Acute Oncology Consultant Roles and Responsibilities

Name of responsible group	Acute Oncology Pathway Board
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Provider Lead	All GM, EC & MC providers managing acute oncology patients
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1.1	Jan 2021	Update from YS, JM & KW
1.2	Jan 2021	Revisions from KK, CM, LL – MRI & Tameside
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Reviewers:

Name	Title/Responsibility	Date	Version
Acute Oncology Pathway Board	GM, EC & MC AO Board		1.6

Approvals: This document will have final approval by the following groups/organisations

Title/Responsibility	New Date	Version
GM & EC Acute Oncology Pathway Board		
GM Cancer Commissioning Managers		
GM Trust Directors of Operations		

1. Purpose

The purpose of this paper is;

- To outline the roles and responsibilities of Medical and Clinical Oncologist's when delivering Acute Oncology (AO) across the Network.
- To ensure that systems are in place to meet national requirements and regional recommendations on AO.
- To embed a culture of accountable leadership and personal accountability.
- This does not reflect all the additional work streams relating to CUP/MUO.

2. Context

Greater Manchester (GM), Eastern Cheshire (EC) and Mid Cheshire (MC) consultants provide an AO Consultant outreach service across the GM, EC & MC footprint, supporting 10 local Acute Trusts with an Emergency Department (ED). Over time, the development of nursing AO expertise and the turnover of medical and clinical oncologists, the roles and responsibilities of the acute oncologist within local Trusts have become more varied. This has resulted in disparity and inequity of service across the our network within the provision of AO Programmed Activities (PAs) that are currently provided.

To ensure consistency of approach in how each Trust delivers the acute oncology agenda there requires strong leadership from AO consultant's so that local and national quality standard measures are met, thus enhancing the AOS and continually driving service improvement and evidence based best practice.

3. Proposed Roles and Responsivities

The following section displays proposed roles and responsibilities for the organisation and each oncologist, whether it's a Clinical Lead (CL) role or a Direct Clinical Care role (DCC). The CL and DCC roles are in line with the Quality Surveillance Programme (QSP) 2017 and 2018 Measures. Such proposed roles and responsibilities would help to establish effective and clearly-defined AOS across the region and bring about benefits for patients and staff.

3.1 Organisation

- Those delivering AO should be recognised as a sub- specialist area.
- Oncologists with a special interest in AO should have dedicated time to lead on service development included in their job plans, including training for Oncology trainees.
- Consultants with a special interest in AO should be offered training to support service leadership. It would then be expected that AO Consultants show evidence of CPD in AO Service Development and Leadership during their appraisal.
- All Consultant Oncologists have an obligation to support delivery of AOS (even if they do not deliver it themselves).
- Each DGH should have a named 5 day rota whereby local AO teams have access to AO advice and support outside of the established PA's. This includes access to on call Consultant and Parental Team Consultant for advice.

- AO Clinical Leads should have continued access and the ability to feed into these, if necessary, organisational structures that can influence and oversee change across all primary, secondary and tertiary organisations linked to unscheduled cancer care.
- To be fully effective, accountable and innovative AO Leaders need to be supported to participate with national-level collaboration with education, research and data collection.

3.2 Acute Oncology Clinical Lead

AO leaders are optimally placed to provide service level feedback to local, regional and national cancer leads.

***Quality Surveillance measure 1**:*
There should be a single AO Group (AOG) for the hospital with a single named AO lead with responsibility for AOS's. The AOG membership should include: - an oncologist who is a member of the acute oncology clinical team (AOCT); - a haemato-oncologist, if the hospital has a haematology service, treating malignant disease; - a specialist oncology nurse who is a member of the AOCT - a named lead healthcare professional for MSCC (who is usually, but not necessarily, medical) - a clinical oncologist, if not included in the above - an ED consultant; if the hospital has an ED department - a physician who is on the acute medical take rota; - a person agreed as representing management of AOS's; - a representative of a specialist palliative care team - a representative of primary care.

There should be specified and timetabled time in the work plan(s) job description(s) of named secretarial/administrative staff, for support for the work of the AOS's for the hospital. Terms of reference: - each member (or one of them from each profession, as relevant), from the professions listed above, should be their profession's and/or directorate's lead for AO, for the hospital; - the AOG should have the delegated responsibility from the hospital's management to; act as the co-ordinating body for matters relating to AO between the hospital's clinical directorates and departments and between the hospital and other hospitals in the cancer alliance; ensure the implementation of the national guidance and quality indicators for AO for the hospital AOG meetings: - AOG meetings: The team should meet regularly, at least every six months and record attendance.

***Quality Surveillance measure 3**:*
There should be rotas for AO which include - a 24/7 consultant on call service for telephone advice to health professionals - a 7 day nurse rota during which, the nurse should be available for consultations with and/or ward visits to patients presenting with AO problems, admitted during the previous 24 hrs.

