NHS England

*Northern England Strategic Clinical Network*

# Network Chemotherapy Group

# Constitution
# 2014

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| Author: | Mr S Williamson, Chair of Network Chemotherapy Group | | | | |
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| Contact Details: | Mr S Williamson | | | | |
| Telephone: | 0113825 2976 | | | | |
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**The Constitution has been agreed by:**

| | |
|---|---|
| **Position:** | Chair of Network Chemotherapy Group |
| **Name:** | Mr S Williamson |
| **Organisation:** | Northumbria Healthcare NHS FT |
| **Date Agreed:** | 04.07.14 |

| | |
|---|---|
| **Position:** | Medical Director |
| **Name:** | Dr M Prentice |
| **Organisation:** | Cumbria, Northumberland, Tyne and Wear Area Team |
| **Date Agreed** | 13.08.14 |

| | |
|---|---|
| **Position:** | Clinical chemotherapy Services Multi –Professional Team representative<br>14-1E-107s Policy for Preventing Regular Deviation from the Network Agreed Treatment Algorithms |
| **Name:** | **Organisation:** |
| Mrs M Robertson | City Hospitals Sunderland NHS FT |
| Mr C Polwart | Co Durham & Darlington NHS FT |
| Mr D Sproates | Gateshead Health NHS FT |
| Mr A Hughes | Newcastle upon Tyne Hospitals NHS FT |
| Ms K Lockhart | North Cumbria University Hospitals NHS Trust |
| Mr B Wetherill | North Tees & Hartlepool NHS FT |
| Mr S Williamson | Northumbria Healthcare NHS FT |
| Dr A Humphreys | South Tees Hospitals NHS FT |
| Ms R Tindle | South Tyneside NHS FT |
| **Date Agreed** | 13.08.14 |

| | |
|---|---|
| **Position:** | Heads of Chemotherapy Services<br>14-1E-108s 24 Hour Telephone Advice Service for Patients |
| **Name:** | **Organisation:** |
| Mrs M Robertson | City Hospitals Sunderland NHS FT |
| Ms J McClelland | Co Durham & Darlington NHS FT |
| Dr G Summerfield | Gateshead Health NHS FT |
| Mr A Hughes | Newcastle upon Tyne Hospitals NHS FT |
| Mr S Williamson | North Cumbria University Hospitals NHS Trust |
| Mr B Wetherill | North Tees & Hartlepool NHS FT |
| Mr S Williamson | Northumbria Healthcare NHS FT |
| Dr A Humphreys | South Tees Hospitals NHS FT |
| Mr M Walton | South Tyneside NHS FT |
| **Date Agreed** | 13.08.14 |

| | |
|---|---|
| Network Chemotherapy Group members agreed the Constitution on: | |
| **Date Agreed:** | 13.08.2014 |
| **Review Date:** | May 2015 |

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## INTRODUCTION

**Cross Reference**

The Network Chemotherapy Group (NCG) is a multi-professional group made of health professionals from organisations across the North of England Cancer Network covering a population of 3.06 million. This document outlines the Network Chemotherapy Group Constitution and Terms of Reference and will be reviewed on an annual basis.

## STRUCTURE AND FUNCTION

### 14-1E-101s Chemotherapy Network Configuration

The Chemotherapy and oncology pharmacy services in the network are detailed in appendix 1 and 2.

The NCG and its associated services comply with the relevant ground rules for networking. Please see appendix 3.

### 14-1E-102s Network Group Membership

The NCG includes the following representatives:

- representative from each multi-professional team in the network – see Appendix 3
- representative from the network oncology pharmacy group (NOPG) - Mr C Polwart
- a representative from the network chemotherapy nurses group (NCNG) – Mrs M Robertson
- named member responsible for users' issues and information for patients – Ms A Featherstone
- named secretarial/administrative support – Helen Douglas

See Appendix 3 for NCG Terms of Reference.

### 14-1E-103s Network Group Meetings

**Annual Report**

The NCG meets regularly and record attendance.

See Annual Report for attendance list.

| Date | Time | Location |
|---|---|---|
| 13.02.13 | 1.30 pm | Evolve Business Centre |
| 22.05.13 | 1.30 pm | Evolve Business Centre |
| 18.09.13 | 1.30 pm | Evolve Business Centre |

**14-1E-104s Work Programme and Annual Report**

**Annual Report**
**Work Programme**

The NSSG will produce an annual report and work programme in discussion with the strategic clinical network (SCN) and agreed with the medical director of the relevant NHS England area team.

**14-1E-105s Network Leadership**

Mrs M Robertson is the network lead chemotherapy nurse and the chair of the NCNG.

The designated network lead pharmacist is Mr C Polwart

See Appendix 4 and 8 for list of responsibilities, role and the time specified.

**14-1E-106s Criteria for Acting as an Assessor of Competence**

The NCG has agreed the ongoing criteria necessary for a staff member (other than those considered initially capable as assessors) to be considered capable of assessing the competency of other staff to practice in the chemotherapy services of the network.

The criteria specifies:

- the professional staff group or groups the assessor is a member of
- the particular competencies for which they are deemed capable as an assessor
- that they are currently authorised as competent for those competencies
- any additional criteria which the network agrees are necessary
- the network has agreed the criteria which determine when:
  a) competency and
  b) the authorisation of capability as an assessor should be reviewed.

See Appendix 5 for Criteria for Acting as an Assessor of Competence.

## CO-ORDINATION OF CARE / PATIENT PATHWAYS

### 14-1E-107s Policy for Preventing Regular Deviation from the Network Agreed Treatment Algorithms

The NCG has agreed a written policy with the multi-professional teams for preventing regular deviation from the treatment algorithms agreed with the NSSGs.

The policy states:

- the exceptional circumstances under which such a deviation could occur
- the procedure which is then required to authorise it.

See Appendix 6 for Policy for Preventing Regular Deviation from the NSSG Agreed Treatment Algorithms.

