfusion • Contract available for obtaining specialist products • List of designated cancer specialist pathologists • List of specialist clinicians

3. Diagnosis

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Effective		e) Cancer work completed by specialist pathologists – Histopathology, Cytology f) Specialist clinician resource – Endocrinology, Chemistry, Haematology, Transfusion g) Electronic collection of minimum dataset items h) Agreed policy for referral of specimens for Pathology review outside the service. Including process for handling and transportation. i) Timely reporting to referral clinician – as per protocol for specific laboratory investigation. j) All new cancers are registered with the Regional Cancer Registry k) Access to regular Pathology storage and collection services with transfer protocols l) Process MUST be in place to immediately report unexpected findings of cancer		• Evidence of collection of minimum datasets • Pathology specimen transfer policy • Pathology protocol and audit including reporting time • Data is input to the relevant national database / screening programme • Storage and collection protocols
3.7 **Radiology** **CQC** **Safe** **Effective**	Radiology services for patients with cancer are provided by suitably qualified staff within an accredited facility.	a) There must be rapid access for diagnostic referrals e.g. Mammography, MRI, CT b) All Radiographers involved with specialist imaging must demonstrate relevant qualification and evidence of on-going competency. c) All reporting must be undertaken by a specialist Radiologist relevant to the field. d) Validated reports must be generated according to the investigation protocol and issued to the referring clinician in a timely manner appropriate to the clinical findings.	Regulation 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Audit of access times by investigation • Register of qualification and audit of performs • Register of Radiologists by speciality • Reporting protocol in place and evidence of audit
3.8 **Intervention fluid specimen / tissue biopsy**	Surgery	a) Interventional procedures must be undertaken at the earliest opportunity from receipt of referral and within a timescale that is clinically acceptable.	Regulation 9, 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk.	• Audit of time of request to intervention or review of a sample of request forms

3. Diagnosis

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
CQC **Safe** **Effective**		b) Such procedures to be performed only by clinicians with the relevant qualification and competencies.	Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Evidence of procedures performed in line with scope of practice

4. Surgery

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
4.1 – Pre-operative assessment **CQC** **Safe** **Effective**	Patients having surgery are informed, prepared and risk-assessed using credible assessment tools to ensure safe preparation for surgery.	a) Approved patient information is readily available. b) Key worker- which would be appropriately assigned and should be a Clinical Nurse Specialist (CNS) or specialist radiographer or specialist SACT nurse. c) Supportive services for psychological care, physiotherapy, occupational therapy, dietetic and speech and language support is readily accessible d) There is evidence of clinical risk management using credible assessment tools e.g. VTE, mobility, falls, tissue viability, ASA score etc. e) There is evidence of referral for specific investigations as indicated. f) Support is available from all relevant disciplines as required: GP / Macmillan / Dietician / Physiotherapy / Speech Therapy /clinical psychology etc. thus offering holistic support and assessment. g) Fully informed written consent can be evidenced with risks and benefits discussed and considered. This must include consent for potential additional treatments e.g. Blood Transfusion. h) MRSA screening is undertaken as per policy with prophylactic treatment as appropriate. i) Patients must be discussed at an apparopriate tumour specific MDT prior to surgery(see section 2)	Regulation 11 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations NHS England (n.d.). *NHS England» Commissioning for Quality and Innovation*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/.	• Sample of information given • Evidence of key worker • Evidence of AHP and psychological support service available • Evidence of clinical risk audits • Audit of additional referrals by speciality • Evidence of access to support services and the offer of a Holistic Needs Assessment • Audit of completeness of consent forms • MRSA screening audits
4.2 – Surgery **CQC** **Safe** **Effective**	Surgery for patients with cancer is undertaken safely and within acceptable timescale.	a) Specialist Consultant surgeon and Anaesthetist, both fully Registered and Licensed with the GMC. b) The surgical team are registered with the NMC / HPC. Unqualified staff can demonstrate NVQ / relevant competency skills. All staff can demonstrate competency to fulfil their role and evidence CPD. c) Patients are admitted within a timescale acceptable and convenient to them and which is clinically appropriate. d) The WHO surgical safety checklist is fully utilised.	Regulation 11 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Evidence of GMC registration and scope of practice • NMC registration records available and competencies relating to role completed • Audit of decision to treat and date of treatment plus review of patient experience survey • WHO checklist audit

4. Surgery

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		e) Histology sample is to be sent to a Consultant Histopathologist who holds relevant specialist registration and a full licence to practice. f) Prophylactic measures are taken as per NICE / Local Policy Guidelines e.g. Infection prevention and VTE		• Audit of specimen reporting and speciality of histo- pathologist • Evidence of preventative measures – audits and documentation
4.3 - Post-operative Management **CQC** **Safe** **Responsive**	Patients with cancer having surgery have 24hr access to care and support to enable safe and effective post-operative recovery.	a) There is evidence of a suitably skilled multi-disciplinary workforce – professional registration, relevant competencies and CPD. A key worker is available - which would be appropriately assigned and could be a Clinical Nurse Specialist (CNS) or specialist radiographer or specialist SACT nurse. b) 24hr access to relevant services c) Level 2 / 3 care is accessible if required within the facility or a written transfer service level agreement (SLA) is in place.	Regulation 9, 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Mccormick, B. (2012). *Pathway peer review to improve quality*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2013/11/NQB-12-05-01-a.pdf. Parker, S. (2016). *Clinical Guidelines for the Management of Breast Cancer West Midlands Expert Advisory Group for Breast Cancer*. [online] *NHS England*. Available at: https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2018/02/guidelines-for-the-management-of-breast-cancer-v1.pdf.	• Evidence of specialist staff being available • Evidence of on call rota by speciality • Protocol for medical cover and contacting the patients consultant • List of specialist staff held in central location • Pathway for level 2/3 care and SLA
4.4 Post-operative Management **CQC** **Caring** **Effective**	Patients with cancer having surgery closely monitored following their operation: care is evidence-based with patient involvement.	a) There is an evidence-based care pathway and treatment protocols. b) There is evidence of ongoing clinical assessment and application of NEWS2 scoring. c) There is evidence of pain and nausea assessments with application of an evidence-based algorithm.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Review of treatment pathways and protocols • Audit of NEWS2 scoring • Audit of pain and nausea and interventions • Protocol for the use of ambulatory pumps and PCA's

4. Surgery

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		d) Evidence of patient empowerment and independence e.g. use of ambulatory pumps, PCAS		
4.5 Post-operative Management **CQC** **Caring** **Responsive**	Patients with cancer having surgery closely monitored following their operation: care is evidence-based with patient involvement.	e) Patient-centred care, support and counselling is provided. f) The food and hydration need of the patient are met with flexibility and choice whilst also considering religious and cultural background. g) Patients have private access to facilities such as TV, telephone, Wi-Fi and radio to meet the needs of the patient group. h) Patient and significant others are informed regarding treatment plan and the patient is involved with decision-making process. i) The patient is afforded privacy and private time with family / visitors j) Family members & / or significant others of patients affected by cancer have a dedicated private room they can use.	Regulation 11 and 14 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Macmillan Cancer Support (2024). *Macmillan Quality Environment Mark*. [online] Macmillan.org.uk. Available at: https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/mqem [Accessed 29 Sep. 2024].	• Pathway indicating access to support and counselling • Selection of menus and review of patient experience survey • Review of patient facilities • Evidence of patient and significant others involved in decision making • Evidence of private room as an inpatient and out patient • Review of relative/significant other facilities
4.6 Post-operative Management **CQC** **Caring** **Responsive**	Patients with cancer having surgery are discharged at an appropriate time and with the necessary information and support	a) Evidence of discharge planning and community support – e.g. access to the Palliative Care Team. Pain control and discharge medication are discussed prior to discharge. b) Clear instructions are given to the patient and significant others about what action should be taken following discharge in the event of complications. c) Clear instructions are to the patient and significant others around follow up and next steps	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Pathway for discharges and policy • Evidence of discharge summary and documentation
4.7 Emergency admission **CQC**	Patients with cancer having surgery are able to access safe and appropriate care in the	a) An emergency admissions procedure is in place in the event of acute re-admission.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at:	• Pathway for emergency admission in place including patients being aware of contact details • Agreed pathway for readmissions which require another facility

4. Surgery

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Caring **Responsive**	event of complications post-discharge.	b) If the facility cannot safely re-admit the patient the patient and / or significant others must be accurately informed about what action they should take.	https://www.cqc.org.uk/guidance-regulation/providers/regulations	• SLA detailing emergency re admission arrangements

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.1 Quality governance and risk management **CQC** **Effective** **Well led**	Effective quality governance and risk management systems are in place for all Systemic Anti -Cancer Therapy (SACT) administration	Hospital Level a) SACT services have representation on hospital/ local governance committee and any escalations are referred to the organisations National Governance. b) There is a named lead clinician in all organisations involved in SACT administration who has representation on the Medical Advisory Committee. c) The organisations local cancer lead and the oncology pharmacist must have dedicated time to the role but may not be full time in this role and must work collaboratively with organisations lead chemotherapy nurse. d) Systems are in place to develop, approve, implement and regularly review policies for the safe delivery of SACT across the organisation. e) Robust education and training programmes are in place for all staff involved (directly or indirectly) in SACT services. To include ancillary staff, porters and support workers. f) An Operational Policy is in place for the specific service and how this is delivered in relation to all other services. Organisational Level a) Corporate/local policies and Clinical Management Guidelines are available to all staff involved in the delivery of SACT and must include: • Safe handling and administration of SACT drugs • Operational policy for SACT services • Operational policy for Acute oncology services • Operational Policy/protocol for Desensitisation (where appliable) • MDT referral process	Regulation 9, 10, 17 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Healthcare Improvement Scotland (2023). *Systemic Anti-Cancer Therapy Delivery (SACT) – Healthcare Improvement Scotland*. [online] Healthcareimprovementscotland.scot. Available at: https://www.healthcareimprovementscotland.scot/publications/systemic-anti-cancer-therapy-delivery-sact/ [Accessed 29 Sep. 2024]. Nationally recognised organisations guidance including: • BCCN: http://www.bccancer.bc.ca/ • NCCN: https://www.nccn.org/ • NCI: https://www.cancer.gov/ • ASCO: https://www.asco.org/ • ASH: https://www.hematology.org/ • ESMO: https://www.esmo.org/ National Quality Board (2017b). *National Quality Board Quality Surveillance Groups National Guidance*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/07/quality-surveillance-groups-guidance-july-2017.pdf.	• The local and/or national Governance committee minutes • National Governance Group meeting minutes showing actions taken. • MAC membership • Job description of the organisation's Lead cancer Roles (for both Nursing and Pharmacy) • Processes for polices development and review are documented. • The polices and guidelines are available and in date. • Education and training programmes for staff involved in SACT services and compliance rates • Local service operational policy • Staff are aware where these polices, and guidelines are, and can access them with ease.

