Clinical Chemotherapy Service
Oncology Pharmacy Service
Intrathecal Chemotherapy (ITC)
Higher Intensity Chemotherapy Facility

Operational Policy

Clinical Chemotherapy Service Team members agreed this policy

Publication Date: November 2019
Version Number: Version 10
Operational Policy Review Date: October 2021
Clinical Chemotherapy Service Operational Policy

This Operational Policy has been agreed by:

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Organisation</th>
<th>Date Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Lead Cancer Clinician</td>
<td>Mr Matthew Perry</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>03.09.19.</td>
</tr>
<tr>
<td>Head of Service for Chemotherapy</td>
<td>Dr Sharadah Essapen</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>30.09.19.</td>
</tr>
<tr>
<td>Lead Chemotherapy Nurse</td>
<td>Emma Masters</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>02.10.19.</td>
</tr>
<tr>
<td>Manager for Lead Chemotherapy Nurse</td>
<td>Victoria Mumford, Divisional Head of Nursing for Oncology</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>07.10.19.</td>
</tr>
<tr>
<td>Trust Head of Pharmacy</td>
<td>Damien Kelly, Chief Pharmacist</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>30.09.19.</td>
</tr>
<tr>
<td>Lead Pharmacist</td>
<td>Sally Seymour</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>19.08.19.</td>
</tr>
<tr>
<td>Trust ITC Lead</td>
<td>Dr John de Vos</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>23.08.19.</td>
</tr>
<tr>
<td>Trust Chief Executive</td>
<td>Louise Stead</td>
<td>Royal Surrey County Hospital NHS Foundation Trust</td>
<td>19.11.19.</td>
</tr>
</tbody>
</table>

## Contents

The Clinical Chemotherapy Service ................................................................. 5

Introduction ........................................................................................................ 5

Purpose and Outline of the Service provided by the Clinical Chemotherapy Service .... 6

Leadership arrangements and responsibilities (B15/S/a/itc-16-cc-001,002, B15/S/a/itc-16-cp-001, B15/S/a/itc-16-002) ................................................................. 8

Facilities (B15/S/a/itc-16-cc-006) .................................................................. 8

Capacity Planning (B15/S/a/itc-16-cc-007) ......................................................... 11

Membership and meeting arrangements of the Chemotherapy Multi-professional Team (CCS) .... 12

Chemotherapy Working Party (B15/S/a/itc-16-cc-003) ..................................... 12

Training, assessment, competency & registers (B15/S/a/itc-16-cc-004,005) .......... 13

Workload Arrangements (B15/S/a/itc-16-cc-007) ............................................. 16

Out of Hours Chemotherapy (B15/S/a/itc-16-cc-007) ..................................... 18

Agreed Policy and List of Treatment Algorithms (B15/S/a/itc-16-cc-008) .......... 18

Treatment Protocols (B15/S/a/itc-16-cc-009) ................................................. 19

Practice Guidelines and Protocols (B15/S/a/itc-16-cc-010) .............................. 20

Guidelines and Protocols for Systemic Therapy Acute Oncology Presentations (B15/S/a/itc-16-cc-011) ................................................................. 21

Treatment Records Prior to a Course and Cycle ............................................ 23

Treatment Plan and Summary (B15/S/a/itc-16-cc-017) .................................... 24

Electronic Prescribing (B15/S/a/itc-16-cc-012,013) ..................................... 24

The Chemotherapy Pathway (B15/S/a/itc-16-cc-014,015,016,020) ................ 25

24-hour telephone advice service (B15/S/a/itc-16-cc-022) .................................. 34

Provision of Patient Information (B15/S/a/itc-16-cc-023) .............................. 34

Consent Form (B15/S/a/itc-16-cc-021) ............................................................ 35

Patient Experience Exercise ............................................................................ 35

Systemic Anti-Cancer Therapy (SACT) Dataset (B15/S/a/itc-16-cc-018) .......... 35

Error Recording and Reporting (B15/S/a/itc-16-cc-019) ............................... 36

The Oncology Pharmacy Service ................................................................. 37

Service Leadership (B15/S/a/itc-16-cp-001) .................................................... 37

Aseptic Preparation Audit (B15/S/a/itc-16-cp-002) ......................................... 37

Vinca Alkaloids (B15/S/a/itc-16-cp-003,004,005) ......................................... 37

Trust ITC Declaration (B15/S/a/itc-16-001) ..................................................... 39

Leadership and Organisation (B15/S/a/itc-16-002) ........................................ 39

Case Volume and Risk Assessments (B15/S/a/itc-16-003) ............................ 39

Training Policy (B15/S/a/itc-16-004) ............................................................... 39

Waiver to the National Guidance on Administration by ST1 or ST2 Medical Staff (B15/S/a/itc-16-005) ................................................................. 40

Intrathecal Chemotherapy Register (B15/S/a/itc-16-006) ................................ 40

Registration Procedure (B15/S/a/itc-16-007) ....................................................... 40

Storage in Pharmacy (B15/S/a/itc-16-008) ......................................................... 40

Issuing of ITC drugs (B15/S/a/itc-16-009) ....................................................... 40

Sequencing of IV and IT Chemotherapy (B15/S/a/itc-16-010) .................... 40

Labelling of ITC drugs (B15/S/a/itc-16-011) .................................................. 40

Collection of ITC drugs (B15/S/a/itc-16-012) .................................................. 41

Storage outside of Pharmacy (B15/S/a/itc-16-013) ......................................... 41

Designated ITC Room (B15/S/a/itc-16-014) ...................................................... 41

Local Intrathecal Protocol (B15/S/a/itc-16-015) ................................................ 41

ITC Administration within Normal Working Hours (B15/S/a/itc-16-016) ........ 42

ITC Prescription Chart (B15/S/a/itc-16-017) .................................................. 42

ITC Checking Procedure (B15/S/a/itc-16-018) ................................................. 42

Higher Intensity Chemotherapy Facility .......................................................... 43

Designated Beds and Agreed Number of Single Rooms (B15/S/a/itc-16-chi-001) .. 43

Supporting Facilities (B15/S/a/itc-16-chi-002) .............................................. 43

Consultant Rota (B15/S/a/itc-16-chi-003) ......................................................... 43

Neutropenic Patient Staffing Ratio (B15/S/a/itc-16-chi-004) .......................... 43

Presence of Specialist Staffing Ratio (B15/S/a/itc-16-chi-005) ........................ 44
Venous Access Specialist (B15/S/a/itc-16-chi-006) ..........................................................44
Microbiology Advice (B15/S/a/itc-16-chi-007) .................................................................44
Clinical Audit of the Service (B15/S/a/itc-16-chi-008) .................................................45
Appendix 1: Chemotherapy Working Party Terms of Reference (B15/S/a/itc-16-cc-003) ...46
Appendix 2: Pharmacy and Oncology Steering Group Terms of Reference ...............48
Appendix 3: List of responsibilities of CCS Head of Service (B15/S/a/itc-16-cc-001) ....50
Appendix 4: Work plan for CCS Lead Chemotherapy Nurse (B15/S/a/itc-16-cc-002) ....54
Appendix 5: List of responsibilities of CCS Lead Chemotherapy Nurse (B15/S/a/itc-16-cc-002) ..................................................................................................................55
Appendix 6: List of responsibilities of the CCS Lead Pharmacist .................................60
Appendix 7: Areas outside SLCC where chemotherapy is administered (B15/S/a/itc-16-cc-006). ..................................................................................................................68
Appendix 8: Membership list of the Trust Drug and Therapeutics Committee ...........69
Appendix 9: St Luke’s Cancer Alliance Chemotherapy Algorithms August 2019 (B15/S/a/itc-16-cc-008) ...........................................................................................................72
Appendix 10: List of responsibilities of the named designated pharmacists ............73
Appendix 11: ITC Accountability Agreement (B15/S/a/itc-16-002) .................................77
Appendix 12: Admissions Policy for Haematology Oncology Patients (B15/S/a/itc-16-chi-001).78
Appendix 13: Sample Consultant Haematologist On-Call Rota (B15/S/a/itc-16-chi-003) .81
Appendix 14: Sample Consultant Microbiologist On-Call Rotas (B15/S/a/itc-16-chi-007) .82
THE CLINICAL CHEMOTHERAPY SERVICE

Introduction

This document defines the operational policy of the Clinical Chemotherapy Service (CCS) at St Luke’s Cancer Centre, Royal Surrey County Hospital Foundation Trust. St Luke’s Cancer Centre serves the St Luke’s Cancer Alliance population of 1.2 million.

The St Luke’s Cancer Alliance began operating from April 2014. This replaced the Surrey, West Sussex and Hampshire Cancer Network which was established in the summer of 2001.

The St Luke’s Cancer Alliance comprises of 9 Clinical Commissioning Groups and the Surrey/Sussex Specialist Commissioning Area Team. The boundaries of the St Luke’s Cancer Alliance lie within the South East Coast Strategic Clinical Network.

Within St Luke’s Cancer Alliance, chemotherapy for malignant disease is provided by the following Acute Trusts:

- Ashford and St. Peter’s Hospitals NHS Foundation Trust (ASPH)
- Frimley Park Hospital NHS Foundation Trust (FPH)
- St Luke’s Cancer Centre (SLCC), Royal Surrey County Hospital NHS Foundation Trust (RSCH)
- Surrey and Sussex Healthcare NHS Trust (SASH)

Each Trust provides a Clinical Chemotherapy Service (CCS) for each locality group, following the Manual for Cancer Services Chemotherapy Measures 2014.

Chemotherapy Operational Policies at each Trust are prepared with input from all disciplines involved in providing the Clinical Chemotherapy Service, via the Local Chemotherapy Group of the individual Trust. The policy is agreed by the Head of the Clinical Chemotherapy service for the individual Trust and submitted to the Cancer Alliance Chemotherapy Group for approval.

The guidance and procedures in this document refer to the treatment of adult cancers, for both solid tumour oncology and haematological malignancies.

This document is to be used to support the Cancer Alliance Policy and Guidelines for the Safe Prescribing, Handling and Administration of Cytotoxic Drugs (hereafter referred to as the Cancer Alliance Cytotoxic Policy). This Policy is available on the St Luke’s Cancer Alliance website:

https://st lukescanceralliance.co.uk/alliance-cytotoxic-policy/
The Cancer Alliance Policy covers guidelines for:

- Health and Safety
- Staff Responsibilities
- Standards for Preparation
- Administration of Cytotoxic Agents
  - Pre-Treatment Assessment Requirements
  - Nutritional Assessment during Chemotherapy
  - Storage
  - Transportation
- Administration in Exceptional Circumstances
- Dispensing and Administration of Oral Cytotoxic preparations
- Pharmacy reconstitution of Parenteral Cytotoxics
- Administration of Cytotoxics
  - Classification
  - Administration in a Non-Designated Site
  - Equipment / Facilities Required before Chemotherapy Administration
  - Venous Access
- Administration of Parenteral Cytotoxics
- Administration via Specific Routes
- Intrathecal/Intraventricular Chemotherapy
- Ambulatory Pumps/Home Chemotherapy
- Disposal of cytotoxic waste
- Accidental Contamination/Exposure
- Cytotoxic spillages
- Education and training
- Procedures for ‘one-off’ prescribing and application for new regimens

Purpose and Outline of the Service provided by the Clinical Chemotherapy Service


The dedicated oncology / haematology-inpatient ward (Onslow) has 34 beds. Chilworth Day Unit has designated facilities for day care chemotherapy and procedures.

The Clinical Chemotherapy Service is run by a multi-professional team via the Chemotherapy Working Party and the Pharmacy and Oncology Steering Group. The responsibility within these two groups differ with the chemotherapy working party being responsible for the operational issues within the CCS and the steering group being responsible for developing and delivering the Trust Chemotherapy Strategy. The responsibilities, objectives and membership of the
Chemotherapy Working Party and Pharmacy and Oncology Steering Group are included in the Terms of Reference for these groups (Appendix 1 and 2).

The Oncology Pharmacy Service is provided by a team of specialist pharmacy staff. The base for much of their work is the dedicated satellite pharmacy within St Luke’s Cancer Centre. This is where all chemotherapy prescriptions are verified. Oral chemotherapy and supportive care medicines are dispensed in the St Luke’s PharmCo Dispensary. Medication counselling is provided by the pharmacy team in St Luke’s. A clinical pharmacy service is provided to Onslow Ward. Parenteral chemotherapy is supplied from the on-site MHRA licensed Pharmacy Aseptic Unit.

Specialist Palliative Care is provided by a full time Consultant in Palliative Medicine and a team of Specialist Palliative Care Clinical Nurse Specialists. This service is currently available seven days a week 9am to 5pm. Out of hours specialist care advice is available via an on-call consultant rota via Phyllis Tuckwell Hospice.

The RSCH benefits from all of the diagnostic, treatment and support facilities expected of a large modern general hospital. Radiology services include ultrasound scanning, CT, MRI and interventional radiology. Nuclear medicine and PET-CT facilities are available on site. Histopathology and associated pathology services are all available. Critical Care provides pre-operative assessment, high quality peri-operative care with step down care available through all levels and a full outreach facility.

The RSCH is a single site NHS Foundation Trust. The intrathecal chemotherapy (ITC) service is an undivided service across the whole Trust.

Intrathecal chemotherapy is only administered during normal working hours i.e. 08:00 to 18:00 hrs Monday to Friday (excluding Bank and Public Holidays).

There is no paediatric intrathecal chemotherapy service at the RSCH.

For further details see the Trust Intrathecal Chemotherapy Policy on the St Luke’s Cancer Alliance website: http://stlukescanceralliance.co.uk/intrathecal-chemotherapy-policies/

Also, the updated national guidance on the safe administration of intrathecal chemotherapy (HSC 2008/001).
Leadership arrangements and responsibilities (B15/S/a/itc-16-cc-001,002, B15/S/a/itc-16-cp-001, B15/S/a/itc-16-002)

Head of Service (B15/S/a/itc-16-cc-001)

The Head of Service is Dr Sharadah Essapen (Consultant Clinical Oncologist).

The list of responsibilities for this role has been agreed by the Trust Lead Cancer Clinician (Appendix 3).

Lead Chemotherapy Nurse (B15/S/a/itc-16-cc-002)

The Lead Chemotherapy Nurse is Emma Masters. This has been agreed by Dr Sharadah Essapen (Head of Service) and the line manager (Divisional Head of Nursing).

She has regular personal involvement in chemotherapy administration as part of their timetable. This is demonstrated in the work plan for the role (Appendix 4).

The list of responsibilities for this role has been agreed by Dr Sharadah Essapen (Head of Service) and the line manager (Divisional Head of Nursing) and the post holder (Appendix 5).

Lead Pharmacist (B15/S/a/itc-16-cp-001)

The Lead Pharmacist for the Oncology Pharmacy Service is Sally Seymour, Deputy Chief Pharmacist Cancer, Aseptic and Research Services (CARS).

The list of responsibilities of this role has been agreed by the Trust Lead Cancer Clinician and the line manager, Damien Kelly (Chief Pharmacist) (Appendix 6).

ITC Lead (B15/S/a/itc-16-002)

The Trust ITC Trust Lead is Dr John de Vos (Consultant Haemato-Oncologist). He is accountable to Louise Stead (Chief Executive) for compliance with the national ITC guidance and the ITC Chemotherapy Measures (Appendix 7 – Accountability Agreement).

Facilities (B15/S/a/itc-16-cc-006)

Designated clinical areas

Patients having planned admissions for IV chemotherapy for malignant disease are admitted preferentially to either Onslow Ward (for inpatient chemotherapy) or Chilworth Day Unit (for day-case chemotherapy). The only exception would be in exceptional circumstances where the patient’s condition led them to be an inpatient on another ward e.g. ITU.

Administration of chemotherapy in the following clinical areas has been agreed by the Head of Service for Chemotherapy and the Lead Oncology Nurse:
<table>
<thead>
<tr>
<th>Type of Clinical Area</th>
<th>Name of Clinical Area</th>
<th>Number of beds/chairs</th>
<th>Opening times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>Onslow Ward</td>
<td>34</td>
<td>24 hours 7 days per week</td>
</tr>
<tr>
<td>Day Care</td>
<td>Chilworth Day Unit</td>
<td>4 beds, 55 chairs</td>
<td>08:00 to 18:00 hrs Monday – Friday</td>
</tr>
</tbody>
</table>

On the days that chemotherapy is being given the area is only to be used for this purpose or other oncology/haematology outpatient/day case aseptic treatments or procedures.