## PATIENT EXPERIENCE

### 14-1E-108s 24 Hour Telephone Advice Service for Patients

The NCG, in consultation with the CCSs heads of service, has agreed the minimum specification of the 24-hour service which stipulates that:

- it is available 24-hours a day, seven days a week, for telephone advice to patients having chemotherapy, on the side effects and complications and how to obtain help and treatment for them
- it covers the whole network
- it may be divided into more than one local service each covering one or more localities, or one or more CCSs, each local service with its own set of contact numbers. This set of local arrangements, ie configuration of the network-wide service should be agreed as part of the minimum specification
- each local service should be staffed at any one time by at least one member of staff making up a 24-hour duty rota
- the level of training or professional qualifications necessary for these staff, should be agreed by the network chemotherapy group as part of the minimum specification.

See Appendix 9 for 24 Hour Chemotherapy Telephone Advice Service: Minimum Service Specification
See appendix 7.

## CLINICAL OUTCOMES / INDICATORS

**14-1E-109s Review of Deviations from Network Treatment Algorithms** **Annual Report**

The NCG has reviewed the records from the Network's clinical chemotherapy services (CCSs), of the deviations from the NSSG agreed treatment algorithms.

**14-1E-110s Network Chemotherapy Error Report** **Annual Report**

The NCG reviews the reported errors and the resulting actions of the CCSs annually.

## Appendix 1 - Chemotherapy Heads of Service

| PCT Referral Pathways | Hospital Trust | Hospital Sites | Chemotherapy (Insert √ where applicable and include locations) | | | Chemotherapy Lead | Chemotherapy Profile |
|---|---|---|---|---|---|---|---|
| | | | **Day** | **Ward** | **Community** | | |
| Redcar & Cleveland (137,400)<br>Middlesbrough (142,400)<br>North Yorkshire and York (133,165) | South Tees Hospitals NHS FT | James Cook University Hospital (JCUH) | Chemotherapy DU<br>Haema-tology DU<br>Urology Oncology outpatients | 14 (Oncology)<br><br>18 (Haematology) | | Dr Alison Humphreys | All solid tumours |
| | | Friarage Hospital | Mowbray Suite Oncology/Haematology outpatients | | | | Breast, Lung, LGI, Gynae, Urology |
| Stockton on Tees (192,400)<br>Hartlepool (91,300) | North Tees & Hartlepool NHS FT | University Hospital of North Tees | Chemo Day Unit (both sites), Haematology Day unit NT<br>Urology NT | 38 NT<br><br>Urology dept NT | | Mr Bill Wetherill, Aseptic Services Manager<br>Trust Chemotherapy Lead | Breast, LGI, Lung, Urology, Pancreatic, Haematology |
| | | University Hospital of Hartlepool | | | | | Breast, LGI, Lung, Urology, Pancreatic, Haematology |
| Newcastle (292,200) | Newcastle Upon Tyne Hospitals NHS FT | AOS at both Freeman and RVI Chemotherapy at Freeman and RVI | Ward 36 Freeman(Adult)<br><br>Ward 14 RVI (Paediatrics) | Ward 33,34, 35 Freeman(Adult)<br><br>Ward 4 RVI (Paediatrics) | | Dr Andy Hughes | All solid tumours Haematology |
| North Tyneside (198,500)<br>Northumberland (312,000) | Northumbria Healthcare NHS FT | North Tyneside General Hospital | √ on all sites | | | Mr Steve Williamson | Breast, Lung, LGI, UGI, Gynae, Urology |
| | | Wansbeck General Hospital | | | | | Breast, Lung, Lower GI, Upper GI |
| | | Hexham General Hospital | | | | | Breast, Lung, UGI, LGI, Gynae, Urology, Sarcoma |
| | | Berwick Infirmary | | | | | Breast, Lung, Upper GI, Lower GI |

| PCT Referral Pathways | Hospital Trust | Hospital Sites | Chemotherapy (Insert √ where applicable and include locations) | | | Chemotherapy Lead | Chemotherapy Profile |
|---|---|---|---|---|---|---|---|
| | | | Day | Ward | Community | | |
| Gateshead (191,700) | Gateshead Health NHS FT | Queen Elizabeth Hospital | √ on site at QE Hospital | | | Dr Scott Marshall | Breast, Colorectal, Gynae Oncology, Lung, Upper GI, Haematology |
| Sunderland (283,500) *Easington (55,700) | City Hospitals Sunderland NHS FT | Sunderland Royal | √ | √ B28 | √ Home Washington PCC | Mrs Melanie Robertson | All tumour groups with the exception of Skin |
| South Tyneside (153,700) | South Tyneside NHS FT | South Tyneside District Hospital | √ OHDU | | | Mrs June Pattison | Breast, LGI, Lung, Urology, Gynae, UGI |
| Co Durham, North (237,854) *Easington split inc in Sunderland pathway | County Durham and Darlington NHS FT | University Hospital of North Durham | √ | Joan James Chemotherapy Day Unit | | Ms Jayne McClelland | Breast, Lung, LGI, Prostate, Pancreatic |
| | | Shotley Bridge Hospital | √ | Woodlands | | | Breast, Lung, LGI |
| Co Durham, South (217,246) Darlington (100,800) | | Darlington Memorial Hospital | √ | Wd 42 | | | Breast, Lung, LGI, Bladder, Prostate, UGI |
| | | Bishop Auckland Hospital | √ | Mara Unit | | | Breast, Lung, Lower GI, Bladder, Prostate, UGI |
| Cumbria (321,854) | North Cumbria University Hospital NHS Trust | Cumberland Infirmary Carlisle (CIC) West Cumberland Hospital (WCH) | √ CIC – Clinical Oncology Haematology Bay (Larch D) | √ CIC – Larch D | √ NOT AN ACUTE TRUST SERVICE Children's Community Nurses across North Cumbria (Patients seen at the PTC in Newcastle) | Dr J Nicoll (from 1.7.13 Mr.S . Williamson) | All solid tumours and haematology level 1. Adult only. |
| | | West Cumberland Hospital (WCH) | WCH – Henderson Suite | | | | Non Intrathecal Chemotherapy Trust |