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		• Survivorship initiatives (recovery package) • Management of all potential acute oncological concerns. Nausea and Vomiting • Management of Stomatitis, Mucositis and Diarrhoea • Management of Neutropenic Sepsis • Management of Extravasation or Infiltration • Management of Alopecia • Management of Hypersensitivities and Allergic reactions including Anaphylaxis b) SACT National/local policy guidance is reviewed internally by a lead oncologist, lead cancer nurse and lead cancer pharmacist, if this is not available then external review is recommended. These should be approved by the organisations National Governance committee. c) Internal quality review programme for SACT services in each organisation and actions reviewed through the organisation's National Governance Process.		
5.2 Quality governance and risk management **CQC** **Effective** **Well led**	Adverse incidents are reported as per national organisational policy	a) All clinical incidents are reported as per national organisational policy. To also include incidents specific to SACT patients: • Death within 30 days of SACT • Neutropenic sepsis • Extravasation • Spillage of SACT • Confirmed VTE events b) This should be audited across the organisation and reported at the national and local governance group meetings.	NHS (2023). *NHS England» Learn from Patient Safety Events (LFPSE) Service*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/. NHS England (2024a). *Patient Safety Incident Response Framework and supporting guidance*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/.	• Evidence of national and local review of cancer incidents, investigation and dissemination of learning across the organisation. • Evidence of audit reports in National and local Governance Group meeting minutes.

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.3 Quality governance and risk management **CQC** **Effective** **Well led** **safe**	The service is risk assessed appropriately	a) Organisational Policy and risk assessments are in place regarding • Risk to patients and relatives • Risk to service and organisational infrastructure • COSHH risk assessments specific to SACT to include PPE and use of closed system devices as appropriate. b) These are reviewed as per national organisational policy.	Health and Safety Executive (2013a). *Safe handling of cytotoxic drugs in the workplace - Health and Social Care*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm HSE (2022). *HSE Guideline on the Safe Handling of Cytotoxic Drugs*. [online] Corporate. Available at: https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-guideline-on-the-safe-handling-of-cytotoxic-drugs/ [Accessed 29 Sep. 2024]. NHS England (2024a). *Patient Safety Incident Response Framework and supporting guidance*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/.	• Discussed and evidenced in minutes of organisational individual Hospitals Clinical Governance and Health and Safety meetings. • COSHH risk register and assessments on site. • General risk assessment register and assessments on site. • Review national organisational policy

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.4 Education and training **CQC** **Safe** **Responsive**	SACT specific education and training is accessible to all staff involved in SACT services.	c) Education and training programmes for SACT management are available to staff within the organisation. This should include specific programmes for the following staff groups as a minimum: • SACT nurses • ward nurses (where applicable) • Pharmacy teams • oncology pharmacy staff • porters and home care delivery drivers • house-keeping d) The specific training programme for each staff group should be reviewed internally by a lead oncologist, lead cancer nurse and lead cancer pharmacist, if this is not available then external review at this level is recommended. The final programme should be approved by the National Governance Group meeting. e) An annual competency assessment and /or update training should occur as a minimum. f) There should be a list of each staff group trained as competent in SACT which should be updated when staff are added or removed or at least annually which is ever is sooner. g) There should be evidence that all training is documented.	Regulation 9, 12 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations BOPA (2024). *BOPA Education & Training Standards for Registered Pharmacy Professionals working in Cancer Services Version 5.0 August 2024 - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-cancer-pharmacy-education-and-training-standards/ [Accessed 29 Sep. 2024]. BOPA (2023). *BOPA SACT Verification HUB (including the passport) - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/verificationhub/ [Accessed 29 Sep. 2024]. UKONS (2024). *UKONS digital SACT competency passport* . [online] UKONS Oncology Nursing Society. Available at: https://ukons.org/resources/systemic-anticancer-therapy-mig/ [Accessed 29 Sep. 2024].	• Specific education and training programmes for the following staff groups available to review: • SACT nurses • Ward nurses (where applicable) • Pharmacists • Oncology pharmacists • Porters • Houses-keeping • Evidence of internal or external review • Minutes of National Governance Group meeting where this has been approved. • Evidence of annual competency assessments and /or training for each member of staff. • Evidence of the list of each staff group trained as competent in SACT which has been reviewed in the last year. • Evidence that all training is documented.
5.5 Education and training **CQC**	Minimum expertise levels will be set within all SACT services to ensure that the appropriately skilled	The manager locally within the organisation responsible for SACT services will ensure that: a) A minimum of TWO suitably SACT trained nursing staff are available in all areas within the clinical setting whilst SACT is being administered	Regulation 9, 17 and 18 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at:	• Review of staff rota where SACT administration has occurred. • Confirm processes with staff • Review SACT administration policy. • Review risk assessment

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe **Responsive**	staff are present whilst SACT is being administered	b) For verification of SACT – Level 2 member of Pharmacy staff. c) For dispensing and accuracy checking of SACT there must be a minimum of 2 Level 1 Pharmacy Staff. d) Level 1 and 2 pharmacy staff should have access to Level 3 staff whilst SACT is being managed. e) Within the home setting: Risk assessment and policy is in place to allow single SACT nurse checking and delivery. f) A patient commencing SACT will be started within working hours to enable accessibility to support services i.e., pharmacy, radiology and pathology	https://www.cqc.org.uk/guidance-regulation/providers/regulations BOPA (2024). *BOPA Education & Training Standards for Registered Pharmacy Professionals working in Cancer Services Version 5.0 August 2024 - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-cancer-pharmacy-education-and-training-standards/ [Accessed 29 Sep. 2024]. BOPA (2023). *BOPA SACT Verification HUB (including the passport) - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/verificationhub/ [Accessed 29 Sep. 2024]. The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf	• Review staff rota where a patient has been started on cycle 1. • Review prescriptions for start times for cycle 1 • Review SACT administration policy • Review of training and education records
5.6 Assessment and decision to treat **CQC** **Safe** **Effective**	The decision to treat a patient with SACT should be made by a Consultant	For first line treatment: a) The patient should be discussed at an appropriate Multidisciplinary Team Meeting (MDT). This can include virtual MDT. b) The MDT report should be documented and a copy of the report should be placed in the patient notes. c) The patients latest clinic letter and MDT proforma should be available prior to SACT administration d) All patients should have a treatment plan (see 5.8) for each course of SACT	Regulation 9, 12 and 18 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Patient notes review. • Note audit • Report of audit presented for review. • Review of Treatment Plans

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		e) First cycle of SACT will be prescribed by consultant oncologist or consultant haematologist.		
5.7 Assessment and decision to treat **CQC** **Safe** **Effective**	There is comprehensive patient assessment prior to SACT treatment	a) All patients should be introduced to an appropriate SACT Nurse assigned to their care at diagnosis or when they enter a pathway of care within the organisation. b) Ideally, all patients should be introduced to an appropriate Clinical Nurse Specialist assigned to their care at diagnosis or when they enter a pathway of care within the organisation. c) If the CNS is not available on site the patient will be contacted by the CNS or an appropriately trained individual within a reasonable timeframe. This timeframe will be communicated to the patient. d) There should be active patient involvement regarding the treatment pathway. e) All patients should attend a pre SACT assessment with each new course of SACT commenced with a SACT Nurse and preferably an Oncology Pharmacist or Technician.	Regulation 9 and 18 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations GOV.UK (2019). *Health and Social Care Act 2008*. [online] Legislation.gov.uk. Available at: http://www.legislation.gov.uk/ukpga/2008/14/contents.	• Review processes • Review processes • SACT consent documented and in notes • Review patient notes
5.8 Assessment and decision to treat **CQC** **Safe** **Effective**	Comprehensive treatment plans are developed and implemented for every patient undergoing SACT treatment	a) A treatment plan is recorded for each patient, this should include: - • Diagnosis and staging. • Performance status. • Co-morbidities. • Treatment intent. • Pre-SACT tests required. • Approved protocol name. • Planned number of cycles. • Frequency and method of administration. • Any deviation from protocol • Anticipated follow up arrangements	Regulation 9 and 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf	• Review individual treatment plan in case notes or on electronic prescribing system

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.9 Information, support and consent **CQC** **Safe** **Effective**	All patients receiving SACT within the organisation have access to appropriate information	a) Patient Information to include: • SACT regimen specific administration and toxicity information • Medicines they will be given to prevent or manage toxicity • Signs, symptoms and management of extravasation • 24 hour Emergency contact details • Specialist nurse contact details • Safe handling of patient waste and spillage advice (where relevant for liquid SACT) • Safe handling, storage and disposal of oral SACT if appropriate b) A record of the information provided is documented in the patients notes. c) All information provided to the patient should be provided verbally and in a form that the patient can review throughout their treatment pathway. i.e. written, braille, audio, digital to ensure informed consent.	Regulation 9 and 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf UK SACT Board (2024). *Consent for Systemic Anti- Cancer Therapy (SACT)*. [online] Available at: https://www.cancerresearchuk.org/sites/default/files/guidance_on_consent_for_sact.pdf [Accessed 29 Sep. 2024]. National Patient Safety Agency (NPSA) (2008). *Oral anticancer medicines: risk of incorrect dosing*. [online] GOV.UK. Available at: https://www.gov.uk/drug-safety-update/oral-anticancer-medicines-risk-of-incorrect-dosing.	• Review patient notes and review sample information given to patients • Review patient notes • Review information options available • Review local and corporate guidelines/polices where relevant
5.10 Information, support and consent **CQC** **Safe**	Informed consent is taken at an appropriate time following the provision of information in 5.9	a) Valid written medical informed consent must be obtained before ALL SACT is commenced. b) Consent to SACT should be sought by the appropriate SACT specialist trained to do so. This should be following appropriate information provision within a time frame that allows the patient to assimilate the information.	Regulation 9 and 11 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Review patient notes for copy of consent • Review time frame on consent and patient notes. • review procedures • Consent form has regimen specific information • Review processes with staff.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Effective		c) Individual drug toxicity should be detailed on the consent form and confirmed as discussed with patient. d) In the case of regimen specific information, the regimen should be specified on the consent form. e) The patient should be given a copy of the consent form Consent should be reconfirmed at time of SACT administration by the treating team f) CRUK consent forms should be used and completed in full	UK SACT Board (2024). *Consent for Systemic Anti- Cancer Therapy (SACT)*. [online] Available at: https://www.cancerresearchuk.org/sites/default/files/guidance_on_consent_for_sact.pdf [Accessed 29 Sep. 2024].	• Audit and report of audit presented for review. • Review that CRUK consent forms are being used and fully completed
5.11 Information, support and consent **CQC** **Responsive** **Caring**	Patients undergoing SACT treatment have ready access to relevant information and support throughout their pathway of care	a) Patients must have ready access to a Key worker- which would be appropriately assigned and could be a Clinical Nurse Specialist (CNS) or specialist SACT nurse. b) SACT nurse led holistic assessment must take place prior to SACT administration to inform, support and advise patients. c) All information should be repeated as often as necessary, given in writing and reinforced on each visit. d) Patients should have 24-hour access to professional advice and inform out of hours. e) Processes are in place for referral to specialist services when required, e.g. Physiotherapy, Community nurses, hospice care.	Regulation 9, 12 and 18 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations National Cancer Action Team (2010). *Ensuring Better Treatment Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist National Cancer Action Team Part of the National Cancer Programme*. [online] Available at: https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf.	• Key worker named in patient notes. Review Key worker list. • Review pre-assessment process. Review patients notes. • Review processes with staff • Review processes. • Review processes.
5.12 Prescribing and documentation **CQC**	Only appropriately qualified /competent practitioners will prescribe SACT.	a) Consultant oncologists or haematologists should always make the decision to treat when a new treatment regimen is initiated. b) RMO grade should not be authorised to prescribe SACT.	Regulation 9, 12, 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at:	• Review treatment plan • Review patient prescriptions. • Review patient notes • Review patient notes • Review processes. Unplanned audit • Review sample prescriptions