Nurses participating in the AO assessment rota should be assessed as competent by the AO lead and supported by 7 day access to a consultant oncologist.

Proposal for 1 & 3: Each Acute Trust (with an ED) should have a named Lead Oncologist for AO providing **1 SPA per week** (minimum) to support the lead role.

Clinical Lead Responsibilities:

- Named lead should also be on the AO 5 day oncology rota for AO advice.
- The AO Lead is responsible for ensuring access to face 2 face reviews and/or video consultations, at the request of the AO nursing team. Whenever possible this should be within 48 hours request.
- Ensure appropriate members attend a weekly AO meeting/Multi-Disciplinary Team (MDT) with local AO teams members.
- Awareness of the Trust Clinical Lead Cancer of Unknown Primary (CUP)/Malignancy of Unknown Origin (MUO).
- Chair of the AO SG within the local Trust (at least 2 x a year).
- AO Oncology leads must engage with local Operational managers and governance as a means of driving investment in improvement of AOS.
- Attendance and visibility at local Trust key operational management meetings, such as Directorate/Divisional /Business Unit meetings to ensure effective coordination of AOS.
- Act as the key link between AO SRG and local Trust's Operational/Performance committee's to ensure that the AO/CUP strategy is progressed.
- Link in with key operational managers to ensure that the relevant Directorate/Division/Business Unit contributions to achieving high quality AO/CUP services are clear and achievable.
- AO leaders, on behalf of their non-AO Oncology colleagues, are responsible for the outward face of acute clinical cancer care and should provide regular routine feedback at departmental level and to site-specific MDTs.
- Ensure that the MDT works to the most recently published national and network guidelines and protocols in AO/CUP and makes any necessary changes accordingly.
- Ensure sustained AO/CUP education & training support to local AO team(s).
- Continued delivery of AO in all contexts is dependent upon the training and clinical exposure of future AO clinicians and will require that trainees be exposed to AO at both Cancer Centre and Cancer Unit/District General Hospital (DGH) level.
- AO Leaders should cooperate with local Oncology Clinical Leads in ensuring that enough relevant training is delivered and assessed by expert AO clinicians.
- Annually monitor progress regarding compliance against cancer measures, participating fully in the Quality Surveillance process and ensuring any remedial action plans following peer review are implemented.
- Monitor Trust-wide performance and service level contribution against the national standards for AO/CUP and cancer performance targets.
- Provide assurance to local and Trust's Executive Team that standards of care are being consistently maintained and ensure an ongoing awareness and understanding of the Trust's overarching responsibilities for delivery of cancer services.
- Report any deviations from, and risks to, achieving AO/CUP service standards, ensuring that the risk is appropriately communicated and recorded within the Trust and that there are mitigating actions in place.
- Take action against areas of non-compliance, escalating risks in relation to non-compliance to Operational/ Performance meetings and Executive level as necessary

- Work collaboratively to support the development of business cases related to AO/CUP with local operational teams, including provision for cancer ambulatory care.
- Attendance at AO Pathway Board (Quarterly).
- To lead on (or nominate) local MSCC services.

3.3 Leadership support

The role of Clinical Lead requires robust management support to ensure that leadership is effective. Such support includes;

Role/Resource	Responsibilities
DGH Cancer Manager Support	• Ensuring an effective communication process for the onward distribution of outputs from meetings to others within the local Trust • Ensuring that the necessary actions are disseminated for implementation • Delivering key messages to their business operations • Working with the Clinical Lead to ensure that QSP measures are met, and any areas of risk/issues are escalated appropriately within the correct Trust governance structure • Joint partnership working with the CL to monitor the AOS and opportunities for service improvement (internal peer review process).
Designated administrative and data support	• Sending out SG agenda's/notes and papers • Recording and dissemination of SG minutes • Booking of meeting rooms/venues for SG • Recording attendance/apologies • Maintaining active membership/distribution lists (with input from SG members) • Input and maintain AO data in AOT database • Assist in the smooth running of the service, and provide administrative support to the AOT.
AO nursing resource	• Ensuring continuity of AO services • Liaising with all wards and departments within local Trust regarding AO patients • Undertaking regular audits and service reviews • Showing visible presence in all Trust areas • AO education and training within the Trust • Maintaining prospective data collection and real time performance management.
Leadership development	• Peer review/support/personal development • Leadership and Service Improvement programmes supported as part of the Leadership pathway.

3.4 AO Direct Clinical Care Role

Quality Surveillance Measure 2:
There should be an Acute Oncology Team (AOT) with the following membership: Consultant Oncologist, Consultant Haemato-oncologist, Consultant in Palliative Medicine, Acute Oncology Nurses, and an identified individual (Clinical Oncologist or Therapy Radiographer) who is available for advice on radiotherapy and is able to coordinate urgent assessment for palliative radiotherapy treatment. There should be cover arrangements in place for all of the above.

Proposal: There should be a minimum **5 PAs AO Direct Clinical Care (DCC)** per Acute Trust (for cross cover) – this can be delivered by multiple named Oncologists.