## Appendix 2 - Lead Pharmacists

| PCT Referral Pathways | Hospital Trust | Hospital Sites | Oncology Pharmacy (Insert √ where applicable) |
|---|---|---|---|
| Redcar & Cleveland (137,500)<br>Middlesbrough (140,500)<br>North Yorkshire and York (132,200) | South Tees Hospitals NHS FT Trust | JCUH<br>Friarage Hospital | Adrienne Stark |
| Stockton on Tees (191,100)<br>Hartlepool (90,900) | North Tees & Hartlepool NHS FT | University Hospital of North Tees & University Hospital of Hartlepool | Mr Bill Wetherill |
| Newcastle (284,300) | Newcastle Upon Tyne Hospitals Foundation NHS Trust | Freeman Hospital and Royal Victoria Infirmary | Mrs Denise Blake |
| North Tyneside (197,200) | Northumbria Healthcare NHS FT | North Tyneside<br>Hexham<br>Wansbeck General Hospital | Mr Steve Williamson |
| Northumberland (311,100) | | | |
| Gateshead (190,800) | Gateshead Health NHS FT | Queen Elizabeth Hospital | Mr David Sproates |
| Sunderland (281,700)<br>*Easington (55,700) | City Hospitals Sunderland NHS FT | Sunderland Royal | Mrs Karen Shield |
| South Tyneside (152,400) | South Tyneside NHS FT | South Tyneside District Hospital | Dr Ruth Tindle |
| Co Durham, North (235,300) *Easington split inc in Sunderland pathway | County Durham and Darlington NHS FT | University Hospital of North Durham | Mr Calum Polwart |
| Co Durham, South (215,400)<br>Darlington (100,400) | | Darlington Memorial Hospital | Mr Calum Polwart |
| Cumbria (322,200) | North Cumbria University Hospital NHS Trust | CIC, WCH | Diane Donnelly |

## Network Chemotherapy Group (NCG)
## Terms of Reference

### Purpose

The purpose of the Network Chemotherapy Group is to ensure best practice in the use of cancer chemotherapy and systemic therapies in the NECN.

### Terms of Reference

The Network Chemotherapy Group:

1. Act as an expert body within the Cancer Network and for NHS England Area Team for advice and information relating to chemotherapy and other systemic therapies for cancer. (Note NHS England has responsibility for National Cancer Drug Fund and baseline commissioning of cancer medicines)

2. Accept all NICE and NHS England recommended drugs.

3. Ensure protocols for the use of therapies considered by the NHS England are made available following their approval.
4. Clinically approve and give recommendations for good practice on supportive therapies for chemotherapy that would be funded via tariff and are hence not suitable for commissioning by NHS England. It is recognised that implementation of these therapies will be undertaken at Trust level without additional funding.

5. Establish and maintain links with Network Site Specific Groups (NSSGs) ensuring chemotherapy and related drug issues are integrated into clinical and referral guidelines for all tumours.

6. Provide co-ordination and consistency across the network with the implementation of Chemotherapy Quality Measures contained in Department of Health (DoH) Manual for Cancer Services: Chemotherapy Measures and NICE guidance on applicable chemotherapy agents, through communications with locality chemotherapy groups.

7. Develop a clinical and corporate governance framework for chemotherapy providing a direct link for reporting clinical and corporate governance issues to statutory bodies in the strategic clinical network.

8. Agree a work programme, which takes account of national and network priorities in the delivery and organisation of chemotherapy services.

9. Agree written guidelines and protocols for chemotherapy, as detailed in the DoH Chemotherapy Measures

10. Share best practice in implementation of standards for intrathecal (IT) chemotherapy

11. Ensure NICE and NHS England prescribing guidance for cancer drugs is followed uniformly across the Network and implemented in a timely fashion.

12. Develop network guidelines for chemotherapy service models ensuring new approaches to chemotherapy delivery (e.g. home chemotherapy) are safe, evidence based, patient-centred and equitable

13. Integrate service improvement and modernisation initiatives into the chemotherapy group work-plan ensuring the following are considered in local chemotherapy delivery:
    - The involvement of front line staff in planning processes to support chemotherapy services
    - Liaison with Commissioners in NHS England to ensure best value for money
    - The use of capacity and demand (scheduling) strategies in chemotherapy services including CPORT implementation
    - Mapping to assess risk at different points in the pathway
    - Provision of patient information

14. Monitor the ability of Trust Chemotherapy Services to prepare, deliver and administer therapies approved by the committee and develop a chemotherapy workforce strategy for the future provision of chemotherapy services.

15. Maintain the Network formulary/ list of approved regimens in line with those regimens funded by NHS England.

16. Ensure audit and research activities are undertaken in relation to prescribing of Chemotherapy and associated therapies.

17. Monitor compliance with the NECN policy for preventing regular use of non-approved chemotherapy regimens (treatment algorithms) and receive exception reports.

18. Review Trust Chemotherapy Service reports on errors and action plans for errors that occur in the chemotherapy Services

19. Agree the workplan and terms of reference of the Network Chemotherapy Nurses Group and the Network Oncology Pharmacy Group

20. Encourage the use of new medicines in National Cancer Research Network clinical trials and ensure suitable exit programmes for patients no longer involved in trials.

Operational Procedures of Network Chemotherapy Group (NCG)

**Membership**

NECN Lead Pharmacist -Calum Polwart
NECN Lead Cancer Nurse – Melanie Robertson
Patient and Carer Partnership Panel Representatives – Clare Singleton
Chair of the Network Chemotherapy Nurses Forum = Melanie Robertson
Oncology Pharmacy Group Chair = Calum Polwart
A lead nurse of a clinical chemotherapy service
Representative from each acute Trust Local Chemotherapy Group

- Durham & Darlington = Calum Polwart
- Gateshead = David Sproates
- Newcastle = Andy Hughes, Gail Jones, Ashraf Azzabi, Jane Beveridge, Lynzie Middleton
- North Cumbria = Kate Lockhart
- North Tees = Bill Wetherill
- Northumbria = Steve Williamson & Jill Starkey
- South Tees = Alison Humphreys & Wendy Anderson
- South Tyneside = Ruth Tindle
- Sunderland = Melanie Robertson

Solid Tumour Oncologist(s) - Alison Humphreys
Haematological Oncologist(s)/ Haematologist- Gail Jones
University/academic oncology representation -
Paediatric Oncology/Pharmacy - Lynzie Middleton

**Members' responsibilities**

Each member may nominate a deputy who will attend in their absence.
Each member will be responsible for ensuring he/she reflects the views of their NSSG/ locality group at meetings.