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe **Effective**		c) All SACT prescribers should have access to all relevant clinical data (including MDT outcomes) to support safe and appropriate prescribing d) A treatment plan is recorded by the responsible SACT consultant (see 5.8) and this is kept in the patients notes. e) A copy of the treatment plan should be sent to the patients GP. f) There will be a single SACT prescription for all medicines including supportive care and hydration g) All SACT prescriptions are readily accessible in the patient's records (notes or online) for audit purposes.	https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2008). *For better, for worse?* [online] Available at: https://www.ncepod.org.uk/2008report3/Downloads/SACT_report.pdf .	• Review patient records for evidence of patient prescriptions
5.13 Prescribing and documentation **CQC** **Safe** **Effective**	All SACT regimens in use in an organisation will have a robust validation process	a) All SACT regimens must be: • Based on robust evidence and national/ international guidance • Approved by an oncology pharmacist • Approved by a cancer site specific consultant oncologist/ haematologist OR for home care: Approved by Clinical Lead for SACT b) This process of SACT regimen approval must be agreed through the National Governance Group meeting and published in a policy. c) SACT prescriptions should be prescribed on an electronic prescribing system designed for this purpose. d) If electronic prescribing is not available pre-printed regimen specific prescriptions should be utilised. e) If pre-printed prescriptions are in use there should be clear policy on how these are controlled and how assurances are made around version control f) Handwritten prescribing must be avoided	UK SACT Board (2022). *Standards for the safer use of electronic Prescribing and Medicines Administration (ePMA) systems for use in Systemic Anti-Cancer Therapy (SACT) Services*. [online] Available at: https://www.uksactboard.org/_files/ugd/638ee8_5613776913e5415f81f31610e4a4a862.pdf [Accessed 29 Sep. 2024]. BOPA (2021). *BOPA Guidance on the contents of a SACT protocol - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-guidance-on-contents-of-sact-protocol/ [Accessed 29 Sep. 2024].	• Review sample SACT protocols • Review SACT protocols approval process. • Review example prescriptions. • Review example prescriptions • Review example prescriptions • Review compliance with BOPA Standards for Reducing Risks Associated with ePMA for SACT. British Oncology Pharmacy Association. • Review mins of National Governance Group meeting.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		g) Where electronic prescribing of SACT is in use within an organisation this should follow the UK SACT Board Standards for the safer use of electronic Prescribing and Medicines Administration (ePMA) systems for use in Systemic Anti-Cancer Therapy (SACT) Services. The electronic prescribing platform and its use should be annually audited, and results reported at the National Governance Group meeting.		
5.14 Prescribing and documentation **CQC** **Safe** **Effective**	Off Label and Off Licence prescribing	a) There should be a policy around off label and off licence drug prescribing within the organisation. b) It should state as a minimum that: • only approved regimens should be used within the organisation • any treatment regimen which deviates from standard ie off label and off licence must be discussed & ratified by the organisational National Governance Process • There should be a process to get urgent approval of an off label or off licence regimen. This should include the MDT decision, verification from an independent consultant oncologist/ haematologist within that tumour site and an oncology pharmacist as a minimum. • All urgent approvals must be discussed post use at the National Governance Group meeting and trends identified. c) Any off-label or off-licence treatment must be documented in patient notes and fully discussed with the patient and consented as off label or off licence use. d) Ideally off label or off licence prescribing should be shared across the whole independent sector to highlight trends in prescribing.	UK SACT Board (2022). *Standards for the safer use of electronic Prescribing and Medicines Administration (ePMA) systems for use in Systemic Anti-Cancer Therapy (SACT) Services*. [online] Available at: https://www.uksactboard.org/_files/ugd/638ee8_5613776913e5415f81f31610e4a4a862.pdf [Accessed 29 Sep. 2024]. General Medical Council (2021). *Prescribing unlicensed medicines*. [online] www.gmc-uk.org. Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines. BOPA (2021). *BOPA Guidance on the contents of a SACT protocol - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-guidance-on-contents-of-sact-protocol/ [Accessed 29 Sep. 2024].	• Review policy around off label and off licence prescribing. • Review Off label and Off licence request forms • Review minutes or discussions at Organisation's National Governance Meeting • Review off label or off licence prescriptions either electronic or prr-prnted prescription and off label and off licence protocols • Review patient notes and consent. • Review any documentation of this occurring.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.15 Prescibing and Documentation	SACT Protocols	a) There should be a protocol in place for all SACT regimens used within an organisation b) This protocol should be readily available to all staff involved with the prescribing, dispensing and administration of SACT c) This protocol should contain the details of the regimen under the following headings: • Name of Protocol • Indication • Therapeutic Intent of the Regimen • Number of Cycles • Length of Cycles • Administration days • Doses of all SACT drugs • Supportive Drugs • Dose Modifications • Pre-assessment and monitoring • Side Effects • Contra-indications and Precautions • Extravasation risk • If it is being used off-label or unlicensed • The evidence used to write the protocol • A disclaimer that the information may not be up to date • Approval Process	BOPA (2021). *BOPA Guidance on the contents of a SACT protocol - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-guidance-on-contents-of-sact-protocol/ [Accessed 29 Sep. 2024].	• Review of Protocol library against prescriptions used • Review of accessibility of protocols to all staff that require them • Review of conents of protocols
5.16 Pharmacy clinical verification of SACT **CQC**	All SACT prescriptions are clinically verified by a pharmacist	a) All SACT prescriptions should be clinically verified by a suitably trained oncology pharmacist or technician, who demonstrates appropriate competence and is locally authorised /accredited for the task. b) This competence should be in line with the BOPA accreditation programme for staff involved in the verification of SACT prescriptions	Regulation 9, 12, 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Check SACT prescriptions for who has clinically verified the prescription. • Review list of pharmacists who are deemed competent to clinically verify SACT scripts. Check it has been updated within the last year. • Ask staff about support network available.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe **Effective**		c) There should be a list of pharmacists/technicians who are deemed competent to clinically verify SACT prescriptions stating what level they are. This should be updated whenever pharmacists or technicians are added or removed or annually whichever is sooner. d) There must be a support network in place within the organisation for pharmacists or technicians clinically verifying prescriptions for SACT to have senior colleague support. e) Clinical verification should adhere to the BOPA standards for Pharmacy Verification of Prescriptions for Cancer Medicines f) Clinical verification should be documented in a clear, unambiguous manner on the patient's prescription. g) When a pharmacist or technician is clinically verifying SACT prescriptions it is recommended that this is done in protected time within a suitable environment which allows the pharmacist to concentrate without interruptions.	BOPA (2024). *BOPA Education & Training Standards for Registered Pharmacy Professionals working in Cancer Services Version 5.0 August 2024 - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-cancer-pharmacy-education-and-training-standards/ [Accessed 29 Sep. 2024]. BOPA (2023b). *BOPA Standards for the Pharmacy Verification of Prescriptions for Cancer Medicines Version 4.2 November 2023*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-standards-for-clinical-pharmacy-verification-of-cancer-medicine-prescriptions/. BOPA (2023a). *BOPA SACT Verification HUB (including the passport) - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/verificationhub/ [Accessed 29 Sep. 2024]. BOPA (2015). *BOPA Clinical Workforce Plan Chemotherapy Service Specification Medicines Optimisation, Safety and Clinical Pharmacy workforce plan*. [online] Available at: https://www.bopa.org.uk/wp-content/uploads/2019/07/BOPA-Medicines-Optimisation-Safety-and-Clinical-Pharmacy-workforce-plan-January-2015-1.pdf [Accessed 29 Sep. 2024].	• Check SACT prescriptions clinical verification. • Ask staff about the environment when completing clinical verification.
5.17 Supply and receipt of SACT within pharmacy	SACT is obtained from reputable sources.	a) All SACT must be ordered via a pharmacy department b) Where outsourcing occurs the organisational procedures for using external pharmaceutical companies must be followed.	Beaney, A. (2016). *Quality Assurance of Aseptic Preparation Services: Standards Part A | Fifth edition*. [online] Royal Pharmaceutical Society. Available at:	• Check processes for ordering SACT • Check contents of SOP