All efforts must be made to ensure that chemotherapy is only to be administered in the designated areas.

At RSCH Intrathecal Chemotherapy is administered in the designated Haematology Room in the outpatient department, Level B, St Luke’s Wing. See updated national guidance on the safe administration of intrathecal chemotherapy (HSC 2008/001) and separate Trust Intrathecal Policy for details (on St Luke’s Cancer Alliance website as previous).

For areas outside SLCC where oral or topical (including intravesical) cytotoxic drugs are to be administered to adults for malignant and non-malignant conditions, and where chemotherapy is administered to paediatric oncology patients (Appendix 7). Designated prescribers in these areas are also defined.

The criteria for chemotherapy administration in a non-designated location are identified in the Cancer Alliance Cytotoxic Policy.

Privacy and dignity within the whole department (inpatients, outpatients and day case attenders) is ensured via all staff following the Trust ‘Privacy and Dignity Policy’.

**Documentation**
In all of the St Luke’s clinical areas where chemotherapy is administered, the following documentation is accessible electronically:

- This Operational Policy for the Provision of Chemotherapy Services at St Luke’s;
- Cancer Alliance Cytotoxic Policy;
- Regimen details as specified in the Cancer Alliance list of acceptable chemotherapy regimens to be administered within St Luke’s at RSCH;
- Protocols and equipment for the management of the following emergencies:
  - Anaphylactic Shock (see Cancer Alliance Anaphylaxis Guidelines);
  - Extravasation of Cytotoxic drugs (see Cancer Alliance Extravasation Guidelines);
  - Cardiac Arrest (See RSCH Local Clinical Protocols ‘Red Book’);
  - Spillage of Cytotoxic drugs (see Cancer Alliance Cytotoxic Policy).

**Equipment**
In all areas where chemotherapy is administered the following equipment must be present:
- Anaphylaxis kit
- Extravasation kit
- Hot/cold packs
- Spillage kit
- Eye Wash
- Resuscitation trolley
- Cytotoxic waste bins
- Protective clothing

**Storage Facilities**

Within St Luke’s the following are the specific storage areas for cytotoxic drugs which are clearly marked for this specific use:

<table>
<thead>
<tr>
<th>Chemotherapy administration area</th>
<th>Refrigerated storage</th>
<th>Room temperature storage</th>
<th>Intrathecal preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onslow Ward</td>
<td>Fridge in locked chemotherapy preparation room</td>
<td>Designated cupboards in locked chemotherapy preparation room</td>
<td>N/A</td>
</tr>
<tr>
<td>SLCC Outpatient ‘Haematology Room’</td>
<td>Designated fridge</td>
<td>N/A</td>
<td>Dedicated, lockable intrathecal chemotherapy fridge</td>
</tr>
<tr>
<td>Chilworth Day Unit</td>
<td>Lockable fridge in each bay and preparation room</td>
<td>Designated lockable cupboards in each chemotherapy bay</td>
<td>N/A</td>
</tr>
<tr>
<td>Oncology Pharmacy</td>
<td>Designated fridges in locked pharmacy</td>
<td>Designated cupboards in locked pharmacy</td>
<td>N/A</td>
</tr>
</tbody>
</table>

See the Cancer Alliance Cytotoxic Policy for specific storage requirements for cytotoxic drugs.

**Transportation**

Items sent out from the Pharmacy Aseptic Services Unit are wrapped in heavy duty polythene wrapping and heat-sealed. All cytotoxic drugs are clearly labelled as such. Cytotoxic drugs are then placed into a box or envopak marked with cytotoxic tape which is sealed ready for transportation.

Cytotoxic drugs are transported to the wards/departments by the pharmacy porter, member of the pharmacy staff or a representative from the ward who are familiar with the nature of the product being transported.

Cytotoxics for intrathecal administration are transported in a dedicated box and are not removed until administration is due or the dose is transferred to the designated lockable fridge in the Haematology Room, Oncology Outpatients Level B. Only staff registered for this task on the Trust Intrathecal Chemotherapy Register may perform this task.

See the Cancer Alliance Cytotoxic Policy for further specific transport requirements for cytotoxic drugs.
**Disposal**
See the Cancer Alliance Cytotoxic Policy for specific disposal requirements for cytotoxic drugs relating to:
- Used disposable equipment
- Contaminated non-disposable equipment/items
- Protective clothing and wipes
- Part-used doses
- Patient waste/body fluids
- See RSCH Trust policy for the disposal of waste
- All administration equipment must be disposed of in accordance with local Health and Safety procedures.

**Capacity Planning (B15/S/a/itc-16-cc-007)**

Capacity is capped at a given number of chemotherapy administration appointments. If this number is reached an escalation process is activated whereby the senior nurses, i.e. Outpatient Manager, Lead Chemotherapy Nurse and Lead Oncology Nurse, would be notified. On an ongoing basis the administration team would alert the individuals above if activity is approaching maximum capacity. Capacity planning meetings are also held at critical times such as bank holidays. These involve members of the administration, nursing and pharmacy teams. During these meetings, decisions are recorded in the minutes which are subsequently circulated to the team. At any point where escalation occurs, the senior nurses (as above) would liaise with medical colleagues to agree the mitigation e.g. deferring/omitting specific regimens or days within a regimen, usually palliative in intent.

The ‘Scheduling Module’ within the electronic prescribing system is used as the CCS tool for capacity planning.
Membership and meeting arrangements of the Chemotherapy Multi-professional Team (CCS) Chemotherapy Working Party (B15/s/a/itc-16-cc-003)

The membership of the Chemotherapy Working Party (including professional roles and responsibilities) is as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultants</strong></td>
<td></td>
</tr>
<tr>
<td>Consultant Medical Oncologist, Lead Clinician Medical Oncology (Head of Chemotherapy Service)</td>
<td>Dr Sharadah Essapen Ext 6807</td>
</tr>
<tr>
<td>Consultant Haematology-Oncologist</td>
<td>Dr John de Vos Ext 4488</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td></td>
</tr>
<tr>
<td>Divisional Head of Nursing for Oncology</td>
<td>Victoria Mumford Ext 6883 Blp 76 1245</td>
</tr>
<tr>
<td>Lead Chemotherapy Nurse (work plan includes involvement in chemotherapy administration)</td>
<td>Emma Masters Ext 4273 Blp 71-0860</td>
</tr>
<tr>
<td>Oncology Matron</td>
<td>Sarah Branch Ext 4273 Blp 76-6515</td>
</tr>
<tr>
<td>Sister Daycare Services</td>
<td>Alison Holden Marion Brown Ext 6772/6842</td>
</tr>
<tr>
<td>Lead Research Sister</td>
<td>Sarah De Swert Ext 4397/6766</td>
</tr>
<tr>
<td>Outpatient Manager (Sister)</td>
<td>Denine Williams Blp 71-0812</td>
</tr>
<tr>
<td>Onslow Ward Manager</td>
<td>Carol Burrows Karolina Kliczbor Ext 6860</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
</tr>
<tr>
<td>Deputy Chief Pharmacist (Cancer, Aseptic and Research Services) (Representative on the Trust Drugs and Therapeutics Committee)</td>
<td>Sally Seymour Ext 6903 Blp 71-0990</td>
</tr>
<tr>
<td>Lead Protocol Development Pharmacist</td>
<td>Susan Taylor Ext 6765</td>
</tr>
<tr>
<td>Oncology Pharmacy Operations Manager</td>
<td>Helen Kimber Ext 6765</td>
</tr>
<tr>
<td>Aseptic Services Manager</td>
<td>Caroline May Blp 71-4588</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
</tr>
<tr>
<td>Oncology Specialty Manager (Relevant Hospital Manager)</td>
<td>Tatjana Voitiekute Ext 4273</td>
</tr>
</tbody>
</table>

The Chemotherapy Working Party meets monthly, on the third Wednesday of the month. The minutes (including a record of attendance) are taken by the Oncology SBU Administrator. The terms of reference for these meeting are included in Appendix 1.

The Lead Pharmacist is the CCS multi-professional team representative on the Trust Drug and Therapeutics Committee. The membership of the Drug and Therapeutics Committee is included in the terms of reference in Appendix 8.
Training, assessment, competency & registers (B15/S/a/itc-16-cc-004,005)

Prescribing
Within St Luke’s, the decision to initiate a course of systemic anti-cancer therapy (SACT) is made by a Consultant Oncologist or Haemato-Oncologist. Cycle 1 SACT prescriptions must be prescribed and confirmed by a doctor with at least 1 year of specialist training in Oncology/Haemato-Oncology (i.e. ST4 Grade and above or Speciality Doctor with at least 1 year of oncology/haematology experience). Subsequent SACT cycles are prescribed and confirmed by an appropriately qualified, competent doctor, i.e. ST3 Grade and above, Specialty Doctor, Associate Specialist or Oncology/Haemato-Oncology Consultant who have undergone training and competency assessment. Other doctors (FY1, FY2, ST1, ST2 Grades and all those working outside the specialty) do not write or transcribe SACT prescriptions.

The St. Luke’s Cancer Centre induction programme for junior doctors, ST3 and above, (Specialist Registrar grade), and clinical fellows includes a comprehensive set of information to ensure the safe prescribing of SACT. Doctors who are on Specialty Training Programme, either clinical or medical oncology or haematology/oncology, have a very well defined competency assessment which is included in their specialty programme. The curriculum for these specialties includes assessment in:

- Clinical application and evaluation of cytotoxic drugs, endocrine therapies and biological therapies
- Principles of clinical pharmacology of cytotoxic drugs, adverse effects of treatment and their management
- Combination of sequential therapy
- Understanding of how specific interventions can prevent specific toxiciesties associated with chemotherapy
- Role of dose intensifications and indications, complications and adverse effects of high dose therapy

All modules have specific assessments as set in the curriculum for each specialty. It is therefore not necessary to have additional competency assessment for ST4 and above doctors on the Specialist Training Programme. They have to familiarise themselves and comply with the St Luke’s Cancer Alliance Policy for the safe Prescribing, Handling and Administration of cytotoxic drugs, particularly Sections 4.4, 4.5, and 4.6 (https://stlukescanceralliance.co.uk/alliance-cytotoxic-policy/) and are only allowed to prescribe SACT according to alliance-agreed protocols.

Non-medical prescribers must have successfully completed the University-accredited independent/supplementary prescribing course, and be accredited to prescribe SACT, as well as be on the Trust chemotherapy prescribing register before they may start prescribing any SACT. They can then prescribe second and subsequent cycles of SACT within their field of competence. Site-specific Clinical Nurse Specialists who wish to confirm or prescribe chemotherapy must undertake specific chemotherapy training with their Designated Medical Practitioner before being deemed competent and added to the Trust Register.
GPs cannot prescribe chemotherapy. The only exception is on-going hydroxycarbamide for essential thrombocythaemia, in the context of the Surrey-wide shared care protocol where the responsibilities of the specialist, GP and patient are clearly defined.

Nurses who have passed the SACT confirmation competency assessment may confirm SACT prescriptions that have already been prescribed by a doctor / non-medical prescriber as described above.

Cycle 1 SACT prescriptions can be confirmed by specifically identified nurses working within the nurse led clinic, who have been assessed and deemed competent, having completed a local competency document, to confirm cycle 1 SACT prescriptions. A register of nurses approved to confirm SACT prescriptions is available on the trust intranet and updated by the Lead Chemotherapy Nurse.

See National and Trust Intrathecal Guidance for the specific requirements for prescribing intrathecal chemotherapy (on St Luke’s Cancer Alliance website as previous).

**Verification**
This must be performed by a Specialist Pharmacist who has completed the competency-based assessment for clinical checking of parenteral and oral SACT prescriptions.

**Dispensing**
Pharmacy staff must have completed the competency-based training and assessment for the dispensing of oral SACT with BSA-based dosing before undertaking this task.

Only trained and accredited pharmacy staff are permitted to take part in the preparation and reconstitution of cytotoxic drugs. The Pharmacy Aseptics Services Manager takes overall responsibility for maintaining training records of competent individuals expected to take part in any part of the process of the reconstitution of cytotoxic drugs, i.e. aseptic manipulation, labelling or final checking.

It is the responsibility of individual pharmacy staff to ensure they are familiar with the safe handling procedures for cytotoxic drugs.

**Final checking**
Pharmacy staff must have completed the relevant competency-based assessment for final checking SACT prescriptions according to the area in which they are working (whether St Luke’s Dispensary or the Aseptic Unit).

**Administration**
Intravenous chemotherapy may only be administered by nurses with appropriate specialist training. The Lead Chemotherapy nurse will co-ordinate a centrally held register of all such staff treating patients within the Trust and will co-ordinate staff training and monitor and record levels of achievement. From November 2016, staff working directly and regularly in a clinical chemotherapy unit will be able to complete an annual ‘Self Declaration of Competency’ form to reflect clinical competency. Those staff that are new to the department or working less than 2 days or nights per week directly with chemotherapy will be required to undertake an annual clinical chemotherapy assessment in practice before being added or maintained on the Trust
register. Sub-categories of competency will be specified on an individual basis. The list is available on the Trust shared drive.

Any member of staff giving intravenous chemotherapy must ensure that they are familiar with the use and side effect profile of the specific drugs being given. Further information and advice is sought if necessary from BNF, summary of product characteristics (SPC), nurse specialists, consultant oncologist/haematologist on call, medical oncology services, pharmacist on call etc. If in doubt, always ask for advice before commencing treatment. Medical Staff do not administer chemotherapy, outside the responsibilities specified in the ITC National Guidance and Trust Policy.

List of Authorised Assessors
The designated assessors for SACT-related tasks are:

<table>
<thead>
<tr>
<th>Task</th>
<th>Post(s)</th>
<th>Postholder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Prescribers</td>
<td>Head of Service</td>
<td>Dr Sharadah Essapen</td>
</tr>
<tr>
<td>Confirmation of prescriptions</td>
<td>Lead Chemotherapy Nurse Divisonal Head of Nursing for Oncology</td>
<td>Emma Masters Victoria Mumford</td>
</tr>
<tr>
<td>Confirmation of prescriptions, oral and intravenous</td>
<td>Deputy Chief Pharmacist Lead Protocol Development Pharmacist Oncology Pharmacy Operations Manager</td>
<td>Sally Seymour Susan Taylor Helen Kimber</td>
</tr>
<tr>
<td>Dispensing</td>
<td>Outpatient Pharmacy Manager</td>
<td>Modupe Olorunfemi</td>
</tr>
<tr>
<td>Checking of prescriptions</td>
<td>Outpatient Pharmacy Manager Aseptic Services Manager Chief Technician, Aseptic Services</td>
<td>Modupe Olorunfemi Caroline May Kathryn Shields</td>
</tr>
<tr>
<td>Administration</td>
<td>Lead Chemotherapy Nurse Oncology Matron Chilworth Day Unit Managers Onslow Ward Managers</td>
<td>Emma Masters Sarah Branch Alison Holden / Marion Brown Carole Burrows / Karolina Kliczbor</td>
</tr>
</tbody>
</table>

Register of competent staff
The Trust competency register of designated staff includes the list of staff competent in the following areas:

- Medical staff for prescribing of parenteral and oral SACT;
- Non-medical independent and supplementary prescribers for prescribing of intravenous and oral cancer SACT;
- Nursing staff for confirmation of SACT prescriptions which have been prescribed by a designated doctor or non-medical prescriber;
- Pharmacy staff for the pharmacist clinical check (screening) of parenteral and oral SACT prescriptions;
- Pharmacy staff for the final check of dispensed ORAL SACT;
- Staff for the administration of intravenous chemotherapy;
- Paediatric staff for the administration of intravenous chemotherapy;
- Staff for the administration of parenteral chemotherapy by other routes;
- Staff for the administration of oral chemotherapy.

Entry onto the register must be authorised by the assessor specific to the area of competence, as per list of authorized assessors.