All members of the group and those asked to comment on work produced by the group will be asked to declare any conflicts of interest. Any action to be taken on the basis of these declarations will be at the discretion of the chair.

**Organisation of Group**

Group to meet every three to four months
Records will be kept of the proceedings, decisions and advice of the group. These will be circulated as minutes by the secretary of the group

Preparation of agendas and papers for the Group and day to day work generated by group to be undertaken by Chair and Vice Chair
Circulation of papers/agendas by NECN secretariat

**Authority and Accountability**

Reports to Clinical Network Cancer Board
Represented on and works with Network Acute Oncology Group

## Document Control

| | | | |
|---|---|---|---|
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| | 2 (June 11) | Updated to add in point 17 re errors : updated terminology and membership | |
| | 3 (May 13) | Added in responsibilities inherited from NECDAG changed commissioning references | |

## Operational Procedures of Network Chemotherapy Group (NCG)

### Membership

NECN Lead Pharmacist(s) – Steve Williamson/Calum Polwart
Network Quality & Patient Safety Director – Sarah Rushbrooke
Patient and Carer Partnership Panel Representatives – Clare Singleton
Chair of the Network Chemotherapy Nurses Forum - Melanie Robertson
Oncology Pharmacy Group Chair - Calum Polwart

A lead nurse of a clinical chemotherapy service:

| Clinical Chemotherapy Services Site | Trust Lead Chemotherapy Nurse | Nominated nurse to attend the Network Chemotherapy Nurse meeting |
|---|---|---|
| Newcastle | Jane Beveridge | Zoe Collins/Jane Beveridge |
| Northumbria | Allison Nielsen | Alison Nielson/Gill Starkey |
| Gateshead | Michelle Hughes | Michelle Hughes/Deborah Hubbert |
| South Tyneside | June Pattison | June Pattison |
| Sunderland | Jill Bell | Melanie Robertson |
| Co Durham & Darlington | Jayne McClelland | Maureen Flatman/Sandra Gaskill |
| North Tees | Val Storey | Val Storey |
| South Tees | Wendy Anderson | Wendy Anderson |
| North Cumbria | Not Confirmed | Helen Roe |

Representative from each acute Trust Local Chemotherapy Group:

- Newcastle - Gail Jones, Jane Beveridge Andy Hughes, Ashraf Azzabi, Denise Blake
- Northumbria - Steve Williamson & Gill Starkey
- Gateshead - David Sproates
- South Tyneside - Karen Humphreys / Ruth Tindle

- Sunderland - Melanie Robertson
- Co Durham & Darlington - Calum Polwart
- North Tees - Bill Wetherill
- South Tees - Alison Humphreys & Wendy Anderson
- North Cumbria - Jonathon Nicoll & Helen Roe

Solid tumour Oncologist(s) – Alison Humphreys
Haematological Oncologist(s) –
University/academic oncology representation -
Paediatric Oncology/Pharmacy - Denise Blake
Pharmacy Lead - Specialised Services, CNTW Area Team - Will Horsley
Cancer Drug Fund Manager (North) - NHS England - Mandy Nagra

**Members' responsibilities**
Each member may nominate a deputy who will attend in their absence.
Each member will be responsible for ensuring he/she reflects the views of their NSSG/ locality group at meetings.

All members of the group and those asked to comment on work produced by the group will be asked to declare any conflicts of interest. Any action to be taken on the basis of these declarations will be at the discretion of the chair.

**Organisation of Group**
Group to meet every three to four months
Records will be kept of the proceedings, decisions and advice of the group. These will be circulated as minutes by the secretary of the group

Preparation of agendas and papers for the Group and day to day work generated by group to be undertaken by Chair and Vice Chair
Circulation of papers/agendas by NECN secretariat

**Authority and Accountability**
Represented on and works with Network Acute Oncology Group

## Ground Rules for Networking

### Introduction

These ground rules preserve the principles underpinning clinical networking. The principles may be summarised as follows:
• they prevent destructive competition between MDTs for their catchment populations
• they prevent destructive competition between NSSGs for their associated MDTs
• they allow the development of consistent, intra- and inter-team patient pathways which are clinically rational and in only the patients' best interests instead of in the vested interests of professional groups or of NHS statutory institutions.

Before a first peer review assessment of any services which, from the networking point of view, come under the governance of a strategic clinical network (SCN), there should be an agreement between the relevant SCNs which describes which provider and commissioner networks come

under the governance of each particular SCN. The agreement should delineate the boundaries and list the constituent services and commissioners of those networks. On principle, a single SCN should be agreed as being responsible for the network. This specifies the governance framework within which the networks are placed. Ideally this would apply to all services in a geographical area. However, the arrangements in terms of the governance and ownership of staff and facilities may not be coterminous across different disease sites spread over a similar geographical area. The network function will therefore be reviewed at a disease site specific level. The term 'network' in these measures refers to the disease site clinical network unless otherwise specified. The geographical extent of this and the physical facilities and hospital sites involved should be agreed between the relevant SCNs prior to review, and a named SCN should be considered having ownership and requiring/commissioning the review. This principle becomes especially important for cases of clinical networks for the rarer cancers where catchment areas may overlap those of more than one SCN.

**NSSGs**

- the NSSG should be the only such NSSG for the MDTs which are associated with it
- for cancer sites where there is only one level of MDT, the NSSG should be associated with more than one MDT
- for cancer sites where there is a division into more than one level of MDT, i.e. into local and specialist/supranetwork MDTs, the NSSG need only be associated with one specialist/supranetwork MDT as long as it is associated with more than one MDT for the cancer site overall.

*Notes: The NSSG need only be associated with one specialist/supranetwork type MDT but may be associated with more than one.*

**Cross Cutting Groups**

These currently include network groups for:

- chemotherapy
- radiotherapy
- acute oncology.

These groups need to have working relationships with the hospitals/services system and also the NSSGs /MDTs system, if they are to fulfil their role of acting as leaders of the networking process. Because these groups are service specific, not cancer site specific, it seems most important to lay down ground rules to ensure clarity and co-ordination across a given cross cutting service within a network, and leave ground rules regarding the relationship with NSSGs/MDTs, at a more informal and flexible level. The term 'network' here refers to the networking arrangements and coverage of the service in question.