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
CQC **Safe** **Effective**		c) Products may either be fixed dose products to support dose banding or individualised patient specific doses from NHS unit or non NHS commercial organisations that hold a Manufacturers Specials Licence from the MHRA d) Products purchased from an MHRA licensed unit are unlicensed and organisational polices for using unlicensed medicines must be followed. e) There are a small number of licensed standardised chemotherapy doses available f) Where in house preparation occurs (under section 10), this should be compliant with the Quality Assurance of Aseptic Preparation Services: Standards 5th edition as a minimum. This service should be externally reviewed annually ideally by a suitable qualified EL97(52) auditor. g) Receipt of SACT must be done by a suitably trained member of pharmacy staff. h) Receipt of SACT should be done in a suitable area away from normal dispensing areas. i) Storage of SACT should follow 5.27 j) There should be a list of pharmacy staff who are deemed competent to receipt SACT. This should be updated as people are added or removed or annually, whichever is sooner.	https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Quality%20Assurance%20of%20Aseptic%20Preparation%20Services%20%28QAAPS%29/rps---qaaps-standards-document.pdf. NHS Pharmaceutical Quality Assurance Committee (2016). *GUIDANCE ON MANAGING THE SOURCING AND SUPPLY OF READY-TO-ADMINISTER CHEMOTHERAPY DOSES FOR THE NHS A 'How to' Guide Edition 1A*. [online] Available at: https://www.sps.nhs.uk/wp-content/uploads/2016/12/Sourcing-Ready-Made-Chemo-Doses-V1A.pdf [Accessed 29 Sep. 2024].	• If internal aseptic unit, check external report and that is has occurred in the last year. • Ask staff about processes. • Check records for receipt of SACT • See 5.27 • Review list of pharmacists who are deemed competent to receipt SACT. Check it has been updated within the last year.
5.18 Pharmacy dispensing of SACT and supportive medicines **CQC** **Safe**	SACT is supplied from pharmacy safely	a) All SACT prescriptions should be dispensed and accuracy checked by a trained oncology pharmacist, pharmacist, pharmacy technician or assistant who has undergone a minimum of Level 1 training or equivalent, demonstrated their appropriate competence and is locally authorised /accredited for the task. b) There should be a list of pharmacy staff, separated by role, who are deemed competent to dispense and accuracy check SACT prescriptions. This should be	BOPA (2024). *BOPA Education & Training Standards for Registered Pharmacy Professionals working in Cancer Services Version 5.0 August 2024 - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-cancer-pharmacy-education-and-training-standards/ [Accessed 29 Sep. 2024].	• Check SACT prescriptions to assess who has dispensed the prescription. • Review list of pharmacy staff who are deemed competent to dispense SACT. Check it has been updated within the last year. • Review training records for relevant staff.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Effective		updated when a person is added or removed or annually whichever is sooner. c) All supportive medicines for SACT prescriptions should be dispensed by a suitably trained oncology pharmacist, pharmacist, pharmacy technician or assistant who has undergone a minimum of Level 1 training or equivalent, demonstrated their appropriate competence and is locally authorised /accredited for the task.		• Review competency document for relevant staff
5.19 Pharmacy oncology services **CQC** **Safe** **Effective**	Pharmacy services are available and have peer support	a) There should be access to an oncology pharmacy service on all sites that treat patients with SACT. b) Each patient should have a medicines reconciliation carried out before starting a course of SACT c) Each patient should be reviewed by the oncology pharmacist for their pharmaceutical care issues. This should be documented within a structured pharmaceutical care plan / patient record. Ideally this would be face to face. d) There must be a support network in place within the organisation for oncology pharmacists to have senior colleague (level 3) support. e) There must be a support network in place within the Independent Sector for senior oncology pharmacists to have other senior colleague support.	BOPA (2024). *BOPA Education & Training Standards for Registered Pharmacy Professionals working in Cancer Services Version 5.0 August 2024 - BOPA*. [online] BOPA. Available at: https://www.bopa.org.uk/resources/bopa-cancer-pharmacy-education-and-training-standards/ [Accessed 29 Sep. 2024]. BOPA (2015). *BOPA Clinical Workforce Plan Chemotherapy Service Specification Medicines Optimisation, Safety and Clinical Pharmacy workforce plan*. [online] Available at: https://www.bopa.org.uk/wp-content/uploads/2019/07/BOPA-Medicines-Optimisation-Safety-and-Clinical-Pharmacy-workforce-plan-January-2015-1.pdf [Accessed 29 Sep. 2024].	• Review service specification. Ask staff. • Review scheduling of SACT treatments against pharmacy rotas • Review pharmaceutical care plan • Review patient records for pharmaceutical assessments. • Review organisational structure. • Ask relevant staff about support network. • Review mins of Independent Sector Pharmacy Group meetings.

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.20 SACT administration **CQC** **Safe** **Effective**	SACT delivery is in line with health and safety protocols and clinical guidelines.	a) There should be policies and procedures in place for SACT administration. This should include all routes of administration b) SACT is administered in areas which are assessed as safe and appropriate for the treatment being administered. c) Staff who administer SACT are aware of immediate potential side effects, administration related risks and their management d) Resuscitation equipment is available in all areas where SACT is administered. For SACT administered in the patient's home, appropriate community based equipment and medicines will be available e) SACT protocol administration is commenced during normal working hours, wherever possible, when support services and expert advice are available. f) The patient's condition and clinical parameters are assessed using a recognised toxicity grading system immediately prior to administration. g) Partial volume infusions or partial bolus doses MUST NOT BE DELIVERED UNDER ANY CIRCUMSTANCES. All dose reductions should be recalculated and ordered in exact dose volume.	Regulation 9,10, 13 and 22 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf.	• National/local policies and procedures available and in date • Internal audit report. • Confirm processes with staff • Staff competencies available and reviewed in last 12 months. • Review premises • Review staff rota and SACT administration records • Evidence of pre-treatment toxicity scoring in patient notes • Review policy • Confirm processes with staff
5.21 Oral SACT administration	Oral SACT is administered safely	a) Reference to oral SACT MUST be included in all organisational polices/guidelines for SACT. b) Oral SACT MUST follow the same pathway (prescribing/ dispensing/ administration) as IV/SC SACT. c) Patients commencing a programme of care with an oral anti-cancer agent should receive patient education, counselling and follow up on the use of	National Patient Safety Agency (NPSA) (2008). *Oral anticancer medicines: risk of incorrect dosing*. [online] GOV.UK. Available at: https://www.gov.uk/drug-safety-update/oral-anticancer-medicines-risk-of-incorrect-dosing National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2008). *For better, for worse?* [online] Available at:	• Review organisational polices/guidelines for SACT • Review processes for oral SACT are in line with IV/SC processes. • Review patient records for evidence of counselling and education given on oral SACT. This information should be both general and specific to the agent

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		their medicines from an accredited pharmacy professional or nurse	https://www.ncepod.org.uk/2008report3/Downloads/SACT_report.pdf. BOPA (2015). *BOPA Clinical Workforce Plan Chemotherapy Service Specification Medicines Optimisation, Safety and Clinical Pharmacy workforce plan*. [online] Available at: https://www.bopa.org.uk/wp-content/uploads/2019/07/BOPA-Medicines-Optimisation-Safety-and-Clinical-Pharmacy-workforce-plan-January-2015-1.pdf [Accessed 29 Sep. 2024].	• Review how oral SACT is stored, dispensed, transported and administered within the organisation
5.22 SACT administration **CQC** **Safe** **Effective**	Administration of SACT follows National policy and guidance	a) Prior to SACT administration, 2 SACT trained practitioners must independently check the following: HOMECARE: 2nd clinical check is deemed appropriate for single practitioner completion) • Pharmacy clinical verification has taken place • Patient identity in line with local policy • Patient name and number match SACT prescription • Correct date and time of administration • Correct drug name, dose, volume bolus/infusion, diluent, route of administration and administration rate in relation to the prescription • Expiry date and time will not pass before administration is complete • Appearance and physical integrity of SACT • Visual inspection of vascular access site and infusion device rate. • Appropriate pre-medication and/or supportive therapies have been administered.	Regulation 9,10 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf. UK SACT Board (2022). *Standards for the safer use of electronic Prescribing and Medicines Administration (ePMA) systems for use in Systemic Anti-Cancer Therapy (SACT) Services*. [online] Available at: https://www.uksactboard.org/_files/ugd/638ee8_5613776913e5415f81f31610e4a4a862.pdf [Accessed 29 Sep. 2024].	• Review national/local policies and procedures available • Review of patient medical record • Review of SACT prescription and administration record.

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		• Both practitioners will sign the appropriate sections of the administration document.		
5.23 SACT administration **CQC** **Responsive** **Caring**	Treatment record is complete	a) There must be a post treatment summary record on completion of course of treatment. This should include: • Complete record of all treatment cycles of a course given. • Detail of whether this course was completed or not. • If course not completed- reason for cessation (i.e. Toxicity, Sub optimal response, Disease recurrence during adjuvant treatment, Others, or combination of the above) • For non-adjuvant treatment a reference to the response should be included b) A copy of this should be offered to the patient and sent to the GP and other relevant health care professionals c) All patients should have Holistic needs assessment and care planning reviewed as part of Recovery Package for each individual	Regulation 9 and 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations National Cancer Survivorship Initiative (NCSI) (2013). *Living with and beyond cancer*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181054/9333-TSO-2900664-NCSI_Report_FINAL.pdf. NHS England (2018). *NHS England» Living With and Beyond Cancer – Baseline Activity (Jan-Mar 2017)*. [online] England.nhs.uk. Available at: https://www.england.nhs.uk/publication/living-with-and-beyond-cancer-baseline-activity [Accessed 29 Sep. 2024]. Department of Health and Social Care (2011). *The national cancer strategy*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/the-national-cancer-strategy.	• Evidence of post treatment summary record in patients notes • Confirm process with staff • Holistic needs assessment and care planning review available in patients notes. • Review of Recovery Package policy

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
5.24 Extravasation **CQC** **Safe** **Effective**	The risk of SACT extravasation is minimised by following best practice.	a) There should be policies and procedures for the administration of intravenous SACT to include techniques which aim to minimise the risk of extravasation. b) Patients and families are made aware of the potential risk, signs and symptoms of extravasation and actions that they need to take if the symptoms develop c) Risks are fully discussed and documented in the consent process. This must be supported by written information.	Regulation 9, 12 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations The Scottish Government (2012). *CEL 30 (2012): Guidance for the safe delivery if Systemic Anti-Cancer Therapy*. [online] publications.scot.nhs.uk. Available at: https://www.sehd.scot.nhs.uk/mels/cel2012_30.pdf. ESMO (2022). *Supportive and Palliative Care	ESMO*. [online] Esmo.org. Available at: https://www.esmo.org/guidelines/guidelines-by-topic/esmo-clinical-practice-guidelines-supportive-and-palliative-care/chemotherapy-extravasation. Perez Fidalgo, J.A., et al. (2012). Management of chemotherapy extravasation: ESMO-EONS Clinical Practice Guidelines. *Annals of Oncology*, 23(suppl 7), pp.vii167–vii173. doi: https://doi.org/10.1093/annonc/mds294	• Review administration policy • Review training records and annual competency assessment of staff administering SACT • Review information given to patients regarding extravasation • Review consent in patients notes
5.25 Extravasation **CQC** **Safe** **Effective**	The management of suspected or actual extravasation follows current national guidance.	a) There should be an organisational extravasation policy in place to manage suspected or actual extravasation. This should include as a minimum: • Communication processes with GP, consultant, patient and other relevant HCP(i.e. surgeon/CNS) • The requirement to report via the organisation Incident Reporting process	Regulation 9, 12 and 15 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations	• Review organisational extravasation policy for management of extravasation • Review premises for extravasation kit • Review patients notes • Review patients notes • Review mins of National Governance Group