The latest version of the full register is available on the Trust-wide G drive:

G:\Shared\TrustWide\St Luke’s Cancer Alliance Chemotherapy Issues

A separate register of competencies for pharmacy aseptic staff is held and maintained within the RSCH aseptic department.

Training records
Responsibility for training records is held by the designated assessors within each professional group. Records are stored within the department and are reviewed as part of the Trust ‘Personal Development Review (PDR)’ process.

The Trust competency register serves as the CCS record of members of staff currently documented as competent by an authorised assessor; for any given area of competence. This register determines who and only who is authorised to carry out a given task in the CCS.

Workload Arrangements (B15/S/a/itc-16-cc-007)

There is an agreed arrangement where the Head of Service, in consultation with Lead Pharmacist and Lead Chemotherapy Nurse, is able to limit the number of chemotherapy patients when they judge the workload to have reached unsafe levels. If the maximum capacity is anticipated, the escalation process is activated as previously described (14-3S-105).

The CCS has access to the Emergency Planning Policy for the department to aid this process if required.

The capacity for an individual Clinical Chemotherapy Service to provide the safe administration of chemotherapy may be influenced by internal and external factors affecting the following:

Facilities
- Cytotoxic reconstitution service provided by pharmacy
- The designated locations in which chemotherapy is administered
- Ward e.g. the numbers of beds available

Staffing
- Pharmacy staff to:
  - provide the reconstitution service
  - final check preparations prepared by the reconstitution service
clinically check chemotherapy prescriptions

- Nursing staff to:
  administer chemotherapy
  co-ordinate the patient’s journey
  prescribe chemotherapy and supportive therapies if a non-medical prescriber.

- Medical staff to:
  review patients and prescribe chemotherapy
  provide medical support to cover the administration of chemotherapy.

At SLCC the following individuals, or their deputies, must be informed if operational managers have concerns about capacity issues affecting the safe delivery of a Chemotherapy service:

- Lead Chemotherapy Nurse and Oncology Matron
- Deputy Chief Pharmacist (CARS) / Pharmacy Aseptic Services Manager
- Head of Chemotherapy Service in liaison with the Clinical Director and Associate Director for Oncology and Medical Physics

These individuals will discuss the nature of the capacity issue and decide on a plan of action:

**Short term action**
Amendments to the Chemotherapy service may be made by implementing the following as appropriate:

- Identify the number of patients who can safely be treated with their chemotherapy in relation to the number of staff available to provide the service, i.e. medical, nursing and pharmacy staff.

- Identify those patients for whom it is essential they receive their chemotherapy on the same day and those patients, who can safely have their chemotherapy delayed, taking the following into account:
  - The complexity of the patient’s treatment regimen, schedule of treatment, clinical condition. If in doubt discuss with the patient’s Consultant.
  - The patient’s journey to the Trust (e.g. distance, ambulance)
  - The patient’s ability to travel (e.g. performance status)

- Reschedule patients’ chemotherapy where appropriate.

- Record the capacity issue using the Trusts Clinical Risk process, in order to identify funding or long term issues.

**Long term action**
Issues relating to the long term capacity of the Clinical Chemotherapy Service to provide a safe chemotherapy administration service must be addressed through the Trust Chemotherapy Working Party and Oncology and Medical Physics Clinical Governance meeting.

Business cases for the improvement of staffing or facilities must be prepared and submitted though the Trust business planning programme.
**Out of Hours Chemotherapy (B15/S/a/itc-16-cc-007)**

It is recommended that cancer chemotherapy is **initiated** within normal working hours (i.e. 08:00-18:00 Monday – Friday). The risk of accidents is increased when complex cytotoxic regimens are given outside normal working hours, when support services, clinical expertise and back up are at a minimum.

The exception would be cancer chemotherapy initiated during normal working hours, but which requires subsequent administration out of hours due to scheduling of the regimen e.g. twice daily dosing that falls into the evening, or doses on subsequent days which fall over a weekend.

A record of all out-of-hours chemotherapy should be maintained within each Trust.

There is no cytotoxic reconstitution service outside of normal Monday to Friday working hours, and there are no exceptional circumstances whereby it may be arranged to reconstitute chemotherapy outside of these working hours. If appropriate, transfer the patient to another treatment centre.

Where possible, Monday to Friday, chemotherapy should be given before 18:00. Where chemotherapy must be administered outside normal working hours, this would take place on Onslow Ward. The Ward Manager takes responsibility for ensuring the off-duty includes the availability of a chemotherapy-trained nurse.

Intrathecal Chemotherapy is only administered during normal working hours, i.e. 08:00 to 18:00 hrs Monday to Friday excluding Bank and Public Holidays (as per Trust ITC Policy).

**Agreed Policy and List of Treatment Algorithms (B15/S/a/itc-16-cc-008)**

The multi-professional team have agreed to adopt the list of treatment algorithms produced by the Cancer Alliance via the Site-Specific Groups (see August 2019 list in Appendix 8). The algorithms in this list are updated at least every 2 years.

The list covers all agreed chemotherapy for solid tumour oncology and haemato-oncology for all cancer sites covered by the CCS.

The intention is to prevent individual practitioners using unorthodox, obsolete and unpredictably varying practices, which may be against the opinion of their peers.

The Cancer Alliance One-off Chemotherapy Regimen Process is followed where a chemotherapy regimen is not on the approved list of regimens or treatment algorithm for that tumour site (refer to Cancer Alliance Cytotoxic Policy for full details of one-off chemotherapy procedure).

One-off chemotherapy protocols may only be initiated (and the first cycle prescribed) by the Consultant Oncologist or Haemato-Oncologist responsible for the patient’s care. The Consultant must complete a One-off Chemotherapy Regimen ‘Green Form’ identifying all
details required, to enable all healthcare professionals responsible for the care of the patient to safely deliver the regimen to the patient. The ‘green form’ proforma is available from the St Luke’s Cancer Alliance website: http://stlukescanceralliance.co.uk/wp-content/uploads/2015/10/one-off-protocol-form.pdf

The One-off form must be approved by an oncology pharmacist before the patient’s treatment can be prescribed or administered. The route of funding of the particular chemotherapy regimen must be confirmed before treatment is booked.

All off-protocol requests are reported to the CCS Chemotherapy Working Party on a monthly basis. This allows an opportunity to pick up any trends or anomalies.

All chemotherapy referrals that are off-algorithm or off-protocol are accompanied with an ‘Off-protocol request form’. These forms are intended to record, in each case:

- The regimen used or change in order of the regimens;
- The indication for the deviation.

All off-protocol request forms are collated by the Lead Protocol Development Pharmacist at the end of each month and reported as a regular agenda item at the CCS Chemotherapy Working Party meeting. This report is reviewed for trends or anomalies. Where there is frequent use of an off-protocol regimen, this is referred to the Lead Protocol Development Pharmacist for writing of a new protocol.

**Treatment Protocols (B15/S/a/itc-16-cc-009)**

The CCS agrees to use the Cancer Alliance chemotherapy regimen protocols. All chemotherapy must be prescribed following one of these regimen protocols. They are stored on the St Luke’s Cancer Alliance website: http://stlukescanceralliance.co.uk/

The only exception being in exceptional cases, where the patient’s condition necessitates use of the ‘off-protocol process’ (as previously described).

Once a new regimen has been commissioned, there will typically be a 30-day implementation period to allow time for the:

- Treatment protocol to be written and approved
- Template prescription to be written, validated and approved on Aria
- Aseptic Unit worksheet to be produced, as relevant
- Staff training to be completed (where necessary)
- Medicines to be added to the Pharmacy system, minimum order levels set and stock ordered (where necessary)

Once all of the above have been completed satisfactorily, the Oncology Pharmacist with responsibility for treatment protocols will e-mail confirmation to the relevant Oncology /
Haematology medical staff that the protocol has now been approved for recruitment of patients.

Each regimen protocol will contain the following details:

- Cancer type;
- Name of regimen and therapeutic drugs used;
- Therapeutic intent; palliative, neoadjuvant, adjuvant, radical, as applicable;
- Doses of therapeutic drugs including maximum cumulative doses where applicable;
- Routes of administration
- Number of cycles of whether this is indeterminate;
- Length of cycle and number and timing of administrations within a cycle;
- Tests required before starting a course and prior to an individual cycle;
- Supportive drugs with each cycle;
- Therapeutic drug dose modifications and their indications;
- Main toxicities and specific measures to be taken to minimise toxicity:
  - Emetogenic potential
  - Extravasation classification

The regimen protocols are updated at least every 2 years.

The incorporation of regimen protocols onto the electronic prescribing system is agreed by the Head of Service.

**Practice Guidelines and Protocols (B15/S/a/itc-16-cc-010)**

Other useful protocols can be found as follows:

- **Cytotoxic administration techniques**

- **Care of venous access devices, including the treatment of line complications**
  See Trust policy for the care of IV access devices - available on the Trust intranet.

- **Use of drug delivery devices**
  Baxter infusion pumps are in use throughout St Luke’s Cancer centre for administration of all intravenous infusions including chemotherapy. All staff must be competent in the safe operation and application of the pumps. On induction, all staff are trained to ensure competency to manage the safe use of the Baxter infusion pumps. Written records of induction and training are kept by each department manager.

- **Use of devices to prevent alopecia**
  These are offered to patients where scalp cooling is recommended in the regimen protocol. The manufacturer’s instructions are used and followed. All staff undertake
training in the use of these devices prior to them being used in practice.

- **Use of haematopoietic growth factors (G-CSF)**

- **Use of blood and blood products**
  See Trust guidelines within the RSCH Local Clinical Protocols ‘Red Book’.

- **Resuscitation**
  Resuscitation trolleys are in the SLCC Chemotherapy Outpatients corridor and on Onslow/Chilworth Day Unit shared ward area. The replacement process for all Emergency Kits is as follows: kits are replaced at expiry and after use, they are sent back to the RSCH pharmacy department for replacement. Expiry dates are checked on a weekly basis on Chilworth Day Unit and on Onslow Ward.

- **Dose Banding tables**
  At SLCC cytotoxic drugs are prepared in doses according to agreed dose bands as per Trust guidelines for ‘Dose Banding of Chemotherapy Drugs’ - available on the St Luke’s Cancer Alliance website: [https://stlukescanceralliance.co.uk/dose-standardisation-of-chemotherapy-drugs/](https://stlukescanceralliance.co.uk/dose-standardisation-of-chemotherapy-drugs/)
  For electronic prescriptions, the dose banding is applied automatically based on the dose banding tables in the ‘Security’ module of the Aria system. When a pharmacist clinically checks a paper prescription they will endorse the prescription chart with the nearest dose banded dose, and sign and date the entry. The prescriber does not need to countersign this entry.

- **Spillage of chemotherapy**

- **Guidance on NHS patients who wish to pay for additional private care**

**Guidelines and Protocols for Systemic Therapy Acute Oncology Presentations (B15/S/a/itc-16-cc-011)**

- **Recognition and treatment of allergic reactions including anaphylaxis**
Anaphylaxis kits are stored in the Treatment Preparation rooms on Chilworth Day Unit and Onslow ward.

- **Management of CMV**

- **Management of diarrhoea**

- **Recognition and treatment of cytotoxic extravasation**
  There is an extravasation kit in each bay on Chilworth Day Unit and on Onslow ward.

- **Management of hypomagnesaemia**

- **Immunotherapy-related adverse events**

- **Use of Low Molecular Weight Heparins (LMWH) and Direct Oral Anticoagulants (DOACs) in adults with cancer / malignancy**

- **Prevention and management of oral mucositis**

- **Use of anti-emetics with chemotherapy**
• **Neutropenic sepsis pathway**
  See Cancer Alliance Neutropenic Sepsis Guidelines – on St Luke’s Cancer Alliance website:

• **Management of Palmar-Plantar Erythrodysesthesia (PPE)**
  See Cancer Alliance PPE Guidelines – on St Luke’s Cancer Alliance:

• **Prevention and treatment of tumour lysis syndrome**
  See Cancer Alliance Tumour Lysis Guidelines – on St Luke’s Cancer Alliance website:
  [https://stlukescanceralliance.co.uk/wp-content/uploads/2015/10/Tumour-Lysis-Syndrome-V4-12.15.pdf](https://stlukescanceralliance.co.uk/wp-content/uploads/2015/10/Tumour-Lysis-Syndrome-V4-12.15.pdf)

• **Regimen specific complications**
  See individual chemotherapy regimen protocols - on St Luke’s Cancer Alliance website

All the guidelines and protocols previously referred to are common throughout the Royal Surrey County Hospital NHS Foundation Trust.

**Treatment Records Prior to a Course and Cycle**

There will be treatment records for each patient prior to the start of a course of SACT; the following information will be included:

- Patient identification;
- Weight, height, body surface area;
- Cancer type;
- Treatment intention;
- Regimen and doses;
- Route of administration;
- Number of cycles intended;
- Frequency of cycles and of administrations within a cycle;
- Investigations necessary prior to starting the whole course;
- Investigations to be performed serially during the course;
- Number of cycles after which the response to treatment is to be reviewed;
- Attendances managed by agreed non-medical staff (nurse-led).

There will be a treatment record prior to commencing each cycle that includes:

- The results of essential serial investigations applicable to that cycle (and prior to an administration within a cycle, if applicable);
- Any dose modifications and whether or not they are intended to be permanent;
- Any cycle (or administration) delays;
• Any introduced support drugs not recorded in the treatment record prior to the start of the course;
• Performance status (using WHO system);
• Any toxicities following the previous cycle (using NCICTC grading system).

**Treatment Plan and Summary (B15/S/a/itc-16-cc-017)**

A treatment plan is sent to the GP prior to commencing a course of SACT in the form of a clinic letter. This includes:

- Treatment regimen;
- Planned start date;
- Planned duration;
- Treatment intent - palliative, curative, adjuvant, neoadjuvant, other.

There will be a treatment summary for each patient after the final course of treatment has been administered. This is in the form of a clinic letter and is copied to the patient’s GP. It will include:

- Whether the course was completed or not;
- If not completed – the reasons for cessation:
  - Toxicity
  - Sub-optimal response (for non-adjuvant treatment)
  - Disease recurrence during adjuvant treatment
  - Others, or combination of the above.
- For completed courses of non-adjuvant therapy a reference to the response.

A copy of the summary is offered to the patient and sent to the patient’s GP and any other relevant health-care professionals.

**Electronic Prescribing (B15/S/a/itc-16-cc-012,013)**

The Clinical Chemotherapy Service uses the Varian electronic prescribing system (Aria Medical Oncology) that fulfils the following:

- It enables electronic prescribing using approved protocols;
- It has replaced manual prescriptions as the default for the CCS;
- It provides an auditable record of chemotherapy, prescribed and administered; the record encompassing mandatory chemotherapy dataset;
- It enables data extraction.

The trained Super Users of this system are responsible for training other members of staff within their professional group. There is supplementary user-support via the electronic prescribing system manager and their team.
Manual prescriptions are available for use in an emergency if there are faults with the electronic system. A business continuity plan is in place to guide clinical staff through the alternative processes in the event of a system failure.

The system has unidirectional interfaces from the Trust PAS system (APAS) and the Trust Pathology system (ICE). These allow electronic transfer of demographic information and blood results. The system enables the electronic transportation of prescriptions from clinic to pharmacy and then to the designated area for administration of treatment. This removes the need for manual transcription.

There is deliberately no procedure for manual patient registration or entry of blood results in order to ensure accuracy of the dataset. The PAS interface for entry of patient details would always be working if the system was working – and otherwise the business continuity contingency procedure would be implemented. If the blood results had not come into the system via the Pathology interface, the ICE printout would be filed in the patient notes, and used as the source of information.

The system is not currently able to support an interface to the Pharmacy JAC dispensing system.

The standard operating procedure for the process of consideration of suggested new variations to the system’s use, including new regimens and/or modification of regimens is summarized as follows:

As part of the regimen protocol approval process, the Protocol Pharmacist will pass all new and amended protocols to the Lead Electronic Prescribing Pharmacist (Chemotherapy). This will then allow the regimen/amendments to be added to the electronic prescribing work plan thus ensuring they are incorporated onto the system. This is agreed by the Head of Service.