These services are required to have local multi-professional management teams. These are not equivalent to the site specific groups and are treated differently in the measures. The ground rules for MDTs do not apply to them.

- The network group for a given service should be the only such group for that service for all the hospitals/services it is associated with.
- The equivalent reciprocal ground rules to this for hospitals and services would be; any given hospital should be associated with only one network group for any given service, and any service should be associated with only one network service group.

*Note: Hospitals and services are mentioned separately because, for the purposes of peer review and data gathering, it has been necessary to clearly define individual services and*

*delineate their boundaries in terms of staff and facilities. Sometimes a declared 'service' may cross more than one hospital.*

**MDTs**

For MDTs dealing with cancer sites for which the IOG and measures recommend only one level of MDT (i.e.no division into local and specialist or their equivalent. e.g. Breast MDTs):

- The MDT should be the only such MDT for its cancer site, for its catchment area.

*Notes: The principle of a given primary care practice agreeing that patients will be referred to a given MDT is not intended to restrict patient or GP choice. A rational network of MDTs, rather than a state of destructive competition can only be developed if i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations and /or workload are counted, for planning purposes. It is accepted that individual patients will, on occasion, be referred to different teams, depending on specific circumstances.*

- This ground rule does not apply to the carcinoma of unknown primary (CUP) MDT or the specialist palliative care (SPC) MDT. This is because, for this ground rule to be implementable, it is necessary to define a relevant disease entity in terms of objective diagnostic criteria which governs referral at primary care level. This is not possible for CUP or SPC, by the nature of these practices.
- The MDT should be the only such MDT for its cancer site on or covering a given hospital site.

*Note: This is because for patient safety and service efficiency, there should be no rival individuals or units working to potentially different protocols on the same site. This does not prevent a given MDT working across more than one hospital site. Neither does it prevent trusts which have more than one hospital site, having more than one MDT of the same kind, in the trust. This ground rule does not apply to SPC MDTs, since there may be more than one distinctive setting for the practice of SPC on a single given hospital site.*

- The MDT should be associated with a single named network site specific group (NSSG) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.

*Note: MDTs which are IOG compliant but deal with a group of related cancer sites, rather than a single site, may be associated with more than one NSSG, but should have only one per cancer site. e.g. A brain and CNS tumours MDT also dealing with one or more of the specialist sites such as skull base, spine and pituitary could be associated with a separate NSSG for each of its specialty sites.*

For cancer sites for which there is a division into local, specialist and in some cases, supranetwork MDTs, the following apply to the specialist/supranetwork MDTs. The above ground rules still apply to the 'local' type MDTs

- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site, for its specialist/supranetwork referral catchment area
- The specialist/supranetwork MDT should be the only such specialist/supranetwork MDT for its cancer site on or covering a given hospital site
- The specialist MDT should act as the 'local' type MDT for its own secondary catchment population. If a supranetwork MDT deals with potentially the whole patient pathway for its cancer site, this ground rule applies to the supranetwork MDT. If it deals with just a particular procedure or set of procedures, not potentially the whole patient pathway, it does not apply.

*Note: This is in order that the specialist/supranetwork MDT is exposed to the full range of clinical practice for its cancer site. The specialist MDT should be associated with a single named network site specific group (NSSG), (or possibly one per individual cancer site, as above) for the purposes of coordination of clinical guidelines and pathways, comparative audits and coordination of clinical trials.*

**Review Date: June 2015**

**Appendix 4 - Network Lead Pharmacist, List of Responsibilities, Role and Time Specified**

## NECN Lead Pharmacist Roles and Responsibilities

### Aims of Document

To clarify the roles and objectives for Network Pharmacists in NECN for purposes of Peer Review post 1st April 2013 NHS changes.

### Introduction

Following the Changes to NHS new system, the Cancer Networks can no longer employ's pharmacist sessions. The network pharmacists are now Area Team Cancer Pharmacists, employed by NHS England to support commissioning of cancer medicines. This means there are functions previously provided longer able to be supported.

### Time for Responsibilities

The ongoing support to the network is provided by the two Area Team Cancer Pharmacists, both of whom provide 2 sessions (0.2wte) to the Area Team. Time needed to complete Network Lead Pharmacists tasks is negotiated with the Area Team.

However as part of NHS England the Network Pharmacist can provide a board strategic over view and leadership to Network be the Network source of pharmaceutical advice.

For the purposes of Peer Review Calum Polwart is the Network Lead Pharmacist.

### Responsibilities

- Provision of expert pharmaceutical advice on cancer medicines use
- To support Network clinical staff in developing and maintaining relevant protocols and guidelines.
- To work with relevant pharmacy staff, nurse leads and relevant medical staff to provide a link to NHS England Cancer Drug Fund Team.
- To support the audit of cancer medicines use in NECN.
- Attendance at NSSGs to be undertaken on portfolio basis with support from each other depending on levels of activity
- Ad Hoc advisory – e.g. when expert opinion is needed, e.g. press enquirie.

### Office Sessions

Both posts have a commitment to spend time every week in Area Team Office and will be available to Network Team in person on those days.

- Calum Polwart (CP) Thursday
- Steve Williamson(SW) Fridays

# North of England Cancer Network

# Criteria for Acting as an Assessor of Competence

*"Quality and safety for every patient every time"*

***Document Control***

| Prepared By | Issue Date | Approved By | Review Date | Version | Contributors | Comments/ Amendment |
|---|---|---|---|---|---|---|
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For more information regarding this document, please contact:

Steve Williamson
Consultant Pharmacist, North of England Cancer Network
NE Strategic Health Authority, Waterfront 4, Goldcrest Way,
Newcastle Upon Tyne, NE15 7NY
*Steve.williamson@necn.nhs.uk*

**CONTENTS**

## 1. Introduction

This document details the training and associated competence that Health Care Professionals (HCPs) require to enable them to independently deliver OR be mandatory present (supervising) within various aspects of the process including the following tasks: prescribing, dispensing, supplying and administering (including verification) treatment to adult cancer patients. The document also details the requirements for HCPs who have designated responsibility for assessing the competence of others.