5. Systemic Anti-cancer Therapy (SACT)

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		• the processes in place for the referral to specialist plastic surgical services should this be required • The location and contents of extravasation kits at each site where SACT is administered, must be checked as per local policy • Management of SACT extravasation • Inclusion or exclusion of specific antidotes for specific SACT agents (e.g. Dexrazoxane) including access to this b) All SACT extravasation injuries will be recorded in the patient record (including photography) and updated as necessary c) The patient will be followed up and reviewed at regular intervals and the final outcome of management and degree of injury will be reported and recorded in the patient record. d) All extravasation incidents will be reviewed at the National Governance Group	ESMO (2022). *Supportive and Palliative Care | ESMO*. [online] Esmo.org. Available at: https://www.esmo.org/guidelines/guidelines-by-topic/esmo-clinical-practice-guidelines-supportive-and-palliative-care/chemotherapy-extravasation Perez Fidalgo, J.A., et al. (2012). Management of chemotherapy extravasation: ESMO-EONS Clinical Practice Guidelines. *Annals of Oncology*, 23(suppl 7), pp.vii167–vii173. doi: https://doi.org/10.1093/annonc/mds294	• Review of extravasation incidents in last 12 months
5.26 Occupational exposure to SACT **CQC** **Safe** **Responsive**	All cytotoxic medicine is defined as hazardous therefore managed under Control of Substances Hazardous to Health Regulation. All SACT administered will be handled in line with COSHH definition	The overriding health and safety principle is to minimise exposure and to prevent or minimise environmental contamination. a) There is an operational policy in place regarding safe handling of SACT. b) There are systems and procedures in place to minimise occupational exposure in line with COSHH c) There is regular training for all staff involved in SACT regarding safe handling. d) Personal protective wear and equipment, appropriate to the level of handling of cytotoxic SACT, is available to staff and used where appropriate. e) Cytotoxic SACT is issued from a pharmacy as a "ready-made" patient specific treatment dose. f) Procedures specify cytotoxic SACT is not used if there is evidence of any tampering in any way	Regulation 12 and 15 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations European Parliament (2018) *Preventing occupational exposure to cytotoxic and other hazardous drugs* European Policy Recommendations https://www.europarl.europa.eu/doceo/document/A-8-2018-0382_EN.pdf Health and Safety Executive (2013a). *Safe handling of cytotoxic drugs in the workplace -*	• Review operational policy regarding safe handling of SACT. • Review procedures • Confirm processes with staff • Review training records • Confirm processes with staff • Review premises • Confirm processes with staff • Review procedures • Review procedures • Confirm processes with staff • Confirm processes with staff • Review training records • Review risk assessments • Review operational SACT policy • Review staff records

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		g) Procedures specify the action to be taken if the patient is unable to take the cytotoxic SACT in the form presented. h) Systems are in place for the reporting of incidents involving accidental spillage and potential exposure to cytotoxic SACT. i) All SACT areas have appropriate standard spillage kits prominently displayed and staff are all trained in their use. These should be checked as per local policy j) There is regular training for all staff involved in SACT regarding how to use the spillage kits. k) SACT practitioners who are pregnant or breast feeding MUST discuss this with their manager at first appropriate opportunity and a risk assessment carried out. l) Position on handling of SACT during pregnancy is at the discretion of the employing organisation. This should be detailed in the operational SACT policy. m) Occupational Health must be made aware of any individual handling SACT during pregnancy n) Both the unit and pharmacy environments are designed to reduce occupation exposure (see section 1.2)	*Health and Social Care*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm. International Society of Oncology Pharmacy Practitioners (2022). ISOPP Standards for the Safe Handling of Cytotoxics. *Journal of Oncology Pharmacy Practice*, 28(3_suppl), pp.S1–S126. doi: https://doi.org/10.1177/10781552211070933 .	• See section 1.2
5.27 Occupational exposure to SACT **CQC** **Safe** **Responsive**	Receipt, transfer and storage of all SACT is done safely and complies with national guidance.	a) Systems and procedures are in place for the receipt of SACT into the pharmacy according to safe handling procedures. b) SACT must be stored securely and safely in locations separate from other medicines and clearly marked for the storage of SACT only. c) Systems and procedures are in place to ensure SACT is transported in a safe and secure manner. d) See section 1.2	Regulation 12 and 15 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Health and Safety Executive (2013a). *Safe handling of cytotoxic drugs in the workplace - Health and Social Care*. [online] Hse.gov.uk. Available at:	• Review procedures and SOPs • Confirm processes with staff • Review lists of staff suitably trained and locally approved to receipt SACT in pharmacy. Ensure it has been updated annually • See section 1.2

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			https://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm. Specialist Pharmacy Service (SPS) (2018). *Guidance on Handling of Injectable Cytotoxic Drugs in Clinical Areas in in NHS Hospitals in the UK (Yellow Cover) Edition 1 July 2018*. [online] SPS - Specialist Pharmacy Service. Available at: https://www.sps.nhs.uk/articles/guidance-on-handling-of-injectable-cytotoxic-drugs-in-clinical-areas-in-in-nhs-hospitals-in-the-uk-yellow-cover-edition-1-july-2018/.	
5.28 Occupational exposure to SACT **CQC** **Safe** **Responsive**	Disposal of all SACT will follow National policy and guidance	a) Systems and procedures are in place for the safe disposal of unused doses and all items contaminated with SACT. b) Systems and procedures are in place for safe handling and disposal of patient waste potentially contaminated with SACT. c) All staff disposing of SACT clinical waste must be trained in the recognition and safe management of spillage d) All waste must be stored and uplifted according to specialist arrangements for Cytotoxic drugs through the 'Independent Providers' waste contract	Regulation 9,13 and 16 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Care Quality Commission (2010). *Essential standards of quality and safety*. [online] Available at: https://www.elmmb.nhs.uk/www.elmmb.nhs.uk/_resources/assets/attachment/full/0/essential%20standards%20of%20qu_afety%20march%202010%20CQC.pdf Specialist Pharmacy Service (SPS) (2018). *Guidance on Handling of Injectable Cytotoxic Drugs in Clinical Areas in in NHS Hospitals in the UK (Yellow Cover) Edition 1 July 2018*. [online] SPS - Specialist Pharmacy Service. Available at: https://www.sps.nhs.uk/articles/guidance-on-	• Review systems and procedures. • Review systems and procedures. • Review training records • Confirm processes with staff • Review waste management contract for SACT waste • Review Waste Management Audit • See section 1.2

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			handling-of-injectable-cytotoxic-drugs-in-clinical-areas-in-in-nhs-hospitals-in-the-uk-yellow-cover-edition-1-july-2018/	

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
6.1 **Management and staffing** **CQC** **Safe** **Well led**	The management and staffing arrangements in place support the delivery of high quality radiotherapy services	a) The Organisational Structure- is clearly defined with clear reporting lines b) There is evidence of cross-profession input into patient care c) Staffing levels and skill mix- follow recommended guidelines d) There is evidence of staff development, training and continuous professional development with technology and treatment technique. e) There is evidence of working within a Quality Management System including audit and outcomes f) An error classification system-is in place using a recognised system of coding and reporting	Regulation 18 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. *COUNCIL DIRECTIVE 2013/59/EURATOM*. Available at: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2014:013:0001:0073:EN:PDF. British Institute Of Radiology, Medicine, I., National Patient Safety Agency, Society And College Of Radiographers and College, R. (2008). *Towards safer radiotherapy*. London: British Institute Of Radiology. https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/towards-safer-radiotherapy/ Public Health England (2016). *Development of learning from radiotherapy errors Supplementary guidance series*. [online] Available at: https://assets.publishing.service.gov.uk/gover	• Standard patient-data set include MDT notes, specialist MDT's set up for SABR RT • Incident reporting • Oncology Standards Accreditation • Review Training records • Review Policies

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			nment/uploads/system/uploads/attachment_data/file/579541/DL_guidance_finalNB211216.pdf. IPME (2017). *POLICY STATEMENT: Recommendations for the Provision of a Physics Service to Radiotherapy*. [online] Available at: https://www.ipem.ac.uk/media/k3qf33tp/policy-statement-recommendations-for-a-physics-service-to-radiotherapy-nov-2017.pdf.	
6.2 **Radiotherapy referral** **CQC** **Safe** **Effective**	Consultant -led radiotherapy services are prompt, easily accessible and of the highest standards.	a) There is a clinical lead for the radiotherapy service. b) All clinicians managing radiotherapy patients must be: c) Consultant status and a core member of at least one MDT for that cancer d) Fully registered and licensed with the GMC on the specialist register Hold a substantive NHS position within this field or fulfil Policy requirements i.e. evidence of CPD, activity data, annual appraisal e) Able to provide evidence of training in assessment and communication. Robust cross-cover arrangements must be in place for Consultant Oncologists.	Regulation 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations British Institute Of Radiology, Medicine, I., National Patient Safety Agency, Society And College Of Radiographers and College, R. (2008). *Towards safer radiotherapy*. London: British Institute Of Radiology. https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/towards-safer-radiotherapy/ Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf.	• Radiotherapy policy and consultant PP's • Consultants PP compliance records • Minimum data set requirements

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			Royal College of Radiologists at https://www.rcr.ac.uk/clinical-radiology	
6.3 **CQC** **Responsive** **Effective**	Patients with cancer are not delayed awaiting Consultation	a) A procedure for referral for Radiotherapy is in place b) Patient information and the consent process is clearly defined. Patients receive both written and verbal information regarding their treatment and possible side effects. c) A procedure for managing the appointment and scheduling system is in place & the needs & preferences of the patient are considered. d) There is protocol for patient identification at all stages of the treatment pathway e) Records are kept of CT exposures and additional imaging required throughout the planning and treatment process.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists at https://www.rcr.ac.uk/clinical-radiology Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. Boothey, D. (2014). *DELIVERING CANCER WAITING TIMES A Good Practice Guide*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/delivering-cancer-wait-times.pdf. Royal College of Radiologists (RCR) (2019). *Timely delivery of radical radiotherapy: guidelines for the management of unscheduled treatment interruptions, Fourth edition | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/timely-delivery-of-radical-	• Referral to treatment action plans as part of SOF projects to reduce patient waiting times to <5 days • Operational policy • Radiotherapy operating system patient records • Radiotherapy operating system e.g. Mosaiq or ARIA • Audits of 31 days wait time from first consultation to start of RT • Treatment delay and interruptions audits