The full procedure is accessed via the following link:
G:\Shared\Operations\Pharmacy\RTOPD\ePrescribing\SLCC Pharmacy ePx Procedures

The uploaded prescriptions undergo a validation process before being authorised for use in the live system. This process involves Pharmacy, Lead Chemotherapy Nurse and the Tumour Site Lead Clinician. The standard operating procedure is accessed via the Pharmacy G drive as per previous link.

**The Chemotherapy Pathway (B15/S/a/itc-16-cc-014,015,016,020)**

**Patient Identification Procedure (B15/S/a/itc-16-cc-014)**

Patient identification is checked at the following stages in the pathway:

- At each clinic attendance (by Healthcare Assistant or doctor);
- By pharmacy when giving out medication to a patient or carer (Pharmacist or Pharmacy Technician);
- By nursing staff prior to each administration of IV or oral SACT (chemotherapy-trained Nurse).
This is performed by asking the patient to identify themselves by their full name and date of birth. Where any difficulty in communication exists, support would be sought from relatives or carers attending with the patient.

If any discrepancy is found, an explanation would be given to the patient and instead the correct patient sought. If any untoward consequence of the error had occurred, this would be escalated to the responsible line manager for further investigation and action i.e. Consultant, Outpatient Nurse Manager, Oncology Outpatient Pharmacy Manager or Day Services Manager.

**Referral Process for Chemotherapy**

- SACT will be chosen as the treatment modality for a patient by their consultant, depending on the known responsiveness of the tumour, stage of spread, age and general fitness of the patient. Patients may be entered into clinical trials that involve SACT and for these the trial protocol must be read, understood and followed.
- All patients who require administration of SACT in the SLCC at RSCH must be referred for treatment using the Trust Chemotherapy Referral Form. This must be completed and signed by an Oncology/Haematology-Oncology Consultant, Associate Specialist, Staff Grade or ST3 Grade and above. NB the decision to initiate SACT is always made at Consultant level.
- The referral will be reviewed by the Oncology Administration Team to collect Cancer Waiting Times target data.
- The referral will be reviewed by a Specialist Pharmacist to ensure a chemotherapy protocol and funding arrangements are in place for the requested regimen.
- Attendance to SLCC will then be organised by the Chemotherapy Treatment Coordinator in liaison with Senior Chemotherapy Nurses, dependent upon the organisation of pre-chemotherapy investigations as required.
- Details for attendance will then be forwarded to the patient by post or telephone.

**Pre-treatment consultation (B15/S/a/itc-16-cc-020)**

All patients will be offered a pre-SACT assessment appointment with a specialist chemotherapy nurse to undertake this holistic assessment and ensure all investigations have been completed prior to the patient’s arrival to start chemotherapy. Subsequent assessments may be initiated at the patient’s or carer’s request, by a member of the multidisciplinary team during a treatment or review appointment or following a change in management plan/treatment or delivery of bad news.

This appointment is for the patient individually and their carers, not as part of a large group. It takes place separately from other consultations after the treatment plan has been agreed. A designated time of 20 minutes - 1 hour are allowed for this process.

In addition to the assessment and documentation of physical needs all patient and carers are offered an assessment of the following:

- Perceived psychological needs
- Emotional needs
- Psychosexual needs
- Social needs
At this point, the patient is provided with:

1. A ‘Chemotherapy Record’ booklet that provides:
   - The treatment plan;
   - 24-hour contact details;
   - A record of treatments administered;
   - Side effects associated with the regimen and how they may be assessed and what to do in an emergency;
   - Information regarding infections and how to avoid them;
   - Information on sex, pregnancy and family planning;
   - Advice on what to report to doctors when attend clinic / if issues arise at home;
   - Information on medicines to take home.

2. A ‘Neutropenic Sepsis Alert Card’ that provides:
   - Advice on how to get fast track access to emergency care if necessary;
   - Advice for healthcare professionals on how to recognise and treat chemotherapy-induced neutropenic sepsis.

3. (If applicable) An ‘Immunotherapy Alert Card’ that provides:
   - Advice on how to get fast track access to emergency care if necessary;
   - Advice for healthcare professionals on how to recognise and treat complications of immunotherapy treatment.

4. Information relating to other complications of chemotherapy that includes:
   - Cytotoxic extravasation;
   - Nausea and vomiting;
   - Stomatitis;
   - Other mucositis and diarrhoea;
   - Other complications that are regimen-specific e.g. peripheral neuropathy.

The holistic assessment is reviewed prior to each cycle of chemotherapy, at regular intervals and documented on each occasion. Follow up arrangements and support for the ‘end of treatment’ and rehabilitation phases are arranged before the last planned cycle of treatment.

**Checks prior to the Prescription of the First Cycle (B15/S/a/itc-16-cc-015)**

The referring member of Oncology/Haemato-Oncology medical staff (grade ST4 and above or Speciality Doctor with at least 1 year Oncology/Haemato-Oncology experience) should undertake at least the following checks prior to prescribing the first cycle:

- History of specific diseases or conditions affecting fitness for chemotherapy. This includes that the minimum physical and investigational requirements have been met;
- Performance status;
- Prior history of chemotherapy;
- Current patient medication affecting chemotherapy;
- That informed consent has been obtained;
• Regimen against departmental protocols;
• That a holistic assessment has been carried out.

This data is recorded in specific fields in the electronic prescribing system. The electronic prescribing system manager identifies any gaps in data and liaises with medical colleagues to ensure 100% data compliance.

**Checks prior to administration (B15/S/a/itc-16-cc-016)**
These occur at the following stages in the pathway:
• Prescribing ("Pending" on Aria)
• Confirmation ("Approved" on Aria)
• Verification (by Pharmacy)
• Administration

Any omissions or errors within the checking procedures described below will be referred to the appropriate medical team or other professional lead for action. Members of the MDT should always have all the necessary documentation and other information available to them at the point at which the checks are made. If any information is missing (e.g. medical notes, consent form), the pathway should be halted until the necessary information becomes available.

If at any point during the patient pathway, a member of the clinical team identifies that a patient is unfit for treatment on the intended date, they should take the following course of action (according to the status of the SACT prescription on Aria):

<table>
<thead>
<tr>
<th>Point of Detection</th>
<th>Status of SACT Prescription (on Aria)</th>
<th>Action in the event patient is unfit for treatment on the intended date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical team (Medical staff and Nursing)</td>
<td>PENDING</td>
<td>Refer to relevant Consultant team to delete pending prescription. Make a note stating that patient not currently fit in Aria Notes.</td>
</tr>
<tr>
<td></td>
<td>APPROVED (not yet processed by Pharmacy)</td>
<td>Refer to relevant Consultant team to ensure that prescription is deleted. Make a note stating that patient is no longer fit in Aria Notes.</td>
</tr>
<tr>
<td></td>
<td>DISPENSED (has been clinical pharmacist approved and dispensed on Aria)</td>
<td>Inform Clinical Pharmacist team in screening room who will take action as below, depending on supply location(s): Aseptic Unit – if not yet released to clinical area, prescription to be cancelled. If released, discuss with clinical team to confirm action to be taken (e.g. if dose modification required, original dose must be removed from clinical area). St Luke’s Dispensary – if not yet released to clinical area/ patient, prescription to be cancelled. If released, discuss with clinical team to confirm action to be taken (e.g. if dose modification</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>DISPENSED</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>As an additional precaution, the St Luke’s Dispensary will check all dispensed SACT prescriptions awaiting collection and highlight to the Clinical Pharmacist team any which have been waiting &gt; 14 days from the intended treatment start date. The Clinical Pharmacist team will then inform the relevant Consultant team and take further action on their advice according to whether still clinically appropriate for the patient to start treatment, or whether the Aria prescription should be cancelled and medicines returned to stock.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prescribing**

All SACT prescriptions are electronically prescribed. The patient has a chemotherapy folder within their healthcare record which includes the chemotherapy referral form, consent form and nursing documentation. The Chemotherapy Referral and Consent forms are also electronically scanned into the electronic prescribing system by the Chemotherapy Referrals Team. There is an ‘electronic prescribing front sheet’ to act as a summary of treatment to date and aid communication between members of the team. To aid non-chemotherapy trained nurses on Onslow Ward to administer supportive medication, the electronic prescription is printed and kept in the folder (for inpatients only).

At the time of prescribing it is important to liaise with other healthcare staff to co-ordinate the timing and administration of chemotherapy, particularly if a one-off protocol is used.

The checks done prior to prescribing include:

- **Basic observations** include patient’s height and weight (for BSA and dosage calculation) and performance status. Chemotherapy is often given over several cycles. The patient is reweighed prior to each cycle of treatment and the dose adjusted if necessary according to Alliance guidelines: https://stlukescanceralliance.co.uk/wp-content/uploads/2015/10/Monitoring-of-Patient-Weight-policy-V3-12.15.pdf

- **Clinical staging** is normally completed by medical staff prior to starting therapy (including size and site of tumour, lymph node involvement, involvement of other organs, special investigations such as cytogenetics). A clear record that a satisfactory tissue diagnosis has been made is generally available before starting treatment. Before each cycle the patient is usually reassessed to determine whether a clinical response is being achieved or whether there is disease progression despite therapy.
**Essential Investigations and Tests** are specified within each chemotherapy protocol. This includes blood tests, such as FBC, renal and hepatic function, and other investigations, such as blood pressure, urinalysis, EDTA, echo.

It is important to check results and, if abnormal, to confirm whether any dosage modifications are required before initiating treatment.

The acceptable time frame for blood tests before starting a course of treatment, and also before each subsequent dose, has been agreed as below:

- The essential blood tests listed in the chemotherapy protocol should be performed within 28 days of starting Cycle 1*; and within 3 days** of Day 1 of subsequent cycles of SACT, provided no other treatment is given within this window.

  * Care should be taken with patients in an unstable condition; in such patients, investigations may need to be repeated closer to the treatment date than usual, as specified by the prescribing clinician.

  ** For doses given within a cycle (e.g. Day 8, Day 15), any essential blood tests required are ideally performed 1 or 2 days in advance

  ** For continuous anti-cancer therapy (e.g. daily oral dosing, or weekly pulses) with no cyclical nadir, essential blood tests may be performed within 7 days# of subsequent cycles
  (*within 14 days for CML patients, and myeloma patients on iMiD, bortezomib- or daratumumab-based treatments)

  ** For patients seen in St Luke’s clinics on a Thursday or Friday and not receiving treatment until Monday (Thursday clinics) or Tuesday (Friday clinics), 4 day old bloods are acceptable.

  * For patients switching from one regimen to another with no significant break, then essential blood tests should usually be performed within 3 days of Cycle 1 of the new course of treatment.

The above time frames allow for SACT to be prepared and delivered in time for the administration appointment, and should not normally need to deviate from the specified day in the protocol more than as agreed above.

**For St Luke’s Cancer Centre, the locally agreed exceptions to the above time frames are:**

- Haematology chemotherapy prescribed in the haematology Wednesday pm clinics may be administered the following Monday, and so using 5-day old blood results, if agreed with the patient’s haematology consultant.
- Haematology chemotherapy prescribed in the haematology Tuesday pm clinics may be administered on the Friday, using up to **5-day old** blood results (as some patients have their blood tests done on Mondays), if agreed with the patient’s haematology consultant.

- Azacitidine may be prescribed using a maximum of 7-day old bloods

**Radiology and other investigations** depend upon tumour type but often include CT scans, MRI scans, imaging of affected bones and assessment of cardiac function with ECG +/- ECHO/MUGA, EDTA GFR. The Nurse will confirm that any relevant radiology or investigations are completed as per the protocol.

Provided all above criteria are satisfactory, chemotherapy is then prescribed as per the regimen protocol on the chemotherapy referral form, consent form and initial clinic letter.

**Confirmation (= Approval)**

Once the SACT prescription has been prescribed the prescription also needs to be confirmed (= approved on Aria) by a competent member of the nursing or medical staff using the following pre-administration check list (also see the ‘Pre-treatment assessment requirements’ section in the Cancer Alliance Cytotoxic Policy):

- The patient is fit for treatment, e.g. blood results, etc.
- Regimen and individual drug identification;
- Supportive drugs have been prescribed;
- Administration route and duration;
- Cycle number;
- Performance status;
- History of toxicities and complications from previous cycles;
- Minimum monitoring requirements have been met;
- Dose modifications or delays as per protocol and in accordance with the patient’s condition;
- Response assessment according to the relevant regimen and treatment intention;
- Patient consent;

Once the chemotherapy prescription has been confirmed, all inpatient and day care SACT prescriptions will be clinically checked (verified) by an oncology pharmacist following the Oncology Pharmacy procedure ‘Clinical checking of chemotherapy prescriptions’.

**Verification**

At the point of prescription verification, the specialist pharmacist will check the following:

- Critical test results;
- Regimen and individual drug identification;
- BSA;
- Doses;
- Diluents and dilution volumes, and any hydration;
- That supportive drugs have been prescribed;
- Correct administration route and duration;
- Cycle number
- Administration as per the schedule within the cycle;
- History of toxicities and complications from previous cycles;
- Minimum monitoring requirements have been met;
- Dose modifications or delays as per protocol and in accordance with the patient’s condition;

**Administration by Nursing Staff**
The nursing verification procedure is to be performed prior to each administration of intravenous chemotherapy. Two nurses who are trained in intravenous drug administration, one of whom is trained in chemotherapy administration perform this procedure. In exceptional circumstances this may include a chemotherapy trained nurse and a Doctor.

The checks performed prior to administration include:
- Check the consent form and prescription are in accordance with the chemotherapy referral form;
- Check pre-chemotherapy investigations have been completed and results reviewed.
- Be aware of history of toxicities and complications from previous cycles;
- That the minimum monitoring requirements have been met;
- Be aware of dose modifications and delays from previous cycles;
- Be aware of the side effects of all the drugs to be administered.
- When the protocol contains pre-medications, hydration and other supportive medication, ensure that these are prescribed and given in line with the protocol.
- If the injections or infusions have been stored in a fridge they must be allowed to reach room temperature before administration to a patient. This is to reduce the risk of infusion bags splitting during insertion of the giving set, and to reduce venous spasm.
- With another chemotherapy trained nurse check the chemotherapy syringes and/or bags against the prescription as follows:
  - (If there is a discrepancy, contact the Pharmacy Cytotoxic Reconstitution Unit or, out of hours, the on-call pharmacist).
- The patient’s name and hospital number must correspond with prescription and label.
- Cytotoxic medicines must be administered on the date stated on the prescription.
- The name of the drug and infusion fluid on the prescription and the pharmacy label must be identical.
- The volume of fluid prescribed must correspond to the volume stated on the label OR the volume of fluid in a syringe must correspond to the volume stated on the label.
- If multiple syringes are used to make up one cytotoxic dose, the total dose contained in the syringes must be added up to check that it corresponds with the prescribed dose.
- Check the patient identity by asking them to confirm their name and date of birth to ensure that it corresponds to the prescription chart. For inpatients this would also include checking these details against the identity wrist band.
- Check the patient’s allergy status by asking them if they have any known allergies.
- Check the route of administration is the same on the label and the prescription.
- As the chemotherapy doses are checked against the prescription, they should be placed directly in to an individual patient tray.
- The tray should not be left unattended once checked.
• If the checking process is interrupted at any point, staff should be vigilant for this, and the whole process should be restarted.
• There should be a final check involving the patient of the details on each syringe/bag of chemotherapy against the prescription immediately prior to administration.
• Check all doses for particulate contamination, e.g. precipitation, before administration.
• Explain the procedure to the patient, and ensure that written information has been provided and understood.
• Flush well with appropriate compatible intravenous diluent prior to, in between, and after drugs have been administered.
• Ensure the care episode has been documented including signing for all medication administered.
• Prior to discharge, ensure the patient has adequate supplies of all the necessary supportive medication as well as follow-up appointments and blood request forms.