For the purposes of this document the term

- Systemic "Anticancer Medicine' is used to refer to **All** medications, irrespective of their route of administration, with direct anti-tumour activity including traditional cytotoxic chemotherapy such as cyclophosphamide, hydroxycarbamide, small molecule/ antibody treatments such as imatinib, rituximab and other agents such as interferon, thalidomide or lenalidomide. It does not include hormonal or anti-hormonal agents such as tamoxifen and anastrazole
- Competence is used to designate and demonstrate HCPs ability to safely, efficiently and correctly (i.e. competently), carry out a specified area of practice. Within this document HCPs will be referred to as possessing a competency in a specific task with an associated list of competencies that have been achieved.

## 2. Scope of Document

This document applies to Doctors, Nurses and Pharmacy staff. It is suggested that Trusts within the NECN should consider the following key staff groups initially capable and authorised to assess staff competency and, therefore, automatically competent themselves provided they meet the training pre-requisites listed below.

- Consultant oncologists and consultant haematologists, in the protocols relating to the tumour types they subspecialise in - for prescribing chemotherapy. Note this includes paediatric oncologists and haematologists
- Nurses band 7 or above or lead chemotherapy nurses - for administering chemotherapy; as well as the criteria stipulated in the nursing section below
- Lead oncology pharmacist(s) - for prescription checking (verification) and dispensing of chemotherapy

Training pre-requisites

- Where appropriate, professional qualification and registration
- Relevant induction and mandatory training
- Working in specialized clinical practice area
- Maintain continuing professional development pertaining to the practitioner's specialist area of chemotherapy / SACT
- Be in position to perform the designated chemotherapy and / or SACTs 'task' on a regular basis to maintain clinical competence / confidence.
- Maintain adequate training / competency records.

Competency to be an assessor will be assessed locally at each acute Trust.

## 3. Criteria for Acting as an Assessor of Competence

This should detail the ongoing criteria necessary for a staff member (other than those considered initially capable as assessors) to be considered capable of assessing the competency of other staff to practice in chemotherapy services of the network.

Please see below sections for each professional group.

### 3.1 Medical and Clinical Oncologists and Haematologists

An assessor of competence should meet all the criteria below:

- Be a consultant haematologist or oncologist (competent to assess the tumour types they sub-specialise in and give formative feedback to trainees/other staff)
- Must undertake regular continuing professional development including training in the use of workplace based assessments

NB. Documentation approved by the Royal Colleges must be used to evidence the competence of trainees (SpR/ ST3 and above).

Consultants should use the competencies defined for each of the four levels of practice to assess trainee competence. The four levels of competence are;

- review of a patient to receive systemic therapy and authorisation of the next cycle to proceed
- ability to prescribe systemic therapy, within local guidelines, or to continue a planned course of treatment but not initiate the first course of treatment
- ability to initiate systemic therapy for patients with a range of malignancies, whilst prescribing within local guidelines
- ability to initiate all appropriate systemic therapies for a tumour-specific area of clinical practice. Ability to participate in the evaluation of relevant therapies within clinical trials and therefore have a detailed knowledge of the regulatory framework defined for clinical research.

### 3.2 Nursing staff

- All nursing staff and allied health professionals who deliver chemotherapy as part of their role will have undertaken or be working towards a network recognised Chemotherapy module and Chemotherapy Practice Competencies.
- Chemotherapy nurses and allied health professionals who continue to work in the field of chemotherapy should have their clinical knowledge and skills peer reviewed annually against the network recognised Chemotherapy Practice Competencies as part of the local appraisal process.
- Only staff that have demonstrated advanced practice in chemotherapy administration and assessment will be eligible to undertake the assessment of other staff. They must:
    - Have been identified through appraisal or annual peer review process as being competent to assess. This review process will be monitored by the Trust Lead Chemotherapy Nurse.
    - Undertaken an accredited course in chemotherapy at HEI academic level 6 (degree level module)
    - Have undertaken an accredited course in teaching and/or assessing in clinical practice or have covered this in pre-registration training

    - Spend at least 50% of their time in clinical practice
- Their name must be included on the local Trust register
- The particular competencies for which they are deemed capable as an assessor include: Assessment of patients prior to chemotherapy, Administration of chemotherapy and all aspects of the care pathway, pre-, during and post administration

### 3.2.1 Non-Medical Prescribing:

- Nurses must be registered with the professional regulator the Nursing and Midwifery Council (NMC)
- Nurses must complete Non-Medical Prescribing training and assessment as per the NMC's training and assessment programme
- Nurses must have achieved the necessary qualification as an Independent/non-Medical Prescriber and be registered with the NMC as such
- Follow NECN guidance on Non Medical Prescribing for chemotherapy

## 3.3 Pharmacists, Pharmacy Technicians & Assistant Technical Officers

An assessor should be competent as defined below for each area of practice. In addition the assessor must:

- undertake regular continuing professional development
- spend at least 50% of their time in relevant clinical practice
- have no areas of concern with their practice e.g. acceptable error rates as defined by each local acute Trust
- read the relevant standard operating procedures annually
- Ideally undertake a recognised training and assessment course

### 3.3.1 Non-Medical Prescribing:

- Pharmacists must be registered with the professional regulator General Pharmaceutical Council (GPC)
- Pharmacists must complete Non-Medical Prescribing training and assessment as per the GPC's training and assessment programme
- Pharmacists must have achieved the necessary qualification as an Independent/non-Medical Prescriber and be registered with the GPC as such
- Follow NECN guidance on Non Medical Prescribing for chemotherapy

### 3.3.2 Clinical Verification of prescriptions for cancer medicines:

- Pharmacists must be registered with the professional regulator, GPC
- Pharmacists must complete the local Trust's clinical verification training and assessment programme. Which should include a period of supervised verification of chemotherapy prescriptions. During this period all prescriptions should be double checked by trained oncology pharmacist(s) and a log maintained. A suitable number of items/prescriptions for the log should be agreed locally. It is suggested that 50 items or 25 prescriptions with a variety that reflects local case mix is the minimum for secondary care.
- Meet the British Oncology Pharmacy (BOPA) Competencies to support verification of prescriptions for SACT. Available at http://www.bopawebsite.org/publications/docs/bopa-guidance