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			radiotherapy-guidelines-for-the-management-of-unscheduled-treatment-interruptions-fourth-edition/.	
6.4 Treatment Planning **CQC** **Safe** **Effective**	Comprehensive treatment plans are developed and implemented for every patient undergoing radiotherapy treatment	a) There is access to CT planning and virtual simulation b) There is access to MRI and PET CT image fusion for complex planning such as stereotactic RT c) Procedures for treatment planning and pre-treatment checks are in place d) A Treatment planning computer with capabilities for IMRT/VMAT is available.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. SABR Consortium (2019). *Stereotactic Ablative Body Radiation Therapy (SABR): A Resource Endorsed by The Faculty of Clinical Oncology of The Royal College of Radiologists*. [online] Available at: https://www.sabr.org.uk/wp-content/uploads/2019/04/SABRconsortium-guidelines-2019-v6.1.0.pdf. Royal College of Radiologists (RCR) (2020). *Ionising Radiation (Medical Exposure) Regulations: Implications for clinical practice in radiotherapy Guidance from the Radiotherapy Board Produced in association with Public Health England*. [online] Available at: https://www.rcr.ac.uk/media/smmkkrsa/ionising-radiation-medical-exposure-regulations-	• Access to planning in all facilities, Radcalc tool • Dosimetry dashboard system for national planning. • Citrix based system to enable local and remote planning

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			implications-for-clinical-practice-in-radiotherapy.pdf.	
6.5 **CQC** **Safe** **Effective**	Radiotherapy techniques are based on current evidence/ best practice	a) A list of approved protocols is used for all radiotherapy techniques b) Any treatment protocol which deviates from standard protocol must be discussed & ratified by the Clinical Director. c) There is a process for the Introduction of new procedures/techniques	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. Royal College of Radiologists (RCR) (2020). *Ionising Radiation (Medical Exposure) Regulations: Implications for clinical practice in radiotherapy Guidance from the Radiotherapy Board Produced in association with Public Health England*. [online] Available at: https://www.rcr.ac.uk/media/smmkkrsa/ionising-radiation-medical-exposure-regulations-implications-for-clinical-practice-in-radiotherapy.pdf. SABR Consortium (2019). *Stereotactic Ablative Body Radiation Therapy (SABR): A Resource Endorsed by The Faculty of Clinical Oncology of The Royal College of Radiologists*. [online] Available at: https://www.sabr.org.uk/wp-content/uploads/2019/04/SABRconsortium-guidelines-2019-v6.1.0.pdf.	• Approved protocols used and available • Clinical Advisory Team (CAT) process in place. • Reference groups for new procedures, training programmes • Treatment planning competencies

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			Royal College of Radiologists (RCR) (2023). *Recommendations for using radiotherapy for benign disease in the UK | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/recommendations-for-using-radiotherapy-for-benign-disease-in-the-uk/.	
6.6 **CQC** **Safe** **Effective**	There are defined procedures in place to measure and monitor exposure to radiation	a) Procedures for treatment planning are in place including; b) Relationship between PTV and CTV c) Method of normalisation d) Maximum and minimum expected doses to the PTV or an equivalent DVH e) A DVH for OAR f) All CTV to PTV margins for radical new techniques or changes to current techniques are reviewed against the published data ~~g)~~ There is an implementation programme for the transfer from manual to electronic transfer of data ~~h)~~ The protocols for the construction of a radiotherapy plan have been agreed by Lead consultant oncologist, planning physicist and Lead Radiographers i) The protocols for checking a radiotherapy plan has been agreed by the Clinical Director and Superintendent Therapy Radiographer. j) Established site-specific imaging protocols for IGRT k) Established equipment QA programme	*Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations British Institute Of Radiology, Medicine, I., National Patient Safety Agency, Society And College Of Radiographers and College, R. (2008). *Towards safer radiotherapy.* London: British Institute Of Radiology. https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/towards-safer-radiotherapy/ Health and Safety Executive (2017). *L121 - Work with ionising radiation: Approved Code of Practice and guidance*. [online] Hse.gov.uk. Available at: https://www.hse.gov.uk/pubns/books/l121.htm. SABR Consortium (2019). *Stereotactic Ablative Body Radiation Therapy (SABR): A Resource Endorsed by The Faculty of Clinical Oncology of The Royal College of Radiologists*. [online] Available at: https://www.sabr.org.uk/wp-	• Procedures available and managed within QMS, Mosaiq, ARIA or suitable system • IGRT Audits - CT planning parameters, image verification and QA programme

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			content/uploads/2019/04/SABRconsortium-guidelines-2019-v6.1.0.pdf. Royal College of Radiologists (RCR) (2023). *Recommendations for using radiotherapy for benign disease in the UK | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/recommendations-for-using-radiotherapy-for-benign-disease-in-the-uk/. Royal College of Radiologists (2021). *On target 2: updated guidance for image-guided radiotherapy | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/on-target-2-updated-guidance-for-image-guided-radiotherapy/.	
6.7 **Prescribing of radiotherapy** **CQC** **Safe** **Effective**	The radiotherapy prescription record follows standard protocols	a) The prescription record should contain as a minimum: • Patient ID • Treatment prioritisation category • Diagnosis and treatment site • Dose and fractionation • Patient positioning and aids to positioning • Therapy machine setting for each beam b) Authorisation by a person competent to prescribe the treatment as per the designated IR(ME)R list for each Specialist Care centre.	Regulation 12 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations British Institute Of Radiology, Medicine, I., National Patient Safety Agency, Society And College Of Radiographers and College, R. (2008). *Towards safer radiotherapy.* London: British Institute Of Radiology. https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/towards-safer-radiotherapy/	• Radiotherapy policies and procedures • Referrals • Minimum datasets

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			Royal College of Radiologists (RCR) (2019). *Timely delivery of radical radiotherapy: guidelines for the management of unscheduled treatment interruptions, Fourth edition | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/timely-delivery-of-radical-radiotherapy-guidelines-for-the-management-of-unscheduled-treatment-interruptions-fourth-edition/. Royal College of Radiologists (RCR) (2023). *Recommendations for using radiotherapy for benign disease in the UK | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/recommendations-for-using-radiotherapy-for-benign-disease-in-the-uk/. Royal College of Radiologists (2024). *Radiotherapy dose fractionation, Fourth edition | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/radiotherapy-dose-fractionation-fourth-edition/.	
6.8 **Guidelines** **CQC**	Radiotherapy treatment is delivered in line with published guidelines	c) Minimum equipment available:2 linear accelerators or an agreed SLA arrangement giving access to backup equipment. In the absence of these facilities there should be policies in place to minimise breaks in treatment if any problems occur with the linear accelerator.	Regulation 9, 11, 12 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at:	• Policies and procedures in place • Audit of patient Exposures • Pause and Check Audits • RT Toxicity audits such as skin reactions • Treatment interruptions audit

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe **Responsive** **6.5 Cont.**		d) Procedures for treatment delivery are in place e) Standard treatment protocols are used f) There is a policy for the management of interruptions, gaps in treatment are minimised. g) Procedure and policy for the management of changes to a patients treatment plan/prescription h) Patients while on treatment are reviewed weekly by a review radiographer or the patients' consultant to monitor and manage radiotherapy side effects and toxicities. i) Suitably trained review radiographers can write symptom care plans and dispense medicines from set PGDs. j) Patients are followed up after completion of radiotherapy by phone on a weekly basis k) Patients are invited back to the radiotherapy centres for an assessment of late toxicities 6 weeks post treatment l) Patients have access to dietician, speech and language theorists and clinical psychologist if required m) Policy for out of hours working	https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. Royal College of Radiologists (RCR) (2023). *Recommendations for using radiotherapy for benign disease in the UK | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/recommendations-for-using-radiotherapy-for-benign-disease-in-the-uk/. Royal College of Radiologists (2024). *Radiotherapy dose fractionation, Fourth edition | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/radiotherapy-dose-fractionation-fourth-edition/. Royal College of Radiologists (RCR) (2019). *Timely delivery of radical radiotherapy: guidelines for the management of unscheduled treatment interruptions, Fourth edition | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/timely-delivery-of-radical-	• Malnutrition Screening tool audit

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			radiotherapy-guidelines-for-the-management-of-unscheduled-treatment-interruptions-fourth-edition/.	
6.9 **Verification Procedures** **CQC** **Safe** **Effective**	Procedures are in place to support effective treatment verification	a) There is a multidisciplinary radiotherapy verification group with documented ToR's to coordinate the verification process. b) Procedures for pre-treatment imaging are developed and implemented c) Site specific imaging protocols are available and used d) There is a protocol for on-treatment checks e) There is a protocol for patient specific quality assurance to be carried out on all patients f) There is a comprehensive IGRT training programme to ensure standardised protocols ae implemented for all staff and that each individual is skilled to a consistent level. g) One or more IGRT specialist radiographers and/or physicist to support clinical implementation and application of IGRT	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. Royal College of Radiologists (RCR) (2008). *On target: ensuring geometric accuracy in radiotherapy*. [online] Available at: https://www.ipem.ac.uk/media/mprf2mcw/on-target-ensuring-geometric-accuracy-in-radiotherapy.pdf [Accessed 29 Sep. 2024]. Royal College of Radiologists (2021). *On target 2: updated guidance for image-guided radiotherapy | The Royal College of Radiologists*. [online] www.rcr.ac.uk. Available at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/on-target-2-updated-guidance-for-image-guided-radiotherapy/.	• Minutes and ToR's of Multi discipline RT group • Share point policies & procedures • Radiotherapy Operating policy • IGRT training competencies/records