The details on the chemotherapy prescription chart will include:
• The patient's name
• Date of birth
• Allergy status
• The date for administration
• The regimen, the frequency of administration & cycle number
• The route of administration (see guidelines for intrathecal administration)
• The dose
• The diluent, dilution volume
• The date of preparation
• Expiry date
• Rate of delivery e.g. slow bolus/mls. per hour over ‘x’ hours

The details on the chemotherapy medication label will include:
• The patient's name
• Hospital number
• Date of birth
• The route of administration (see guidelines for intrathecal administration)
• The dose
• The diluent, dilution volume
• The date of preparation
• Expiry date

Cytotoxic medication that is added to an infusional bag of fluid is labelled with the above details. These details are checked as well as the expiry date of the bag of fluid. Although not always written on the prescription chart the nurse administering the cytotoxic medication also notes the type of fluid.

If any of details are missing or incorrect the pharmacy department must be contacted.

*If in doubt, do not proceed.*
24-hour telephone advice service (B15/S/a/itc-16-cc-022)

At SLCC the patient is advised to contact ‘The Chemotherapy Hotline’ accessed via the hospital switchboard 01483 571122 and asking for pager number 76-6516. This chemotherapy support service is provided by band 6 and above chemotherapy trained nurses during working hours. Out of hours, the specialist registrar on-call would be contacted via the hospital switchboard thus providing a 24/7 advice service.

If neutropenic sepsis is suspected, patients will be asked to attend their nearest A&E department immediately. The relevant A&E department and Acute Oncology Team will be phoned by the member of staff making that decision.

For patients receiving their chemotherapy at SLCC, RSCH must be their first contact point for advice, however they may be asked to attend their local A&E or Admissions Unit if urgent medical intervention is required (e.g. potential neutropenic sepsis). The Acute Oncology Team (based at the Cancer Centre with designated PA time allocated to working within the Units) within the local hospitals will see patients and can provide support to health professionals throughout the Cancer Alliance. Conversations of this nature take place between health professionals across the two sites, with the local Trust providing feedback to the patient. An Oncology Specialist Registrar is on call 24 hours a day to provide advice and support to primary and secondary health care professionals.

Provision of Patient Information (B15/S/a/itc-16-cc-023)

At the point of consent, in order that patients fully understand the nature of proposed treatment, information relating to the treatment intent, risks and benefits are given verbally and supported by the use of Macmillan Patient Information Leaflets by the medical practitioner responsible for the patient’s care, Consultant, Associate Specialist, Staff Grade or ST3 Grades and above.

During the new patient pre-assessment visit to the Nurse-Led Chemotherapy Clinic, information will be re-enforced by a chemotherapy-trained nurse verbally and supplemented with additional information to that they have already received e.g. diarrhoea, fluid managements for cisplatin, good mouthcare. The patient will be given advice on how to contact the 24 hour chemotherapy telephone advice service (the hotline). They will also be given information on:

- Neutropenic sepsis
- Cytotoxic extravasation
- Nausea and vomiting
- Stomatitis and other mucositis and diarrhoea

Full details of information given are included under ‘Pre-Treatment Consultation’.

A record of all information given to the patient should be made in the patient’s notes.
Consent Form (B15/S/a/itc-16-cc-021)

All patients receiving a new course of SACT should be provided with all the relevant information on the treatment intent, risks and benefits, in order to be able to make an informed consent on treatment.

Information should be given verbally and supported by the use of written patient information (Macmillan patient information should be used where possible; if not yet available for a particular agent, alternative written patient information for that drug should be sourced).

Information must be given initially by the Consultant or SpR responsible for the patient’s care, and will be reinforced by an appropriately trained chemotherapy nurse.

Full written consent should be obtained on the appropriate form, as defined by RSCH Trust Consent Policy. This should include the name of the regimen and the individual drugs being given. Patients should receive a copy of the signed consent form, and a copy is filed in the patient’s healthcare record.

St Luke’s Cancer Alliance Individual chemotherapy consent forms are available at http://stlukescanceralliance.co.uk/chemotherapy-consent-forms-for-solid-tumours/

RSCH Trust Individual chemo-radiotherapy consent forms are available in paper format.

Patient Experience Exercise

The CCS has undertaken patient experience exercises to obtain feedback on the patients’ experience of the services offered. These have been relating to chemotherapy closer to home, managing hair loss and Nurse led service information and the National Cancer survey.

The exercise here was to ascertain whether patients were offered:

- Patient information
- Assessment of their emotional, practical, psychological and spiritual concerns
- The opportunity of a permanent record or summary of a consultation.

Within the CCS work programme further work will be undertaken over the next year within this important area of service provision.

Systemic Anti-Cancer Therapy (SACT) Dataset (B15/S/a/itc-16-cc-018)

St Luke’s collects SACT data via the electronic chemotherapy prescribing system (Aria). This process is managed by the E Prescribing Systems Manager with information verified by the Oncology Pharmacy team. Data is presented as required for discussion at the Chemotherapy Working Party meeting.
Error Recording and Reporting (B15/S/a/itc-16-cc-019)

The CCS record and report errors according to the Trust error recording system. All incidents are discussed, reviewed and any outstanding actions agreed at the monthly ‘Chemotherapy Working Party’ meeting. This group then has a responsibility to report any significant incidents to the monthly Clinical Governance meeting where the associated action plan may be formalised.
**THE ONCOLOGY PHARMACY SERVICE**

**Service Leadership (B15/S/a/itc-16-cp-001)**

The designated pharmacists for the chemotherapy service are as follows:

Deputy Chief Pharmacist, Cancer, Aseptic and Research Services (Sally Seymour)
- Lead pharmacist for oncology pharmacy service
- Overall responsibility for cytotoxic chemotherapy
- Representative of the Chemotherapy Working Party on the Trust Drugs and Therapeutics Committee

Lead Protocol Development Pharmacist (Chemotherapy) (Susan Taylor)
- Overall responsibility for SACT and supportive care policies and protocols

Oncology Pharmacy Operations Manager (Helen Kimber)
- Overall responsibility for oncology pharmacy services to Chilworth Day Unit and St Luke’s Outpatient Department

Lead Pharmacist Haemato-Oncology (Man-Chie Chow)
- Overall responsibility for oncology pharmacy service to Onslow Ward

Senior Specialist Pharmacist, Aseptic Services (Nicola Hughes)
- Overall responsibility for the aseptic chemotherapy preparation facilities of the pharmacy service

Lead Pharmacist, Clinical Trials (Gaybrielle Livingstone)
- Overall responsibility for clinical trials

The lists of responsibilities of the named designated pharmacists have been agreed by the Lead Pharmacist and the Chief Pharmacist (**Appendix** 6 and 10).

**Aseptic Preparation Audit (B15/S/a/itc-16-cp-002)**

The Pharmacy Aseptic Unit is licensed and therefore is routinely inspected by the MHRA. The inspection report is provided as an Appendix to the Annual Report.

The small volume of section 10 work is inspected by the Regional Quality Assurance Specialist.

**Vinca Alkaloids (B15/S/a/itc-16-cp-003,004,005)**

The Trust Vinca Alkaloid Policy is accessed via the St Luke’s Cancer Alliance website: [http://stlukescanceralliance.co.uk/vinca-alkaloid-policies/](http://stlukescanceralliance.co.uk/vinca-alkaloid-policies/)
This Policy mandates that doses of vinca alkaloid chemotherapy supplied by the RSCH Pharmacy Aseptic Services Department (for both RSCH patients and external chemotherapy services) will be diluted as follows:

- Adults: all vinca alkaloids in 50ml minibag of sodium chloride 0.9% with the exception of vinflunine which is added to 100mL of sodium chloride 0.9%
- Adolescent patients treated in the:
  - Adolescent unit – as per adults
  - Paediatric unit – as per children
- Children: the vinca alkaloid is added to 20mL sodium chloride 0.9% in an appropriate sized syringe

The Trust does not give intravenous vinca alkaloids at higher concentrations than those stated above; therefore the waiver to the National Guidance on Vinca Alkaloid Dilution in Syringes does not apply (B15/S/a/itc-16-cp-005).
THE INTRATHECAL CHEMOTHERAPY SERVICE

Trust ITC Declaration (B15/S/a/itc-16-001)

The intrathecal chemotherapy (ITC) service is a single, undivided service across the whole Trust providing for:
Adult haematology patients
Adult oncology patients

Full details of the intrathecal chemotherapy service are found in the Trust ITC Policy. The master version of this is stored on the St Luke’s Cancer Alliance website: http://stlukescanceralliance.co.uk/intrathecal-chemotherapy-policies/

Leadership and Organisation (B15/S/a/itc-16-002)

The Trust ITC Trust Lead is Dr John de Vos (Consultant Haemat-Oncologist). He is accountable to Louise Stead (Chief Executive) for compliance with the national ITC guidance and the ITC Chemotherapy Measures (Appendix 11 – Accountability Agreement).

The Trust Intrathecal Chemotherapy Lead (Dr John de Vos) has overall responsibility for training (designated Lead Trainer), with regard to intrathecal chemotherapy.

The full list of responsibilities of this role and other delegated individuals are stated in section 3 of the Policy. The delegated individuals are named in Appendix 1 of the ITC Policy.

Case Volume and Risk Assessments (B15/S/a/itc-16-003)

The intrathecal chemotherapy workload is monitored by recording all procedures in a monitoring spreadsheet. This process is described in section 13 of the Policy. The storage location for this spreadsheet is included in section 13 of the Policy. The Delegated Clinical Pharmacist is responsible for monitoring workload and performing a risk assessment where appropriate – see section 3 of the Policy.

Training Policy (B15/S/a/itc-16-004)

The training policy is stated in section 6 of the ITC Policy. This includes both induction and registration training.

The list of authorised competency assessors for ITC related tasks is in Appendix 1 of the ITC Policy.
Waiver to the National Guidance on Administration by ST1 or ST2 Medical Staff (B15/S/a/itc-16-005)

The Trust does not allow ST1 or ST2 grade doctors to administer ITC.

Intrathecal Chemotherapy Register (B15/S/a/itc-16-006)

The Trust ITC Register is accessed via the Trustwide G drive:

G:\Shared\TrustWide\Intrathecal Chemotherapy\6 Intrathecal Register combined.

The process for maintaining and updating the register and ensuring only the most recent version is kept in the appropriate locations is described in section 13 of the Trust ITC Policy (on St Luke’s Cancer Alliance website as previous).

Sections 3, 5 and 6 of the Trust ITC Policy describe who can be registered to undertake the ITC tasks, the induction and registration training and how the annual re-assessment of competence is performed (on St Luke’s Cancer Alliance website as previous).

Registration Procedure (B15/S/a/itc-16-007)

This procedure is stated in section 3 and sections 5 - 12 of the ITC Policy.

Storage in Pharmacy (B15/S/a/itc-16-008)

Once final checked and released by pharmacy staff the ITC drug(s) will be issued/transported immediately. Individual intrathecal doses are not stored in pharmacy (as per section 10 of ITC Policy). Therefore there is no designated refrigerator in Pharmacy.

Issuing of ITC drugs (B15/S/a/itc-16-009)

This procedure is stated in section 11 of the ITC Policy.

Sequencing of IV and IT Chemotherapy (B15/S/a/itc-16-010)

This procedure is stated in sections 7, 9 and 10 of the ITC Policy.

Labelling of ITC drugs (B15/S/a/itc-16-011)

This procedure is stated in section 9 of the ITC Policy.
Collection of ITC drugs (B15/S/a/itc-16-012)

This procedure is stated in section 11 of the ITC Policy.

Storage outside of Pharmacy (B15/S/a/itc-16-013)

Cytotoxics for intrathecal administration are transported in a dedicated box and are not removed until administration is due or the dose is transferred to the designated lockable fridge in the Haematology Room, Oncology Outpatients Level B. Only staff registered for this task on the Trust Intrathecal Chemotherapy Register may perform this task.

This procedure is stated in section 11 of the ITC Policy.

Designated ITC Room (B15/S/a/itc-16-014)

The designated ITC room is the Haematology Room, Oncology Outpatients Level B. The procedure for the use of this room is stated in sections 11 and 12 of the ITC Policy.

Local Intrathecal Protocol (B15/S/a/itc-16-015)

The Trust Intrathecal Chemotherapy Policy clarifies how the national ITC guidance (HSC 2008/001) applies to the RSCH ITC service (on St Luke’s Cancer Alliance website as previous). This policy defines who is permitted to carry out tasks involved with ITC, where the activities take place and where key documents relating to ITC can be found.

There exists an ‘Intrathecal Chemotherapy’ folder in all areas where ITC is dispensed, issued or used and where patients are admitted. These locations are:

- Onslow Ward
- Haematology Room, St Luke’s Outpatient Department, Level B
- Pharmacy Aseptic Services Department
- Oncology Pharmacy Screening Office, St Luke’s Cancer Centre
- Interventional radiology room 7

These folders contain:
- National ITC Guidance
- Trust ITC Policy
- Trust ITC Register

The ‘Master Intrathecal Chemotherapy Folder’ is kept by the Lead Pharmacist.

The process for maintaining and updating the policy and ensuring only the most recent version is kept in the appropriate locations is described in section 13 of the Trust ITC Policy (on St Luke’s Cancer Alliance website as previous).
ITC Administration within Normal Working Hours (B15/S/a/itc-16-016)

This procedure is stated in section 1 of the ITC Policy. Intrathecal chemotherapy is not given out of hours.

ITC Prescription Chart (B15/S/a/itc-16-017)

There is a purpose designed ITC prescription chart (on Aria) which must always be accompanied by a intrathecal chemotherapy questionnaire (also on Aria). An example Aria ITC prescription and Aria ITC questionnaire may be viewed on the Trustwide G drive:
G:\Shared\TrustWide\Intrathecal Chemotherapy\5 ITC Drug Chart and Questionnaire

ITC Checking Procedure (B15/S/a/itc-16-018)

The written ITC checking procedure is found in section 12 of the Trust ITC Policy (on St Luke’s Cancer Alliance website as previous).
**Higher Intensity Chemotherapy Facility**

**Designated Beds and Agreed Number of Single Rooms (B15/S/a/itc-16-chi-001)**

There are 13 available level II haemato-oncology cubicles, with en-suite facilities, based on Onslow Ward. Direct admission for these designated beds is negotiated through discussions with the Trust site nurse practitioner team and the haemato-oncology MDT. This is governed by the direct access policy.

Patients seeking direct admission would use the Trust emergency access, by contacting the on-call haemato-oncology team or Clinical Nurse Specialist or the Emergency Chemotherapy Hotline.

The full admissions policy for haemato-oncology patients is included in Appendix 12.

**Supporting Facilities (B15/S/a/itc-16-chi-002)**

The following facilities are available on site:
- CT scanning which is able to provide emergency CT;
- Bronchoscopy
- Intensive care;
- Renal support.

**Consultant Rota (B15/S/a/itc-16-chi-003)**

There is a Consultant rota which fulfils the following:
- it is staffed wholly by named consultants;
- it provides 24/7 cover for medical advice and/or presence in the facility when required;
- it has a minimum of 3 consultants on the rota;
- each of the consultants is a core member of a haematology MDT and provides inpatient care for the facility as part of their timetable during normal working hours

A sample Consultant rota is included in Appendix 13.