DCC requires a flexible approach ensuring that each local AOT has access to AO medical advice 5 days a week from a named AO consultant (s). The medical AO cover should be clearly documented on a rota and be accessible within local Trusts. The AOS should have access to urgent radiotherapy pathways.

Responsibilities:

- Named member on the AO 5 day oncology rota for AO advice (Advice will principally cover MUO cases and urgent AO clinical enquires that cannot be managed by site specific teams).
- Formal daily Board Round of AO patients, to ensure standard of care in AO is met.
- The AO team are expected to support the AO nursing team with case discussion to facilitate education and learning, in addition to patient management.
- Available for face to face/remote inpatient review for AO/MUO/CUP patients when requested by AO nursing team.
- Attend 50% of AO Steering Group meetings.
- Provide clinical cross cover for AO advice.

3.5 Measure of effectiveness

To ensure that job planning is based on proven activity, the following measures should be documented outputs and visible to local Trusts:

- Chair/attendance at AO SG in local Trust (at least 2 x a year).
- Attendance at AO Pathway Board (Quarterly).
- Contribution to Quality Surveillance Programme (QSP) and evidence of participation in internal Trust review.
- Attendance at Operational Trust meetings/attendance/engagement (at least 2 x a year).
- Evidence of AO teaching/education (competency sign off).
- Involvement and development of clinical Trust operational AO policies within local AO teams.
- AO activity (Yearly AO referrals, with categorisation of CL or DCC role to support with job planning and appraisals).

4. Next Steps

- Take this proposal to the AO Clinical Leads and AO Pathway Board for comment.
- Agree and formalise this proposal through the correct governance channels, ensuring that each consultant with AO in their job plan is fully informed and accountable to this role descriptor.
- Agree the number of PAs that each consultant must provide per each acute Trust.
- Agree a process that ensures that AO is categorised as a sub speciality with reported annual activity, to ensure clinical continuity and consistency, as well as parity of workload.
- Develop a process that ensures that each AO consultant has their AO annual activity and documented role output measures within their annual appraisal and job planning process (clearly identifying Clinical lead role and DCC role).

5. Peer Comparisons

The following sets of criteria are the formal roles and responsibilities that each AO consultant is accountable and responsible for when delivering an outreach AO service on behalf of their host organisation.

Network AOS Consultant responsibilities

1. Ensure systems are in place and operational at Network hospitals to notify the AOS administrator of AO patients admitted to and discharged from the Network hospitals.
2. Responsible for implementing the MSCC pathway (in accordance with MSCC SOP) for patients with suspected MSCC. The AOS consultant is responsible for overseeing that the patient is managed via the MSCC pathway until treatment is initiated or until there is a decision for best supportive care. In the case of uncertainly as to the best management plan for the patient, AOS consultants should aid decision making by discussing the case directly with the relevant site specific oncologist and clinical oncology consultant or neurosurgeon.
3. Tracking IP with a new diagnosis of cancer until they are on a clinically appropriate pathway.
4. Supporting CUP services in line with NICE guidance.
5. A member of the AOS team must review patients with cancer who are admitted to hospital. AOS consultants do not need to see every patient, but should see patients as requested by the AOS nursing team or where there is other clinical concern.
6. Develop relationships with ambulatory services to develop options for rapid access and ambulatory care for patients with cancer
7. Refer into AOS services for ambulatory cancer care where geographically and clinically appropriate
8. Can request a transfer if the patient cannot be managed locally. The patients must be reviewed by an AOS consultant ***and*** discussed and agreed by the disease specific oncologist prior to a request to transfer.
9. Support training and education of the AOS team and support local teaching programmes for doctors especially with regard to MSCC, ICI toxicity and NS.

10. Ensure systems are in place to capture AOS data and report into a quarterly AOS Network meeting
11. Provide a co-ordinating and advisory role between admitting teams and oncology services in order to facilitate optimal clinical management of patients with AO presentations (II &III).

Network AO Clinical Lead responsibilities for the AOS:

1. To ensure that the objectives of the Acute Oncology Service are met
2. To ensure that multi-professional teams within the AOS work effectively together
3. To ensure care is given according to recognised guidelines, protocols and policies
4. To ensure clinical governance and audit are supported
5. To ensure that the AOS meets the peer review quality measures
6. To ensure the attendance levels of core members of the AOS are maintained
7. To prove link to the regional Acute Oncology Service Board
8. To lead on or nominate a lead for service improvement
9. To organise and chair regular meetings reviewing the functioning of the AOS, operational policies, and the training needs of the team
10. To ensure that service activities are audited and results documented
11. To ensure key policies (i.e. oncology assessment within 24 hours of referral, metastatic spinal cord compression pathway, and one hour antibiotic pathway for neutropenic sepsis) are implemented
12. To allow 1 SPA in the job plan dedicated to leading the AOS