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
6.10 **IMRT** **CQC** **Safe** **Well led**	IMRT is delivered in line with published guidelines (Note- this is in addition to measures for standard radiotherapy 6.5 and 6.6 which also apply)	a) There is evidence of relevant and appropriate training of all staff b) A procedure is in place for patient plan quality assurance and control. c) The department is part of an external IMRT audit group and be audited.	Regulation 9, 12, 15 and 19 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists at https://www.rcr.ac.uk/clinical-radiology Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf.	• CPD learning, policies & procedures, Reference groups • Quality assurance document for planning • Minutes and audit results
6.11 **Brachytherapy** **CQC** **Safe** **Effective**	Brachytherapy is delivered in line with published guidelines	a) There is a phased implementation programme for brachytherapy b) The minimum annual workload; is 25 per oncologist per annum over a 3 year period c) For intrauterine insertions- a minimum of 10 per year, with a minimum of 6 per clinician d) Site specific treatment protocols are available e) Procedures for treatment planning are in place f) Procedures for treatment delivery are in place g) Protocols for quality assurance of ultrasound and TPS are in place h) Protocols for planning checking procedures are in place i) Protocols for on- treatment checks and changes to the prescription/plan are in place j) Brachytherapy prescription records should contain as a minimum:	Regulation 9, 12,1 5 and 10 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations GOV.UK (2018b). *The Environmental Permitting (England and Wales) (Amendment) (No. 2) Regulations 2018*. [online] Legislation.gov.uk. Available at: https://www.legislation.gov.uk/uksi/2018/428/regulation/4/made [Accessed 29 Sep. 2024]. Royal College of Radiologists (2012). *Quality assurance practice guidelines for transperineal LDR permanent seed brachytherapy of prostate*	• Organisational Brachytherapy policy • Treatment records and audit • Quality assurance equipment audits • biennial Oncologist and MPE peer review audits • Radioactive substance permit for organisation handling the source -ARSAC certificate or written agreement to used source from ARSAC certificate holder. Inventory of all sealed and unsealed sources. Movement logs • Operational policy • Patient records • Specific brachytherapy protocols for treatment • Patient prescription – audit 5 sets

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
		• Patient identification • Diagnosis and treatment site • Imaging technique: for 3D imaging, 3D sectional imaging modality and contouring procedure • Brachytherapy technique • Treatment prescription and treatment planning • Authorisation by a person from the department list of those competent to prescribe the treatment k) Radiation Oncologist should be ARSAC license holders	*cancer*. [online] Available at: https://www.rcr.ac.uk/media/503n04iv/rcr-audit-resources_quality-assurance-practice-guidelines-for-transperineal-ldr-permanent-seed-brachytherapy-of-prostate-cancer.pdf.	
6.12 **Governance** **CQC** **Safe** **Effective** **Well led**	Patients undergoing radiotherapy are assured of the quality of radiotherapy services	a) External audit- the department is part of an auditing network b) A Planned Preventative Maintenance schedule is in place c) A schedule and log of equipment calibration is kept and maintained. d) All calibration and commissioning of equipment is carried out by a qualified medical physics or radiation expert e) Staff working with radiological equipment should be monitored and records kept f) An RPA carries out a review of departmental radiation protection procedures at least every two years. g) There is a recognised replacement programme in place for al equipment. h) All procedures should have an accredited quality management system to monitor that radiotherapy is delivered as intended and in accordance with protocols and continuous quality improvement.	Regulation 9 of Care Quality Commission (2024). *Regulations for service providers and managers - Care Quality Commission*. [online] www.cqc.org.uk. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations Royal College of Radiologists at https://www.rcr.ac.uk/clinical-radiology Royal College of Radiologists (RCR) (2015). *A guide to understanding the implications of the Ionising Radiation (Medical Exposure) Regulations in diagnostic and interventional radiology*. [online] Available at: https://bir.org.uk/media/209703/bfcr152_irmer.pdf. British Institute Of Radiology, Medicine, I., National Patient Safety Agency, Society And College Of Radiographers and College, R. (2008). *Towards safer radiotherapy*. London: British Institute Of Radiology.	• Evidence of external audit results • Log of equipment calibration • Staff monitoring records • RPA radiation protection audit • Review of equipment replacement programme • Evidence of accreditation/certification

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Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			https://www.rcr.ac.uk/our-services/all-our-publications/clinical-oncology-publications/towards-safer-radiotherapy/ Royal College of Radiologists (RCR) (2020). *Ionising Radiation (Medical Exposure) Regulations: Implications for clinical practice in radiotherapy Guidance from the Radiotherapy Board Produced in association with Public Health England*. [online] Available at: https://www.rcr.ac.uk/media/smmkkrsa/ionising-radiation-medical-exposure-regulations-implications-for-clinical-practice-in-radiotherapy.pdf. Care Quality Commission (2016). *Ionising Radiation (Medical Exposure) Regulations Guidance for employers and duty-holders*. [online] Available at: https://www.cqc.org.uk/sites/default/files/20200826_saue_guidance_updated_aug20.pdf.	

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
7.1 **Quality Assurance and governance around End of Life Care is in place nationally and locally** **CQC** **Responsive** **Well led** **Effective**	End of Life Care (EOL) care policies are based on national guidance that are evidence based	a) National organisational policy for EOL care should be accessible within the organisation. b) Local SOP's will be in place regarding EOL care facilities at each site, including care of the deceased. c) There must be local arrangements for transferring of patient care to hospices or palliative care facilities. d) All incidents regarding deaths should be reported through the organisational reporting system. e) All on site unexpected death of cancer patients should be reported on the organisations reporting system and reported to CQC. f) All death within 30 days of SACT and 60 days of radiotherapy should be reported on the organisations reporting system and to the CQC g) Deaths as above should be appropriately investigated internally and learning shared as per National Learning from Deaths Framework and organisational policy. h) All escalated deaths should be recorded and reviewed at organisational level and learning disseminated appropriately to ward level. This should involve clinicians directing care i) Evidence of compliance to regulations regarding medical certificates of course of death (MCCD)	Department of Health (2008). *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. General Medical Council (2022). *Treatment and care towards the end of life: good practice in decision making*. [online] www.gmc-uk.org. Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/treatment-and-care-towards-the-end-of-life. Leadership Alliance for the Care of Dying People (2014). *One Chance to Get It Right Improving people's Experience of Care in the Last Few Days and Hours of Life*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf. NHS England (2014). *Actions for End of Life Care: 2014-16*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf. NICE (2019). *Overview | End of Life Care for adults: Service Delivery | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng142.	• EOL National Organisational Policy • Local Hospital Service SOP • SLA for external service provision • Organisational Learning from Deaths Policy • EOL Care Planning/ • CQC ratings from review of EOL care • Duty Of Candour Policy • Serious Incident Reporting Framework • Organisational Complaints Framework. • Evidence of sharing learning from events related to EOL care at hospital and national level.

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
			NHS England (2021). *NHS England» Ambitions for Palliative and End of Life Care: a National Framework for Local Action 2021-2026*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/ambitions-for-palliative-and-end-of-life-care-a-national-framework-for-local-action-2021-2026/. National Cancer Peer Review Programme Manual for Cancer Services: Chemotherapy Measures Intelligence National Cancer Action Team Part of the National Cancer Programme Version 1.0 (2008) Download link: Manual for Cancer Standards NHS England (2023). *NHS England» The national medical examiner system*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/.	
7.2 **Systems for Assessment of EOL stage** **CQC** **Responsive** **Caring**	Systems should be in place to identify adults who are likely to be approaching the end of their life.	a) Procedures for identifying adults who are approaching end of are in place including; • Gold Standards Framework (Primary Care) • Supportive and Palliative Care Indicators Tool [SPICT]). b) Advanced care planning should be discussed with all patients identified as being in the last year of life. c) Holistic needs assessment should be conducted by relevant practitioners who have the skills and training to do this. d) Patients and Relatives must be active participants in the EOL care planning process.	Department of Health (2008). *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. NICE (2019). *Overview | End of Life Care for adults: Service Delivery | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng142.	• Ratified end of life care planning documents in use. • Auditable evidence of carer needs assessment for patients identified to be at end of life. • Auditable evidence of advanced care planning to identify where they want to be cared for and die.

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
7.3 **Planning and recording EOL care delivery including symptom control** **CQC** **Responsive** **Well led** **Effective**	There should be an MDT care plan recording an individual's preferences in relation to EOL care and evidence of frequent symptom management review	a) Personalised Care Plans should be in place for ALL patients entering EOL including symptom management. b) Guidance for individual who lacks capacity at EOL should be available in policy format. c) The ReSPECT tool should be considered for all patients where clinical care in the future may be required as emergency where they are unable to make or express choices. This should be in line with the DNACPR process. d) Documented regular review of medication and symptom control in the patient notes. e) Documented regular review of DNACPR status in patients notes. f) Documented evidence whether an Advance Care Plan (ACP) AND/OR Advanced decision to refuse treatment? is in place g) Procedures and documented evidence for identifying carers needs at the end of life. h) Evidence of joint care planning . i) Evidence that the patient has consented to the family or people important to the adult approaching EOL, knowing of deteriorating condition. j) Evidence of documentation relating to the provision to the family or people important to the adult approaching EOL during and after the death of the patient. k) This should be led by a specilaist palliative care physician with practicing priviliges or an SLA with a local provider.	Department of Health (2008). *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. NHS England (2019). *Palliative care pain & symptom control guidelines for adults*. [online] Available at: https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2020/01/Palliative-Care-Pain-and-Symptom-Control-Guidelines.pdf. NICE (2019). *Overview | End of Life Care for adults: Service Delivery | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng142. Resuscitation Council UK (2024). *ReSPECT*. [online] Resus.org.uk. Available at: https://www.resus.org.uk/respect. NHS (2013). *Advance Decisions to Refuse Treatment a Guide for Health and Social Care Professionals*. [online] Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf.	• Audit patients care records for Evidence of: • DNACPR • ReSPECT • EOL Care plan e.g. when or if to stop interventions, anticipatory prescribing and hydration assessment. • Symptom management care plans • Referral to specialist palliative care • Advanced decision to refuse treatment? • Documentation of family or people important to the adult approaching EOL involvement • EOL MDT case conference records • Consent to family receiving information

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
7.4 **Implementation and evaluation EOL care delivery** **CQC** **Responsive** **Well led** **Effective**	Evidence in the care plan demonstrating SMART measurable objectives relating to EOL care planning	a) Audit of all EOL care must be evident in order to evidence good care provided and identify poor areas of care b) Results from audit and learning should be evident in ward meeting minutes and methods of dissemination of information to progress learning Learning from exemplary and ineffective care should be shared	Department of Health (2008). *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. Neuberger, J. (2013). *INDEPENDENT REVIEW OF THE LIVERPOOL CARE PATHWAY MORE CARE, LESS PATHWAY A REVIEW OF THE LIVERPOOL CARE PATHWAY*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf. NHS England (2021). *NHS England» Ambitions for Palliative and End of Life Care: a National Framework for Local Action 2021-2026*. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/publication/ambitions-for-palliative-and-end-of-life-care-a-national-framework-for-local-action-2021-2026/.	• EOL care audit based on these standards. • Dissemination of learning from audit • Actions from learning established • Exemplary practice learning organisation wide
7.5 **Education and Training** **CQC** **Well Led**	To ensure care is delivered in line with national standards for EOL care. To ensure that all individuals delivering this care are trained and competent to deliver this.	a) Practitioners in contact with patients at EOL have access to training and competency assessment b) All teams involved in the EOL care of patients should be trained in breaking bad news and advanced communication skills dependent on the level of involvement. c) Teams directly involved in care should have a portfolio of ongoing learning and development in relation to caring for the dying.	Department of Health (2008). *End of Life Care Strategy: promoting high quality care for adults at the end of their life*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life. Leadership Alliance for the Care of Dying People (2014a). *One chance to get it right*.	• Evidence of learning and competency in EOL caring in their end of year review and CPD portfolio e.g. E-learning for end of life (e-elca) modules. • Evidence of team objective set related to EOL care and development of service.