**Neutropenic Patient Staffing Ratio (B15/S/a/itc-16-chi-004)**

There is an agreed nursing establishment for the Haemato-Oncology ward (Onslow Ward) where designated beds enables the ratio of registered nurse to neutropenic patient to be maintained at a 1:2 ratio. Where there is an acuity score of 50 or above, the Matron would initiate additional staffing in-line with the DOH safe staffing acuity scoring method and actions. Currently the staffing allocation can be flexed to manage the case mix of haemato-oncology / neutropenic patient that requires higher intensity / acuity nursing. On the ward, staff work closely with the Intensive Care Outreach team for any specific / high risk patients to ensure their care is managed safely and appropriately and they receive the dedicated ratio of care required.
**Presence of Specialist Trained Nurse (B15/S/a/itc-16-chi-005)**

Onslow ward is staffed on a daily basis with nurses who have undertaken specialist training in oncology or haematology. Please see list below:

<table>
<thead>
<tr>
<th>Nurses with Specialist Oncology/Haematology Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carole Burrows</td>
</tr>
<tr>
<td>Karolina Kliczbor</td>
</tr>
<tr>
<td>Josie Balanga</td>
</tr>
<tr>
<td>Janice Quiambao</td>
</tr>
<tr>
<td>Claudia Catelo-Kepa</td>
</tr>
<tr>
<td>Sukantala Cox</td>
</tr>
<tr>
<td>Molly Markose</td>
</tr>
<tr>
<td>Maria Girard</td>
</tr>
<tr>
<td>Suwan Thapa</td>
</tr>
<tr>
<td>Alison Law</td>
</tr>
<tr>
<td>Jennith Rellin</td>
</tr>
<tr>
<td>Pobeda Ilieva</td>
</tr>
<tr>
<td>Jincy Korath</td>
</tr>
<tr>
<td>Kamana Rai</td>
</tr>
<tr>
<td>Ricardo Rodriguez</td>
</tr>
<tr>
<td>Dominique Desembrana</td>
</tr>
<tr>
<td>Jofemae Dumancas</td>
</tr>
<tr>
<td>Jenine Estabon</td>
</tr>
<tr>
<td>Irving Mangayao</td>
</tr>
<tr>
<td>Keizel Piemnentel</td>
</tr>
<tr>
<td>Jamille Fanoga</td>
</tr>
<tr>
<td>Helen Eustace</td>
</tr>
<tr>
<td>Kryss Perey</td>
</tr>
<tr>
<td>Leira Quirit</td>
</tr>
</tbody>
</table>

The nursing rota is produced using the e-rostering system whereby each nurse’s training is input into the database, and this ensures that when a rota is drawn up, the correct ratio of trained staff is present for each shift.

**Venous Access Specialist (B15/S/a/itc-16-chi-006)**

Donna Chaplin is the lead for the IV Therapy service across the trust. Donna and the Oncology PICC team are the Intravenous Nurse Specialists who oversee the outpatient day service for PICC insertion within oncology and place PICCs for haematology and oncology inpatients.

**Microbiology Advice (B15/S/a/itc-16-chi-007)**

Consultant Microbiologist advice from is available to medical staff managing the patients undergoing higher intensity treatment.
A daytime microbiology cover rota and an on-call rota (covering nights, weekends and bank holidays) is e-mailed to the RSCH switchboard by the Microbiology Department regularly (see sample rota in Appendix 14). This includes all contact details which can then be relayed to the staff seeking microbiological advice. Switchboard is kept informed when there are any changes made to cover arrangements.

**Clinical Audit of the Service (B15/S/a/itc-16-chi-008)**

The MDT will undertake an annual audit over a 12-month period to review:

1. The number of new cases for level II treatment.
2. The number of separate admissions to the hospital of patients who, while undergoing higher intensity treatment needed admission for the management of complications.
3. The proportion of those patients who were admitted initially to the designated beds as specified above

The results of this audit will be presented in the Annual Report.
CHEMOTHERAPY WORKING PARTY

TERMS of REFERENCE

Frequency of Meetings

The Chemotherapy Working Party will meet on a monthly basis. All members are asked to send deputies if unable to attend any meeting.

Membership

- Lead Clinician for Chemotherapy (Chair)
- Lead Clinician for Haematology
- Divisional Head of Nursing for Oncology
- Lead Chemotherapy Nurse
- Oncology Matron
- Oncology Outpatient Manager
- Day Care Services Manager
- Lead Haematology Nurse
- Acute Oncology Nurse
- Onslow Ward Manager
- Deputy Chief Pharmacist Cancer, Aseptic and Research Services
- Lead Protocol Development Pharmacist (Chemotherapy)
- Oncology Pharmacy Operations Manager
- Pharmacy Aseptic Services Manager
- Oncology and Medical Physics Specialty Manager
- Electronic Prescribing System Manager
Accountability

The Chemotherapy Working Party will be accountable to the Trust’s Drug and Therapeutic Committee. On quality management (including chemotherapy-related incidents) the group will report to the Oncology and Medical Physics Clinical Governance Committee. The Group will also report to the Cancer Alliance Chemotherapy Group via the Chair.

Terms of Reference

The team will be responsible for co-ordinating the multi-professional opinion across the service and be the final common path for advising the Head of Service on the following:

- Implementation of the Chemotherapy Service measures across the service;
- Record and monitor the instances of off-algorithm/off-protocol treatments which are not on the agreed list;
- Clinical governance, audit, quality assurance, quality control and documentation and investigation of incidents;
- Risk management;
- Change management, including introduction of new protocols, techniques and technologies;
- Maintenance of training and competency and matching staff functions to competency;
- Agree a list of acceptable regimens for the chemotherapy service at St Luke’s Cancer Centre. The list covers all agreed chemotherapy for solid tumour oncology and haemato-oncology given by the service;
- Agree a policy with the Cancer Alliance Chemotherapy Group for preventing the use of regimens not on the accepted list;
- Ensure the implementation of NICE Guidance on applicable chemotherapy treatment across the service, ensuring consistency with the rest of the Alliance;
- Develop, implement, review and evaluate new and existing policies and procedures relating to the chemotherapy service in line with local and national guidance;
- Agree a rolling programme for the review of all policies and procedures relating to the chemotherapy service;
- Initiate and agree a programme of clinical audit of the chemotherapy service;
- Prepare, consider and advise on plans for service developments and reconfiguration of chemotherapy services, taking on board the view of all stakeholders and users in the development of the service.

The terms of the Chemotherapy Working Party are agreed by the Head of Service for Chemotherapy of the Royal Surrey County Hospital NHS Foundation Trust.
Appendix 2: Pharmacy and Oncology Steering Group Terms of Reference

Pharmacy and Oncology Steering Group

Terms of Reference

Objectives of the Group

- To strategically and operationally manage all pharmaceutical aspects of the oncology service being delivered by the Trust Pharmacy or PharmCo services.
- To ensure the group has the correct representation from all relevant divisions and SBU’s to oversee performance and governance.
- To provide governance assurance in relation to the delivery of pharmaceutical services to both St Luke’s and Oncology inpatient service and where there are concerns to ensure entry onto the relevant risk registers and implementation of a recovery plan.
- To ensure future plans for oncology development and growth take account of pharmaceutical requirements to support the service.

Roles and Responsibilities of the Group

- To implement the agreed operational decisions discussed and agreed upon by the POPG and to ensure named individuals take accountability for delivery. To ensure a joint vision for oncology services across the two divisions which is then shared through the Executive Team.
- To act as the performance management group reviewing performance against agreed KPI’s between pharmacy and oncology services.
- To sign off agreed levels of activity over the financial year to ensure resource is in place to support anticipated activity.
- To ensure the management of risk through Datix and entry onto the relevant risk register including a recovery plan to manage the risk safely.

Membership of the Group

- Head of Nursing Oncology (Deputy Chair)
- Associate Director Oncology (Chair)
- Matron Oncology
- Associate Director Diagnostic & Clinical Services
- Chief Pharmacist / Deputy
- Oncology Pharmacy Operations Manager
- Clinical Lead Pharmacist for PharmCo
• Management Accountant Diagnostic & Clinical Services
• Research & Development Lead

**Quorate**
When there is above representation from Oncology / Pharmacy and PharmCo (75% of membership)

**Frequency of Meetings**
Monthly
Appendix 3: List of responsibilities of CCS Head of Service (B15/S/a/itc-16-cc-001)

Job Description

Job Title: Lead Clinician
Specialty: Medical Oncology
Base: Royal Surrey County Hospital FT
Accountable to: Clinical Director Oncology and Medical Physics SBU
Medical Director
Appraised by: Clinical Director

Job Summary:

The Lead Clinician is jointly responsible with the Specialty Manager for professional leadership of the Specialty and providing an efficient, effective and reliable clinical service. The responsibilities include clinical governance, professional direction, service planning and the leadership of staff within the specialty. He/she will work in partnership with the Specialty Senior Nurse and Specialty Manager, consultants and other senior staff in the Specialty, such as the Lead Oncology pharmacist, the Clinical Director and the Associate Director and Clinical Governance Facilitator to deliver a safe and effective chemotherapy service at St. Luke’s Cancer Centre which meets relevant National Peer review (IOG) guidance.

Main Duties and Responsibilities

Clinical Governance

Foster a culture that supports the processes of clinical governance and reporting of adverse incidents and the speedy resolution of complaints, with the aim of learning from these and taking action to minimise clinical risks.

Lead the initial investigation of serious clinical incidents within the Specialty, and co-ordinate the response to complaints concerning clinical issues.

Lead Specialty staff in working closely with the Trust’s Patient Advisory and Liaison Service (PALS) Officer to increase patient and carer involvement in the processes of clinical governance.

Encourage full participation by clinical staff in clinical effectiveness and audit to raise the standards of clinical care.

Service

Ensure that, as far as possible within available resources, clinical services provided by the multidisciplinary team meet volume and quality targets and that teams within the Specialty work across the Trust and across other health and social service organisations as effectively as possible.
Take a leading role in the development of the services of the specialty. Encourage members of the Specialty to think of alternative ways of working in implementing changes to practice and the delivery of relevant national guidance.

Take note of College and other professional guidance and in discussion with colleagues set appropriate professional standards within the Specialty. In conjunction with the Care Group Chair, establish appropriate objectives and policies for the Specialty including the implementation of NSF and NICE recommendations.

Maintain effective communication with the Oncology and Medical Physics Clinical Director, Associate Director and Specialty manager and with colleagues in other specialty business units.

Leadership and Management of Staff

Participate in staff appointment and appraisal procedures as appropriate and agree appointments within the Specialty.

Ensure all Specialty medical staff, including consultants, receive both corporate and specialty induction.

Ensure that career grade medical staff within the Specialty receive an annual appraisal and also have professional and personal development plans.

The Lead Clinician will be expected to take part, where appropriate, in disciplinary procedures for medical staff including leading initial investigation.

Training and Development

The Lead Clinician will be encouraged to attend funded formal training and development to enable him/her to fulfil the role. The exact form of the training will be tailored to individual needs after a personal training and development plan has been agreed. Suitable external training will be sourced through the NHS Leadership Centre, the British Association of Medical Managers, professional bodies and other appropriate agencies.
### Person Specification

<table>
<thead>
<tr>
<th>Essential Qualifications/Knowledge</th>
<th>Desirable</th>
<th>A</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant doctor or dentist employed by the RSCH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness and understanding of clinical priorities and professional standards</td>
<td>Membership of appropriate professional bodies in Specialty</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### Skills

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to provide leadership and direction to the specialty</td>
<td>4</td>
</tr>
<tr>
<td>Able to identify and foster best professional practice</td>
<td>4</td>
</tr>
<tr>
<td>Strong interpersonal skills and able to build and maintain constructive working relationships within the Specialty, the Care Group and with service users</td>
<td>4</td>
</tr>
<tr>
<td>Effective communication skills including influencing &amp; negotiation</td>
<td>4</td>
</tr>
</tbody>
</table>

### Experience

| | Substantive experience as a consultant Previous leadership or management experience |
|----------------|---------------------------------------------------------------------------------
| | 4 | 4 | 4 |

### Personal Qualities

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership and credibility</td>
<td>4</td>
</tr>
<tr>
<td>Self-motivated</td>
<td>4</td>
</tr>
<tr>
<td>Team player</td>
<td>4</td>
</tr>
<tr>
<td>Open minded &amp; willing to learn from elsewhere</td>
<td>4</td>
</tr>
<tr>
<td>Integrity</td>
<td>4</td>
</tr>
<tr>
<td>Energy, resilience &amp; drive to deliver targets</td>
<td>4</td>
</tr>
<tr>
<td>Willing &amp; able to balance managerial with clinical responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>Willingness to commit to Trust values</td>
<td>4</td>
</tr>
</tbody>
</table>

### TERMS & CONDITIONS:

Scope of Specialty/Specialties

Specialties included: Clinical Oncology

Terms & Conditions:
Appointment: Nominations sought by the Chief Executive and, if more than one candidate, interview by the Chief Executive (or Medical Director) and Care Group Chairman.

Term of office: 3 years, renewable with the agreement of the Chief Executive and Clinical Director.

Notice: The agreement can be terminated by either party with three months’ notice.

Hours /salary: Up to one fixed session per week or the equivalent superannuable salary depending upon the scope of responsibility.

Annual Leave: There is no additional entitlement to annual leave with this role.

Study Leave: There is no additional entitlement to professional or study leave with this role. The Trust’s study leave policy is to be followed for any requests for management courses, seminars and conferences.
### Lead Chemotherapy Nurse Job Plan – August 2019

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all clinical chemotherapy areas</td>
<td>Check all clinical chemotherapy areas</td>
<td>Check all clinical chemotherapy areas</td>
<td>Check all clinical chemotherapy areas</td>
<td>Check all clinical chemotherapy areas</td>
</tr>
<tr>
<td>Check Chemo Admissions Team for any Issues</td>
<td>Check Chemo Admissions Team for any Issues</td>
<td>Check Chemo Admissions Team for any Issues</td>
<td>Check Chemo Admissions Team for any Issues</td>
<td>Check Chemo Admissions Team for any Issues</td>
</tr>
<tr>
<td>Attend and participate in team meetings when held</td>
<td>Liaise with Systems Manager for any EP related issues</td>
<td>SLCC Service development / Transformation Group issues, i.e. scheduling, coding</td>
<td>Check E Prescribing System for any outstanding sign off for nursing staff</td>
<td>Evaluate weekly data from CDU Co-ordinator for pathway-related issues affecting patients attending CDU and liaise with LON on Monday</td>
</tr>
<tr>
<td>Handover with Lead Oncology Nurse</td>
<td>Work on JMGs for NLC &amp; liaise with Pharmacy</td>
<td>Check Chemo Admissions Team for any Issues</td>
<td>Policy development / Updates</td>
<td>Work in NLC as required to maintain prescribing skills</td>
</tr>
<tr>
<td>Check E Prescribing System for any outstanding sign off for nursing staff</td>
<td>Support Teaching Programme for Nursing Staff in all clinical areas</td>
<td>3 monthly Network Chemo Nurses meeting</td>
<td>Compile Data for deaths within 30 days and distribute to CWP group</td>
<td>Deputise for Matron for Oncology in acting as Senior Nurse cover for the Unit</td>
</tr>
<tr>
<td>Work on CDU to maintain clinical chemo skills monthly</td>
<td>Validation of Electronic prescribing regimens in pending</td>
<td>Monthly SACT data Approval</td>
<td>Undertake Annual Chemotherapy Competency Assessments</td>
<td>Validation of Electronic prescribing regimens in pending</td>
</tr>
<tr>
<td>SaSH / ASPH Outreach chemotherapy Project Meetings</td>
<td></td>
<td>Monthly Clinical Governance Meetings with Actions</td>
<td>Attend Cancer Centre meetings relating to the Transformation project for the Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Site visit / Telephone Contact with Ashford Chemotherapy Unit for support</td>
<td>Pharmacy and Oncology Steering Group with Actions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly Chemo Working Party (CWP) with Actions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Appendix 4: Work plan for CCS Lead Chemotherapy Nurse (B15/S/a/itc-16-cc-002)**
Appendix 5: List of responsibilities of CCS Lead Chemotherapy Nurse (B15/S/a/itc-16-cc-002)

The Royal Surrey County Hospital NHS Trust

Job Description

Job Title: Oncology Lead Chemotherapy Nurse
Band: 8a
Base: Royal Surrey County Hospital
Directorate / Care Group: Oncology/Medical Physics
Accountable to: Trust Head of Cancer Nursing
Professional accountability: Director of Nursing & Patient Experience
Manages: Chemotherapy Admissions Manager
Chemotherapy Admissions Co-ordinator

Job Summary

The post holder will be an expert practitioner in all aspects of chemotherapy and other anti-cancer therapies in the malignant setting. You will be responsible for extending the scope of nursing practice and developing an advanced level of professional autonomy and accountability in the provision of such care. As Lead Chemotherapy Nurse the post holder will be high profile within the organisation, will be accessible and responsive, with strategic responsibility for Oncology, Haematology and Trust Cytotoxic Chemotherapy Service delivery. By acting as the Lead Chemotherapy Nurse, the post holder will be responsible for maintaining quality standards in chemotherapy nursing across the Trust. The post holder will lead a programme of audit and research related to chemotherapy services within the Trust to evaluate clinical effectiveness and address the Health Care Governance agenda. The post holder will lead on education and research relevant to chemotherapy. The post holder will contribute to the Trust’s nursing and professional agenda and promote Royal Surrey County Hospital NHS Foundation Trust as a centre of excellence.