### 3.3.3 Dispensing & checking oral chemotherapy:

- Pharmacists and Technicians must be registered with the professional regulator, GPC. Assistant Technical Officers are not required to be registered
- Pharmacists, Technicians and Assistant Technical Officers must complete the local Trust's dispensing and checking of oral chemotherapy training and assessment programme.
- Follow NECN guidance on Oral Anticancer Medicines

### 3.3.4 Checking of worksheets and labels prior to reconstitution of intravenous chemotherapy:

- Pharmacists and Technicians must be registered with the professional regulator, GPC
- Pharmacists, Technicians and in certain Trusts Assistant Technical Officers must complete the local Trust's training and assessment programme

### 3.3.5 Dispensing/reconstitution of intravenous chemotherapy:

- Technicians must be registered with the professional regulator, GPC
- Technicians and Assistant Technical Officers must have completed each local Trust's training and assessment programme

### 3.3.6 Checking and final release of intravenous chemotherapy:

- Pharmacists and Technicians must be registered with the professional regulator, GPC
- Pharmacists and Technicians must complete the local Trust's checking and final release of chemotherapy training and assessment programme

### 3.4 Intrathecal Chemotherapy

All professional groups involved with the preparation, supply, prescribing, checking, administration and training of personnel involved in the administration of intrathecal systemic anti-cancer therapy must be deemed competent as set out in Trust Local Policy which is in line with the National Guidance (HSC 2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy).

## 4. Review of Competency and Capability as an Assessor

- Once signed off as competent, individuals have a professional responsibility to ensure they maintain that competency.
- Competency and authority to be an assessor should be assessed biannually or following a break in a particular area of clinical practice of greater than or equal to six months.
- Ideally as part of clinical governance arrangements each Trust must maintain a register of staff able to act as Assessor of Competence. It is suggested that the register is maintained by either the Trust Lead cancer clinician, the Chemotherapy Lead Clinician, the Lead Chemotherapy Nurse or the Cancer Manager

- The Trust Lead Clinician / Cancer Manager must ensure clinical governance arrangements are in place to check the Trusts Registered Assessors of competence maintain their competency. It is suggested that this is included during annual appraisal.

## 5. Acknowledgements

This policy has been prepared following consultation with NECN chemotherapy group, Newcastle Hospitals Chemotherapy Group and Medical Education Team.

This policy has been prepared using the approved policy from Kent and Medway Cancer Network

**Appendix 6 - Policy for Preventing Regular Deviation from the NSSG Agreed Treatment Algorithms**

# POLICY FOR MANAGING CHEMOTHERAPY PROTOCOL DEVIATIONS

## Peer Review Measure 3S-121

### North of England Cancer Network

### &

### Cumbria, Northumberland, Tyne and Wear Area Team

**Document Control**

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| | | | | | | |

For information about this document contact:
steve.williamson@nhct.nhs.uk

# POLICY FOR MANAGING CHEMOTHERAPY PROTOCOL DEVIATIONS

## Introduction

Hospital trusts are required to monitor and manage the use of chemotherapy regimens which are not recognised by NHS England as being in routine or baseline commissioning processes. Routine commissioning includes NICE-recommended and any agreed local cancer network protocols, until or unless superseded by NHS England policies or similar.

This document details the arrangements for using, monitoring and reporting use of protocol deviations, which may include 'one-off' chemotherapy regimens that are not part of approved protocols.

Anticancer medicines should be prescribed according to the appropriate protocol which supports routine commissioning. When NHS England protocols are available these will supersede local algorithms.

## Options for handling protocol deviations

1. On occasion when a deviation from a recognised and routinely commissioned protocol is required there are three options:

   A. If the deviation substantively affects the chemotherapy regimen such that it is not recognised as being routinely commissioned and the patient is representative of a prospectively definable cohort then an application for a policy development should be made to the NHS Cancer Drugs Fund www.england.nhs.uk/ourwork/pe/cdf/

   B. If the required regimen has not been recommended by NICE or has been declined for inclusion in the CDF list then an application can be made to the local CDF Individual Funding Request (IFR) panel. Contact mandy.nagra@nhs.net

   C. If the protocol deviation consists of a simple variation to a single drug within a routinely commissioned regimen, and there is little or no impact with respect to the overall drug cost of the regimen, and the variation is recognised as having an improved safety profile; then the trust can process such protocol deviations in accordance with its own governance procedures.

For example, this may require approval from a senior physician, oncologist or pharmacist, or via a drug & therapeutics committee or similar. Trusts are required to document any such decisions and report to the network Chemotherapy Group (point 5). This would include a drug substitution to reduce the potential toxicity of a regimen for an individual patient, for example substituting etoposide instead of doxorubicin in R-CHOP.

2. Where option 1. C has been implemented, trusts are recommended to record the request on a locally agreed form detailing the recognised protocol and highlighting the change to that protocol so that all healthcare professionals involved in the patient's care have the appropriate information to safely deliver treatment.

   Any such form should include as a minimum:

   - Patient details & diagnosis
   - Reason for request (why the recognised regimen could not be used)
   - Regimen details; dose(s), likely duration, cost, clinical references & evidence
   - Prescriber name, signature & date
   - Second clinical opinion or multi-disciplinary team signatory & date (to ensure peer approval)
   - Governance / financial authorisation signature(s) (May be same as 2nd opinion)
   - Oncology pharmacist signature (note: essential to ensure availability of drug)

3. Trusts should ensure they have arrangements to consider the funding and cost implications of any protocol deviations. Trusts will approve such deviations as previously described at their own financial risk. Trusts may wish to consult the appropriate commissioners at the relevant NHS England Area Team.

4. Trusts are required to record all protocol deviations, as described, to the Network Chemotherapy Group (NCG); reference standard 11-3C-120. Deviations from agreed protocols may also be discussed at other network meetings.

5. Patients have a right to request funding from commissioners in exceptional circumstances but to do so the support of their consultant is required. Patients also have an option to purchase medicines using private funds.