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Effective		d) Competencies must be in place for the use of any equipment used to care for patients in EOL care	[online] Available at: https://assets.publishing.service.gov.uk/media/5a7e301ced915d74e33f09ee/One_chance_to_get_it_right.pdf. Royal College of Nursing (2015). *Getting it right every time*. [online] *Royal College of Nursing*. Available at: http://www.rcnendoflife.org/. Log in required. Royal College of Nursing (2015). *End of Life Care | Subject Guide | Library | Royal College of Nursing*. [online] The Royal College of Nursing. Available at: https://www.rcn.org.uk/library/subject-guides/end-of-life-care. Leadership Alliance for the Care of Dying People (2014a). *One chance to get it right*. [online] Available at: https://assets.publishing.service.gov.uk/media/5a7e301ced915d74e33f09ee/One_chance_to_get_it_right.pdf.	
7.6 **Care of the Deceased Patient** **CQC**	The deceased individual should be treated with dignity and respect following death. All expressed wished prior to death should be considered.	Ensure documentation indicates; a) Those patients on an EOL care plans were encouraged to discuss wishes for care after death. b) That the family are involved in this discussion (with patient consent) c) That discussions are sensitively and appropriately documented d) That last offices are conducted and documented per policy taking into consideration the patient's wishes and religious considerations.	National Quality Board (2017a). *National Guidance on Learning from Deaths National Guidance on Learning from Deaths Contents*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf.	• Patient care records

7. End of Life Care (EOL) and Care of the Deceased and Family

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Responsive **Caring**		e) That family or people important to the adult approaching EOL are involved in last offices if the wish to be f) That all reporting and legal documentation is completed appropriately		
7.7 **7.7 Care of the Bereaved Family / People important to the adult approaching EOL** **CQC** **Responsive** **Caring**	Bereaved families and carers should be treated as equal partners following a bereavement Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support	Documented evidence of a) Families be listened to regarding the decision on a patient's b) Plain, understandable language to engage families. c) information provision on how to apply for access to medical and other record should they wish to. d) Hospitals should have a clear policy for engaging with bereaved families and carers. This should include a commitment to welcoming their questions or sharing concerns about the quality of care their loved one received.	National Quality Board (2017a). *National Guidance on Learning from Deaths National Guidance on Learning from Deaths Contents*. [online] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf. NICE (2019). *Overview | End of Life Care for adults: Service Delivery | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng142.	• Information Leaflet for relatives • Patient care records • Local audit • Evidence documented in end of life care plan

8. Cancer Clinical Nurse Specialists

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
8.1 - Access to Cancer CNS's **CQC** **Safe** **Effective** **Responsive** **Caring** **Well Led**	All patients diagnosed with and or treated for cancer must have access to an appropriate qualified cancer CNS during their cancer pathway.	a) There is CNS provision for all patients having surgical intervention for cancer at the point of diagnosis and throughout the cancer journey. b) There is CNS provision for all patients receiving SACT at the point of discussion to treat and throughout the cancer journey	Macmillan Cancer Support (2024). *Macmillan Quality Environment Mark*. [online] Macmillan.org.uk. Available at: https://www.macmillan.org.uk/about-us/health-professionals/programmes-and-services/mqem [Accessed 29 Sep. 2024]. National Cancer Action Team (2010). *Ensuring Better Treatment Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist National Cancer Action Team Part of the National Cancer Programme*. [online] Available at: https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf.	• Staffing rota's • Audit of tumour groups treated within the facility
8.2 **CQC** **Safe** **Effective** **Responsive** **Caring** **Well Led**	All Cancer Clinical Nurse specialists be appropriately qualified and have expertise in their speciality area Leadership within the MDT Advanced Communication and Advocacy skills In depth knowledge of a tumour area	a) CNS's working with cancer patients have a post graduate qualification in cancer care. b) CNS's have the knowledge and technical ability to work in this specialist area of nursing. c) Can co-ordinate and oversee services, and where required personalise for each individuals' complex needs.	National Cancer Action Team (2011). *Ensuring Better Treatment Quality in Nursing*. [online] Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf. National Cancer Action Team (2010). *Ensuring Better Treatment Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist National Cancer Action Team Part of the National Cancer Programme*. [online] Available at: https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf.	• Qualification certificates and competencies • CV with adequate expertise in the specialist area

8. Cancer Clinical Nurse Specialists

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
8.3 **CQC** **Safe** **Effective** **Responsive** **Caring** **Well Led**	Cancer Clinical Nurse specialists must be effective in supporting patients though their cancer treatment Pathway, connecting with all relevant members of the wider MDT Must act as a key worker signposting to support and onward referral where required across the whole pathway.	a) Acting as the patient's key worker across the whole cancer pathway b) An in-depth knowledge of the tumour area(s) in which they work c) Ability to assess a patient's holistic needs d) Supports cancer service development, identifying innovative ways to improve patient care e) Acts as a leader within their local MDT f) Advanced communication skills g) Excellent decision-making abilities	National Cancer Action Team (2011). *Ensuring Better Treatment Quality in Nursing*. [online] Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf.	• Patient and staff feedback • Evidence in case notes • Feedback mechanisms from patients and the MDT
8.4 **CQC** **Safe** **Effective** **Responsive** **Caring** **Well Led**	Patients receiving cancer treatment must have access to holistic needs assessment and care planning CNS must have working understanding of eHNA and Enhanced Recovery Pathway for patients.	a) CNS routinely assessing patients' needs by use of HNA and then effectively implementing a plan to support the patients' needs b) Excellent links with organisations and individuals to signpost patients c) Keep appropriate records to support care and onward referral	Macmillan Cancer Support (2022). *Holistic Needs Assessment (HNA)*. [online] www.macmillan.org.uk. Available at: https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/holistic-needs-assessment. National Cancer Action Team (n.d.). *Holistic Needs Assessment for people with cancer A practical guide for healthcare professionals National Cancer Action Team Part of the National Cancer Programme Living with and beyond cancer*. [online] Available at: https://www.rcplondon.ac.uk/file/3041/download.	• Evidence of the use of the concern's checklist • Evidence of care planning in the patient's case notes • Evidence of links with internal and external organisations that support patients' needs
8.5	Must facilitate patient consenting to treatment through the provision of	a) CNS's ensure that patients have appropriate information to make informed consent around treatment options b) Acting as the patients advocate	National Cancer Action Team (2011). *Ensuring Better Treatment Quality in Nursing*. [online] Available at: https://www.england.nhs.uk/improvement-	• Consent audit • Review of case notes • Patient feedback

8. Cancer Clinical Nurse Specialists

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
CQC **Safe** **Effective** **Responsive** **Caring** **Well Led**	expert advice and guidance around choices Must act as the patients advocate Must ensure junior staff understand the consenting process	c) Reinforcing information giving and taking time to ensure that patients understand the risks and benefits to treatment d) Ensure patients are allowed time to ask questions and make decisions e) Ensure that patients are involved with the planning of their care.	hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf. Department of Health (2009a). *Reference guide to consent for examination or treatment (second edition)*. [online] GOV.UK. Available at: https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition.	• Team understanding of the consenting process
8.6 **CQC** **Safe** **Effective** **Responsive** **Caring** **Well Led**	The CNS must take a role in educating others within the Cancer MDT including the wider non Cancer professionals within sites. CNS must always demonstrate Clinical Leadership	a) Providing specialist education and support for. • The patient • The family and carers • The wider hospital team	National Cancer Action Team (2011). *Ensuring Better Treatment Quality in Nursing*. [online] Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf. National Cancer Action Team (2010). *Ensuring Better Treatment Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist National Cancer Action Team Part of the National Cancer Programme*. [online] Available at: https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf.	• Staff CPD records • Education programme • Conference posters and presentations • Involvement in National Specialist groups like UKONS
8.7 **CQC**	Patients should have access to local support facilities and groups if this is their preference	a) CNS must ensure that all patients have access to an appropriate support group. b) Facilitating support group(s) within the organisation	National Cancer Action Team (2011). *Ensuring Better Treatment Quality in Nursing*. [online] Available at: https://www.england.nhs.uk/improvement-hub/wp-	• Patient and family feedback mechanisms • display or folder of support groups locally, annotation in care record the charity the patient was sign posted to or websites

8. Cancer Clinical Nurse Specialists

Number	Guideline	Details	External Supporting Information	Internal Supporting Information
Safe **Effective** **Responsive** **Caring** **Well Led**	CNS should sign post to these Examples : • Maggie's • Macmillan • Brain Tumour UK • The Prostate Cancer Charity • Breast Cancer Care • Breakthrough Breast Cancer	c) Identifying what is in the local area and signposting or becoming affiliated	content/uploads/sites/44/2017/11/Clinical-Nurse-Specialists-in-Cancer-Care_Census-of-the-Nurse-Workforce_Eng-2011.pdf. Cancer Care Map (2020). *Emotional Support - Cancer Care Map*. [online] Cancer Care Map. Available at: https://www.cancercaremap.org/support-service/emotional-support/?gclid=EAIaIQobChMIn4CJ2Z7C_QIVg9LtCh1BeAbQEAAYAiAAEgIa_vD_BwE [Accessed 29 Sep. 2024].	• CNS use of resources to support locating local services in their working practices e.g., use of the cancer map

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Document Control

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Change History

Draft	Date	Lead Author/Editor	Summary of Change