Main Duties & Responsibilities

Clinical

- To act as a role model and be recognized as an expert by colleagues
- To undertake a review of chemotherapy services within the Trust. Make recommendations to the relevant divisional and Trust wide groups. Identify issues which relate to risk management.

By reviewing:-
  - All current arrangements for chemotherapy delivery
  - The skill mix and work load
  - Process mapping the patients pathway
  - Implementing pre assessment for all chemotherapy patients
Ensuring compliance with cancer peer review measures

- To maintain clinical competency in administration of all cytotoxic drugs.

- Provide and maintain expert knowledge and practice in venepuncture, cannulation, central venous access devices, chemotherapy drugs and biological therapies.

- To be the Nursing Lead for Electronic prescribing for Chemotherapy, providing education, support and records of nurses that have undertaken training.

- Ensure effective use of advanced nursing knowledge and skills, relating to the specialty in order to enhance patient care delivery.

- Lead and formulate policies for the Trust and submit them through the Chemotherapy Working Party group.

- Develop and utilize nursing interventions deemed beneficial to patient care e.g. Telephone clinics, face to face nurse led clinics, aimed at improving the experience of cancer, for patients and families.

- To provide a lead for holistic assessment, implementation and evaluation of the individual Chemotherapy patients’ needs in collaboration with the multidisciplinary team, providing guidance, advice, support and counselling throughout the patient pathway and refer to other professionals for more specialist support as appropriate.

- To lead in the promotion of patient autonomy through education and support so that the individual can make informed choices about their own care.

- Ensure effective liaison between the cancer multidisciplinary teams and the clinical chemotherapy service by regular monitoring on waiting times for chemotherapy, capacity issues to streamline the patient pathway.

- To be seen as a clinical expert and act as a resource to all members of the multi professional teams working within the Trust.

- To be the Lead and have overall responsibility for the safe development of nurse led chemotherapy clinics.

- To extend skills to undertake Independent Nurse Prescribing.

- Communicate with patients and carers to effectively inform them of current treatments.

- Be aware of ethical dilemmas in patient care.

- Ensure all clinical care is evidence based and adheres to local and national Protocols.

- To attend and participate in the local Chemotherapy Group and Network Chemotherapy Meetings.

Teaching/Education

- To be responsible for the development, provision and evaluation of training in the administration of Cytotoxic agents.

- To lead the development of a validated and accredited educational programme for chemotherapy administration / chemotherapy nursing practice.

- Develop chemotherapy nursing competencies for the Cancer Centre in liaison with other key chemotherapy professionals and services in the local Cancer Network ensuring equity of standards.
• To provide annual updates in all aspects of chemotherapy practice to all staff administering cytotoxic agents

• To lead and co-ordinate the annual assessment of staff administering Cytotoxic agents in liaison with the Lead Oncology Nurse

• To promote positive links and a collaborative approach with the University of Surrey / European Institute of Health and Medical Sciences in the provision of innovative and high levels of education in chemotherapy practice.

• Provide support and training to all nurses, AHPs and support workers involved in the care of the chemotherapy patient.

• Provide support and training to primary care professionals involved in the care of chemotherapy patients whose treatment has been initiated at the Cancer Centre.

• To ensure equity of opportunity in providing professional development in chemotherapy which is responsive to service need.

• Co-ordinate and maintain records of study undertaken by staff.

Managerial

• To keep a register of all nurses competent to administer chemotherapy.

• To lead on policy developments for the chemotherapy service in liaison with the Head of Service, Lead Oncology Nurse.

• To promote the development of the chemotherapy services in line with the National Cancer Quality Standards.

• To participate in the Peer Review of Chemotherapy Services.

• To ensure guidelines and protocols relating to chemotherapy practice are up to date, evidence based, reflect National Guidance and that a system is in place for systemic review.

• Liaise with the Trust’s Health and Safety Advisor re an annual COSHH assessment of the chemotherapy service.

• To ensure the view of patients and carers are incorporated in all aspects of chemotherapy service provision.

• To develop, in liaison with the Cancer Centre team, patient information re the chemotherapy service and chemotherapy treatment in line with local Network and National Patient Information Strategy.

• To work with the Radiotherapy Services Manager and Lead Oncology Nurse to improve the service delivered to patients receiving chemo-radiation working within national guidance, research base evidence and recommendations.

• To act as a change agent promoting innovation in chemotherapy practice/services and develop the role of the nurse in the care of the chemotherapy patient including nurse led services.

• To attend and participate in the work of the local and Network Chemotherapy Service Groups and other relevant groups as delegated.

• Participate in service developments, business planning and service review of chemotherapy services.

• To monitor incidents and complaints relating to the chemotherapy service.
• To develop quality systems and approaches to reduce risk in chemotherapy service delivery.

• To organise and chair the SWSH network chemotherapy nurses forum.

• To liaise with the Oncology Network pharmacist about joint meetings of the SWSH chemotherapy nurses and oncology pharmacist throughout the network.

**Research/Audit**

• To promote and initiate research and audit of chemotherapy practice.

• To develop a rolling programme of audits into the chemotherapy services / practice.

• To actively seek to improve practice throughout the application of research evidence.

• To regularly audit the service so patient care is continuously improved and to ensure documentation and record keeping is comprehensively maintained.

• To contribute to Clinical Governance developments in line with the strategic developments of the trust.

**Professional**

• To act at all times within the sphere of the Nursing and Midwifery Council Code of Professional Conduct

• To be aware and adhere to trust policies and protocols

• To act as a professional resource to the team and colleagues

• To delegate appropriate responsibilities to enhance individuals’ level of practice and professional development.

• To ensure and take responsibility for own professional practice and knowledge in line with post Registration Education for Practice and Personal development Plan

• To develop and discuss with the clinical Lead, Trust Head of Cancer Nursing and Lead Oncology Nurse any innovative ideas for further development of the service

• To contribute to and comment on the trust aims and objectives including any business planning process required for provision of cancer chemotherapy services.

• Ensure all records are accurate, complete and permanent in line with Trust policy and NMC guidance

• Work collaboratively with colleagues internally and externally

• To actively participate in ongoing one to one meetings as a minimum quarterly with line manager to review development and performance

• To alert other team members and Clinical Lead of issues of quality and risk

**General**

The Royal Surrey County Hospital is a dynamic organisation; consequently, in discussion with the post holder, this job description may be altered from time to time.

The list of responsibilities for the post will be reviewed and agreed by the Head of Services (Chemotherapy), Lead Cancer Nurse and Oncology Matron and may vary to reflect Local and National Standards and Guidance.
Appendix 6: List of responsibilities of the CCS Lead Pharmacist 
(B15/S/a/itc-16-cp-001)

Pharmacy Department

JOB DESCRIPTION

POST TITLE : Deputy Chief Pharmacist Cancer, Aseptic and Research Services (CARS)
GRADE : 8c
DEPARTMENT : Pharmacy
Clinical Support Service : Pharmacy

MANAGED BY : Chief Pharmacist
ACCOUNTABLE TO : Chief Pharmacist
LIAISES WITH : All RSCH Pharmacy staff
                RSCH Senior Pharmacy Managers
                Trust staff including the Executive team
                SBU staff including Clinical Directors, Associate Directors,
                Consultants, nursing staff and AHPs
                Contracting and Finance staff
                Human Resources
                R&D, Cancer Networks, PCT Commissioners
                External customers

MANAGES : Senior Specialist Pharmacist (Oncology and Haemato-Oncology),
          Aseptic Services Production Manager, Lead Pharmacist(s) Clinical
          Trials, Lead Aseptic Services Pharmacist
**JOB SUMMARY**

- Lead, deliver, develop and evaluate the provision of the Pharmacy Cancer, Aseptic and Research Services (CARS) both within and external to the Trust in order to ensure that patients and commissioners receive the best quality and value service available.
- Ensure that systems are in place to control the operation of all CARS safely, effectively, efficiently and in compliance with all relevant legislation, Licenses, DH guidance, the Trusts Medicines Policy and Trust statements on Corporate Governance.
- Identify key development priorities, “sell” the vision for service provision and secure funding as appropriate.
- Lead the process for managing the entry of new cancer medicines into the Trust and act as representative to the local and regional cancer networks (SWSH and SEC).
- Lead the business planning cycle for the financing of oncology drugs, ensure chemotherapy is appropriately funded and that income for medication use is recovered from the PCT(s) by developing effective management systems for monitoring and reporting.
- Work as a highly specialist practitioner co-ordinating delivery of a comprehensive clinical pharmacy service to oncology, haemato-oncology and palliative care patients.
- Support St Luke’s medical and nursing staff in the development of protocol led, cost effective prescribing.
- Develop links with other healthcare staff to facilitate the sharing of best practice throughout the SWSHCN.
- Ensure that all Trust research involving medication is appropriately managed through the implementation of clinical trials policies and the appropriate contribution to the Trust R&D committee. Ensure that relationships with research networks (including CLRN) are developed in order to maintain staffing at optimal levels for continued clinical trial activity.
- Manage the Aseptic Services team to ensure a high quality and timely service to NHS and external customers that generates targeted income for the pharmacy and Trust.
- Act as the Lead Oncology Pharmacist when dealing with issues of the Paediatric Oncology Shared Care Unit Multidisciplinary Team; supporting the Designated POSCU Pharmacist in delivering the service.
- Ensure that CARS are adequately resourced and that pharmacy staff working within the specialty are trained and competent to undertake the duties required of them.

**RESPONSIBILITIES**

The Pharmacy Department is staffed by approximately 84 whole time equivalents with a staffing budget of £2.9 million.

St Luke’s Cancer Centre (SLCC) serves a population of 1.2 Million patients, of all tumour sites, from across the Surrey, West Sussex and Hampshire Cancer Network. The cancer service treats 75-100 chemotherapy patients per day. The oncology drugs budget is £8.4 million per annum (2009-10). Aseptic services produce 39,000 items per year with an annual turnover of £3.5 million in drug costs and £30K in consumables.

The Pharmacy is engaged in 63 active clinical trials as of August 2009.

**Leadership**

1. Proactively enable the development of the Cancer, Aseptic and Research Services (CARS) on a Trust-wide basis in line with local and national objectives. This will involve interpreting Department of Health (DH) policies and plans and making recommendations for implementation in the Trust.
2. Responsible for the identification, development and implementation of a vision for Cancer, Aseptic and Research Services (CARS) managed in line with the Clinical Governance agenda.
3. Effectively work across traditional boundaries to encourage and support the implementation of innovative new ideas. This may involve services nearer to the patients’ home or development or research or service collaboratives.
4. Continually review skill mix to meet service needs and professional standards in force at the time, reporting any deficits to the Chief Pharmacist with proposals for corrective action.
5. Keep informed of national developments within the fields of Cancer, Aseptic and Research Services (CARS) and ensure that appropriate developments are delivered at RSCH.
6. Assume the responsibilities described in the Trust’s Major Incident Plan specific to post and in the absence of the Chief Pharmacist, lead the Pharmacy Department response.
7. Lead the process for managing the entry of new cancer medicines into the Trust. This involves coordinating the activities of the cancer networks and PCT commissioners with the requirements of clinicians and patients.
8. Influence and negotiate with consultants and other stake holders to ensure that prescribing decisions take into account Network decisions and are based on both evidence and cost implications for secondary and primary care.
9. Provide leadership to the teams of Cancer, Aseptic and Research Services and support them when highly complex and contentious decisions need to be made around rationing and capacity issues.

Service Management

1. Ensure that CAR services are managed to meet legal and RPSGB (Royal Pharmaceutical of Great Britain) requirements e.g. Medicines Act, Misuse of Drugs Act.
2. Monitor and collate evidence relating to the Trust’s compliance to the relevant standards and legislative requirements e.g. RPSGB and MHRA. Ensure that any actions required are incorporated into the Pharmacy Business Plan.
3. Responsible for the adequate staffing of the CAR services. This involves:-
   - Ensuring capacity plans are in place
   - Designing shift patterns and rota templates
   - Ensuring that rules for annual leave approval are followed
   - Relevant staff recruitment, ensuring that the process begins at resignation and that Trust procedures are followed
   - Monitoring the use of bank and agency staff
   - Dealing with complex staffing difficulties, reorganising planned rotas, negotiating to borrow staff from other section managers and dealing with internal conflicts as they arise
   - Reporting on staffing, workload, service developments and risks to the Chief Pharmacist on a regular basis
4. Responsible for the provision and development of clinical pharmacy services to oncology, haematology and palliative care inpatients, day cases and outpatients within resources and in line with local and national cancer standards.
5. Oversee the safe implementation and ongoing maintenance of the chemotherapy e-Prescribing system within CARS.
6. Represent the Local Chemotherapy Group, as defined by the National Manual for Cancer Services, on the RSCH Drugs and Therapeutics Committee for oncology, haematology and palliative care patients.
7. Represent St. Luke’s Cancer Centre at the SWSH Cancer Network Chemotherapy Group and the South East Coast Cancer Drugs and Therapeutics Committee.
8. Responsible for ensuring safe, evidence-based, cost-effective prescribing of medicines used in oncology, haematology and palliative care patients.
9. Participate in meetings or working groups for the development of clinical services or policies relating to oncology patients as determined by changing need or local or national directives.
10. Co-ordinate, chair, take and distribute minutes and actively participate in these meetings, as appropriate.
11. Develop links with other healthcare staff to facilitate the sharing of best practice throughout the Surrey, West Sussex and Hampshire Cancer Network and disseminate throughout the Trust.
12. Liaise with Pharmaceutical company representatives and be responsible for disseminating knowledge of developments to other oncology clinical staff.
13. Provide a comprehensive aseptic service to the Trust and external customers, including chemotherapy, TPN, CIVAS and investigational medicinal products.
14. Manage the provision of aseptic services to external customers and further develop these services in accordance with the Trust’s business plans. Actively promote the service and seek new business opportunities, working closely with the Pharmacy Business Manager.
15. Ensure service level agreements (SLAs) are in place with external customers and ensure systems are in place for monitoring compliance on both sides.
16. Ensure the use of a chemotherapy dose-banding strategy within the Trust and encourage roll-out to external customers.
17. Line manage team leaders with CARS:
   - Lead and support them to review current services and employ innovative methods of service delivery, taking into consideration Medicines Assurance Framework, CQC Standards for Better Health and Trust Corporate Objectives
   - Ensure that they implement and evaluate the agreed pharmacy services for their area in collaboration with other senior managers where appropriate
   - Adjudicate on issues of service provision that may be contentious or controversial
   - Responsible for the development of staff managed through the departmental appraisal and personal development and review process
   - Responsible for managing senior pharmacy staff in line with Trust procedures for dealing with disciplinary, grievance and sickness when necessary
18. Responsible for ensuring investigation of all CARS incidents and complaints. In liaison with the Medication Risk Pharmacist ensure that “root cause analysis” is undertaken for all pharmacy errors within CARS and recommendations identified are acted on in a timely manner.
19. Act as a referral point for all pharmacy staff in the resolution of highly complex or contentious issues in the provision of all services under operational control.
20. Ensure the appropriate support for and detailed level of communication with all sections of the pharmacy (and the wider Trust) in order to deliver a co-ordinated service to patients and staff.

Strategy

Responsible for all aspects of planning and the long term strategy of the CAR Services as defined above

1. Deliver an annual business plan for the pharmacy services managed in order to ensure that all aspects of service development are highlighted and best practice is able to be implemented in the most appropriate and effective way.
2. Develop appropriate business cases for service development, secure funding and implement services changes in order to improve patient care and improve the efficiency of the services.
3. Report on all contributions of the services managed to senior managers and clinicians within the Trust, including risk management and budgetary issues.
4. Identify the risks associated with medicine management within CARS and at the interface with Primary Care and manage changes that will minimise these. This may require the change to what is regarded as existing standard practice and may require careful negotiation in order to overcome resistance in some instances.
5. Set standards for pharmacy services managed and identify and manage changes, which need to occur to achieve these, including the development and maintenance of policies and procedures e.g. aseptic and clinical trials procedures.
   - Effectively communicate such changes to all relevant personnel within the pharmacy and the wider Trust.
   - Evaluate the effects of such changes and ensure that the quality of services provided are recognised and have a high profile nationally.