North of England Cancer Network

# 24 Hour Chemotherapy Telephone Advice Service: Minimum Service Specification

*"Quality and safety for every patient every time"*

Document Control

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| Jane Beveridge | 23.09.13 | Chair of NECN Chemotherapy Group | 23.09.15 | 1.2 | | Re -approved on review by Steve Williamson |

For more information regarding this document, please contact:

*Steve Williamson*
*Chair of NECN chemotherapy Group*
*Steve.williamson@nhct.nhs.uk*

## 1 Purpose

The purpose of this document is to set out the minimum specification for the 24-hour telephone contact service for chemotherapy services across the North of England Cancer Network (NECN). As defined in chemotherapy measure 11-1E-111s. This document provides the minimum specification for 24 hour telephone advice service that Trusts must adopt.

This document does not include Acute Oncology Services (AOS), however Trusts may wish to use this chemotherapy specification as a template for any AOS telephone advice service.

## 2 Background

The chemotherapy peer review measures require the development of an emergency telephone advice service for patients and carers having, or having had chemotherapy. This advice should be provided to patients/carers and healthcare professionals by call handlers suitably trained to provide chemotherapy and Systemic Anticancer Therapy (SACT) related advice.

In order to ensure that this service is provided in a safe and equitable manner to all patients and carers across the network, this minimum service specification has been developed by Network Chemotherapy Group (NCG). Each hospital is then required to agree the specification and put in place the specific local arrangements and training as per measure 11-E-111s in order to support the service.

## 3 The North of England Cancer Network Service Model

- There is **NO** central 24 hour telephone contact number within NECN; rather each Trust within NECN will ensure that there is coverage within their organisation, ensuring that all patients are given a 24 hours telephone contact number. In doing so this contributes to coverage across the whole Network.

- The detail of each service is to be defined locally, e.g. a Trust may have a Service Level Agreement (SLA) with a neighbouring Trust to provide the telephone advice.

- The local Trust 24 hour helplines within the NECN will be available 24 hours a day, 7 days a week, for telephone advice to
  - Patients and carers having, or having had, chemotherapy
  - General healthcare professionals (e.g. GPs, District Nurses)

- Each contact number will be staffed at any one time by at least one member of staff, who meets the training described in Section 4, making up a 24/7 duty rota.

- Staff providing 24 hour advice must have a clear pathway to seek additional advice, as necessary, e.g. from consultant oncologist/ haematologist on-call rotas.

- Each Trust 24 hour service will ensure that no later than the next working day following a call the consultant and team caring for the patient is contacted informing them of the call, the problem, the advice given and the result.

- Each Trust 24 hour service will ensure that within 24 hours of the call ***either*** a return call is made ***or*** follow up on the advice provided to the patient ***to ensure*** that all required actions have been taken.

- The availability of the service will be clearly detailed in patient information as being for urgent advice only. Patients will be provided with:
  - a network agreed alert card with helpline contact numbers clearly printed
  - hand held patient record containing contact numbers and personal treatment record

## 4 Level of training or professional qualifications necessary for staff answering calls

At all hours patients will be able to speak to a registered nurse who is skilled in patient assessment and knowledgeable in the management of chemotherapy related issues. They must have been assessed as competent by their Trust to provide this function.

The training and competency requirements of call handlers providing this service are defined in the Oncology/ Haematology 24-Hour Triage Rapid Assessment and Access Toolkit. Hard copies of the toolkit have been distributed via the Network team to all Trusts; printing details for further copies are available from the Network on request.

## 5 Documentation of Advice

- All calls will be triaged and logged following the "Triage Log Sheet" detailed in the Oncology/Haematology 24-Hour Triage Rapid Assessment & Access Toolkit.

- The following data should be captured for each call:

  - Patient Details (Name, NHS Number, DOB, Telephone Number);
  - Patient History (Diagnosis, Gender, Consultant);
  - Enquiry Details (Date, Time, Name of caller, Contact number, drop in);
  - Reason for call (in patient's own words);
  - Details of any active treatment, including Regimen, whether part of clinical trial, date of last treatment, patient's temperature, whether patient has a central line);
  - Significant medical history;
  - Based on assessment/ triage criteria, whether patient has been given telephone advice, advised of a follow up review or brought in for urgent assessment;
  - Action taken;
  - Triage practitioner;
  - Follow-up action taken;
  - Consultant's team advised y/n

- All of the above details for all calls will then be subject to audit by the Trust Chemotherapy Multi-Disciplinary team for the following purposes:-

  - Assessment of call volumes and types to aid the Network Chemotherapy group in future service planning
  - Quality Assurance of call handling, advice and subsequent patient outcomes.
  - Screening of calls for review at the Network Chemotherapy Nurses Group

- To ensure that this data collection happens in a timely manner, each Trust is required to put a process in place which will capture and record the information centrally to make it readily available for review.

## Appendix 8 - Network Lead Nurse, List of Responsibilities, Role and Time Specified

### NECN Lead Nurse Roles and Responsibilities

### Introduction

Following the changes to the NHS in April 2013, the Cancer networks no longer support cancer nurse leadership. The Northern Strategic Clinical Network gets its chemotherapy nurse leadership from the Chemotherapy Nurses Group which is chaired by Melanie Robertson (Nurse Consultant). The aim of the group is to ensure the safe, effective and economic delivery of chemotherapy services to cancer patients and meet the demands of the National Cancer Plan and Manual of Cancer Service Standards.

### Time for Responsibilities

The ongoing nurse leadership support to the network is provided Melanie Robertson (Nurse Consultant). Time for this role is supported within her Trust role and responsibilities. Personally she will act as a source of expertise for example with ad hoc advisory needs e.g. press enquiries however this will be supported by the chemotherapy nurses group.

The Chemotherapy Nurses Group will:

- Promote equity of chemotherapy nursing service provision across the network including workforce development
- Provide a forum which can focus on the chemotherapy nursing agenda which includes leadership and the patient voice
- Promote the specialist role of chemotherapy nursing in the delivery of cancer services
- Provide a means through which the chemotherapy nurses working with cancer patients can communicate and find peer support and share good practices
- Promote continued professional development, training and educational opportunities in cancer services for chemotherapy nursing staff
- Act as the primary source of advice on chemotherapy nursing issues and should promote co-ordination and consistency relating to these across the network