6. Ensure that pharmaceutical issues are appropriately represented at the relevant Trust, PCT, regional and national committees and ensure that CAR services are considered in all Trust developments where appropriate.

7. Effectively contribute to the development and safe implementation of electronic prescribing packages into the Trust.

8. Effectively contribute to the development of all pharmacy services by active involvement in the pharmacy senior management team.

**Finance**

As a senior manager within the department the post holder is responsible for aspects of procurement and is able to sign orders and invoices to the following values:

- Pharmacy Orders to £50,000 per order
- Trust Orders to £5,000 per order

In addition the post holder is responsible for the monitoring and reporting on the following budgets:-

- Aseptics staff budget and non-PAY budget
- Oncology staff budget
- Clinical trials staff budget
- Clinical trials income
- Oncology drugs

1. Responsible for developing and maintaining accurate information systems which enable monitoring and reporting of expenditure of the above budgets.

2. Ensure that systems are in place and that the Finance Department is informed of any outstanding payments to enable accurate accruals to be made for monthly budget reports.

3. Contribute to negotiations regarding Service Level Agreements that affect the areas under operational control. Ensure that workload is monitored and does not exceed any Service Level Agreement or Contract without appropriate funding.

4. Ensure Pharmacy income from aseptic services external contracts is optimised. Advise the finance department of income generation potential for aseptic services for the forthcoming year and agree achievable income generation targets.

5. Responsible for ensuring a pricing structure for aseptic services is in place and regularly reviewed to ensure that agreed financial targets are met.

6. Ensure that all expenditure on cancer drugs is recovered from the relevant PCT by implementation of effective monitoring and management systems. Act as budget monitor for cancer drug expenditure. Communicate with Clinical Director, Associate Director Consultants and finance staff to report on drug usage and expenditure.

7. Responsible for horizon scanning for chemotherapy clinical practice in order to inform the Trust/PCT financial planning process so that the Trust is adequately re-imbursed for future trends and changes in work

8. Interpret statistics on drug expenditure obtained from the pharmacy computer database, in relation to clinical practice

9. Ensure that Pharmacy income from clinical trials activity is optimised.
10. Ensure that the relationships between drug expenditure in clinical trials, horizon scanning and business cases for service developments are seamless. Negotiate with commissioners to ensure that clinical trials savings are reinvested in the service.

11. Co-ordinate the delivery or service to external customers and ensure that optimal income is received for new services in the future.

**Clinical Practice**

1. Lead by example as a clinical pharmacy practitioner through the provision of a high standard service to a clinical area within the Oncology and Medical Physics SBU.

2. Act as the expert in the field of clinical oncology pharmacy services for the Trust and advise on issues relating to oncology pharmacy as appropriate.

3. Lead the production and updating of chemotherapy and supportive care protocol guidelines, Trust policies and specific proforma prescriptions in line with best clinical practice and national guidance (i.e. National Institute for Clinical Excellence, (NICE)) and ensure their implementation across the Trust.

4. Demonstrate advanced clinical knowledge and plan, manage and review therapeutic programmes (including chemotherapy regimens) to an advanced level:
   - Clinically review prescriptions for accuracy and legality and to ensure the safe, clinically effective and cost efficient use of drugs in patients as allocated
   - Proactively provide advice and information on any pharmaceutical issues to other healthcare professionals and pharmacy staff as needed in order to contribute to the treatment and care of patients.
   - To ensure each individual has a clear understanding of their medicines and support them in the appropriate use of them.
   - To manage patients’ pharmaceutical needs appropriately to ensure the clear and effective communication of patients’ pharmaceutical needs to other pharmacists and healthcare professionals both within the Trust and in other healthcare environments.
   - To follow legal, ethical, professional and employer code of conduct.
   - To ensure high quality patient care, including optimal outcomes and minimal adverse effects of medication use.
   - To demonstrate advanced clinical reasoning and judgement.
   - To demonstrate professional accountability to patients.
   - To demonstrate awareness and commitment to the Trust’s Clinical Governance Agenda.

5. ‘Lead Pharmacist’ for the Oncology Pharmacy Service provided at RSCH for the purposes of peer review against the DH Cancer Services Standards.

6. Lead on pharmaceutical standards encompassed in the DH Cancer Services Standards to ensure compliance with the National Peer review process for the Trust.

7. Provide highly specialised clinical and technical advice and medical information relating to oncology drugs to healthcare professionals, and the SWSHCN where there may be a lack of information and it may be conflicting or contentious.

8. Counsel and advise patients and/or their relatives with regard to their medication, including use of drugs, appropriate administration of oral chemotherapy and appropriate management of chemotherapy-associated side-effects e.g. nausea and vomiting.

9. Deal sympathetically with distressed or upset patients, those with poor understanding or communication difficulties e.g. after head and neck surgery or terminally ill patients.

10. Responsible for maintaining and updating the registers of competent individuals within the process of prescribing, dispensing and supply of intrathecal chemotherapy to haematology and oncology patients treated at the Trust, in line with National Guidance.
11. Maintain competency at a general clinical pharmacist level, in order to cover for duties of clinical pharmacists and dispensary pharmacists across the Trust, to include: clinical checking, final checking, and counselling patients regarding their medication.

12. Manage time effectively when there may be competing demands for attention and to work independently and accurately when under pressure.

**Education and Training**

1. Responsible for ensuring that all CARS staff undertake an appropriate induction according to Department Induction Policy.
2. Responsible for ensuring that all staff undertake accreditations relevant to their role according to Department Accreditation Policy.
3. Responsible for ensuring that all CARS staff undertake mandatory training, undergo an annual appraisal and have a personal development plan.
4. Identify and deliver on action plans to meet the training needs of all relevant staff to support the delivery of a safe, clinically effective, cost effective and innovative service.
5. Provide appropriate education and training to pharmacy and other Trust staff on all aspects of CARS roles e.g. policy implementation, awareness programmes and clinical expertise.
6. Maintain a highly specialised level of pharmacy practice by developing a Continuing Professional Development portfolio.
7. Effectively contribute to the adequate provision of post-graduate training and continuing professional development for pharmacists within areas of expertise.

**Research and service evaluation**

This role is responsible for the research programme within Pharmacy including the Pharmacy Clinical Trials function.

1. Apply the principles of Good Clinical Practice providing professional supervision in the management of clinical trials in line with the International Conference on Harmonisation, Good Clinical Practice European legislation
2. Ensure that the Pharmacy Clinical Trials Policy is developed and maintained and that all Trust staff complies with the content at all times.
3. Sit on the Trust R&D Committee as the Pharmacy Representative
4. Commission and participate in pharmacy audit projects and effectively contribute to multidisciplinary audit across the Trust e.g. NICE, Clinical Trials.
5. Undertake own pharmacy practice research; present at conferences and publish where appropriate.
6. Effectively contribute to research programmes being implemented within the Trust especially with respect to the medication component.
7. Guide and support others to deliver the corporate research agenda.
8. Responsible for pharmacy participation in auditing drug usage and the clinical pharmacy service to cancer patients.
9. Participate in research, quality and audit projects undertaken by the pharmacy department and the Oncology and Medical Physics SBU.
10. Effectively communicate the results of research / audit work and negotiate the implementation of any necessary change with all appropriate staff across the Trust.
11. Ensure that key performance indicators and standards for all areas of responsibility (regionally, nationally or locally set) are monitored, reported and any deviances from the standard / indicator are addressed.
12. Ensure that workload within areas of responsibility are monitored against defined capacity plans (scorecard) and implement measures to ensure that workload is within safe limits.

13. Report on medicine related aspects of implementation of NICE, NSFs, National Patient Safety Association (NPSA) and Department of Health guidance applicable to CARS.

Health and Safety

1. Be aware of the hazards involved in the handling of cytotoxics and make every effort to minimise risks of exposure to themselves and others.
2. Be familiar with and be able to follow cytotoxic spillage procedures.
3. Follow and provide advice on Trust and departmental procedures relating to the safe handling of cytotoxic drugs including management of spillage.
4. Undergo Manual Handling and Fire Training at regular intervals in accordance with Trust policy.
5. Be aware of and comply at all times with regulations relating to the Health and Safety at Work Act, COSHH, the Medicines Act and the Misuse of Drugs Act and any relevant National Regional and local guidelines to ensure a safe and legal delivery of service.

Other Duties

1. Effectively liaise and deputise for other Deputy Chief Pharmacists.
2. Deputise for the Chief Pharmacist, attending Trust Executive meetings, taking on responsibility for the Pharmacy Department and dealing with any medicine issues that arise across the Trust in her/his absence.
3. The post holder will be required to work a late night once a week, regular Saturdays and occasional weekday sessions in the main dispensary.
4. Any other duties as reasonably required by the Chief Pharmacist.
Appendix 7: Areas outside SLCC where chemotherapy is administered (B15/S/a/itc-16-cc-006)

Trust areas where oral or topical (including intravesical) cytotoxic drugs are administered to adults for malignant and non-malignant conditions, and where chemotherapy is administered to paediatric oncology patients:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Drugs used</th>
<th>Location</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>All oral anti-cancer therapy</td>
<td>Medical wards/ICU/Outpatients</td>
<td>When patients admitted for un-associated medical/surgical conditions/procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prescribed by Consultant Oncologists or Specialist Oncology ST3 Grades or above</td>
</tr>
<tr>
<td>Haematology</td>
<td>All oral anti-cancer therapy</td>
<td>Medical wards/ICU/Outpatients</td>
<td>When patients admitted for non-malignant haematological or un-associated medical/surgical conditions/procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prescribed by Consultant Haematologists</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>As specified in POSCU Guidelines and designated by the Paediatric Oncology Centre e.g. vincristine, vinblastine, asparaginase, cytarabine, (N.B. cytarabine generally given in the community), oral methotrexate, tioguanine, mercaptopurine</td>
<td>Paediatric dept (parenteral chemotherapy in positive pressure isolation cubicle)</td>
<td>Prescribed by Paediatric Oncology Consultant and others according to Trust Chemo Register</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5-Fluorouracil intraocular injection Bevacizumab Aflibercept</td>
<td>Ophthalmology dept/Theatres</td>
<td>Prescribed by Ophthalmology Consultants</td>
</tr>
<tr>
<td>Urology</td>
<td>Mitomycin C intravesical BCG intravesical</td>
<td>Compton Ward, Urology Treatment Rm</td>
<td>Prescribed by Urology Consultant</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Methotrexate Azathioprine Cyclophosphamide</td>
<td>Medical wards/Outpatients</td>
<td>Prescribed by Consultant Rheumatologists</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Methotrexate Azathioprine</td>
<td>Medical wards/Outpatients</td>
<td>Prescribed by Consultant Gastroenterologists</td>
</tr>
<tr>
<td>Dermatology</td>
<td>5-Fluorouracil cream Methotrexate</td>
<td>Dermatology dept</td>
<td>Consultant Dermatologist</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Methotrexate</td>
<td>Obs/Gynae Ward/Theatres</td>
<td>Consultant Gynaecologist</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Cyclophosphamide</td>
<td>Medical wards/Outpatients</td>
<td>Consultant Respiratory Physicians</td>
</tr>
</tbody>
</table>
Appendix 8: Membership list of the Trust Drug and Therapeutics Committee
(B15/S/a/itc-16-cc-003)

ROYAL SURREY COUNTY HOSPITAL, GUILDFORD
DRUGS AND THERAPEUTICS COMMITTEE—TERMS OF REFERENCE

1. Constitution/ purpose

The Committee is to be known as the Drugs and Therapeutics Committee (the Committee). The Committee has the powers either specifically delegated in these terms of reference or the Trust’s scheme of delegation.

The Committee is responsible for managing the introduction of new drugs by consensus based on published evidence; to agree processes that ensure patients receive high quality, cost-effective medicines and associated risks are minimised.

2. Membership, Chairmanship and Quorum

(a) Membership

- Consultant representative from Microbiology and Specialities, (each SBU to be represented singly or as a group)
- Chief Pharmacist
- Deputy Chief Pharmacist Operations
- Deputy Chief Pharmacist Cancer, Aseptic & Research Services (Representative from Chemotherapy Working Party)
- Director of Nursing & Operations
- Director of Finance (or representative)
- Patient (lay) representative
- GP representatives (Guildford and Waverley Clusters)
- Surrey PCT (Commissioning and Medicines Management sections).

Deputies may attend in the absence of a Member but that deputy must hold appropriate authority to act.

(b) Chairmanship

The Committee shall appoint a Chairman from amongst the membership for a maximum of a 3 year term.
(c) Quorum

A quorum shall be two RSCH consultants, one RSCH pharmacist, one representative from Surrey PCT, plus one other member.

3. Frequency of meetings

Meetings shall be held monthly except August and December and members must attend at least 70% of all meetings but should aim to attend all scheduled meetings.

4. Terms of authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent advice and to secure attendance of outsiders with relevant experience and expertise if it considers this necessary.

5. Objectives

The Committee shall:

- Manage the entry of new medicines, and regularly review existing medication use, to the RSCH, Milford, Haslemere and Cranleigh Hospitals and ensure that guidelines for medication use are incorporated into the ‘Red Book’.
- Oversee the continuing development and implementation of the Trusts Medicines Management policy, ensuring that any training implications and changes in practice are notified across the Trust. This includes the development and maintenance of drug related protocols, e.g.
  - standing orders
  - patient group directions
  - non-medical prescribing
- Agree RSCH formulary inclusions, deletions, and restrictions and co-ordinate such changes with the Surrey PCT ‘traffic light system’.
- Advise and assist the Trust on prescribing issues, trends and risk, including the notification of SBUs of cost pressures from anticipated changes in prescribing practice.
- Commission and respond to Audit on medication related issues including:
- Local audits on drug use in order to investigate local clinical standards relating to medicines
- Implementation and monitoring of national initiatives (e.g. NICE or NPSA)
- Medication use at the interface between Primary and Secondary care.
- Receive documents and guidance from appropriate sub-groups of D&TC, including:
  - Medication Review Group – reports on medication errors and risk management issues
  - Antibiotic Steering Group
  - Chemotherapy Working Party
  - St Luke’s Cancer Alliance Chemotherapy Group
6. **Accountability**

The Committee’s meetings will be formally recorded and submitted to the Clinical Risk Management Group.

7. **Review of effectiveness**

On a quarterly basis the Committee shall monitor its effectiveness as follows:

- Ensuring its objectives, accountability and reporting arrangements are effective and meet the Committee’s requirements
- The programming and implementation of any action plans
- Membership and attendance record
- Reporting arrangements for any Sub-Committees
- Quorum requirements
Gastro-Intestinal Cancers
Metastatic Gastric or Oesophageal Cancers
Metastatic Colorectal Cancer
Advanced (Stage III and IV) Pancreatic Cancer

Urology
Advanced or Metastatic Transitional Cell Carcinoma of the Bladder
Metastatic Prostate Cancer
Metastatic Renal Cell Carcinoma

Gynaecological Cancers
Advanced Epithelial Ovarian Cancer Stage Ic - IV
Advanced Cancer of the Cervix

Lung Cancer
Advanced Non-Small Cell Lung Cancer

Breast Cancer
(Neo-) adjuvant chemotherapy in early stage breast cancer
Metastatic Breast Cancer

Brain Cancer
Glioblastoma Multiforme

Head & Neck Cancer
Squamous Cell Carcinoma Head & Neck

Skin Cancers
Malignant Melanoma

Haematology
AML
CML
CLL
Diffuse Large B-cell Lymphoma
Classical Hodgkin Lymphoma
Indolent Lymphomas (excluding mantle cell and SLL)
Mantle Cell Lymphoma
Multiple Myeloma
Appendix 10: List of responsibilities of the named designated pharmacists (B15/S/a/itc-16-cp-001)

Lead Pharmacist Haemato-Oncology (Man-Chie Chow)

Liaises with:
- Medical, nursing and other staff involved in the care of oncology, haematology and palliative care patients within the St. Luke’s Cancer Centre (SLCC) at the Royal Surrey County Hospital and St Luke’s Cancer Alliance.
- Responsible for monitoring drug budgets for haemato-oncology services and implementing changes in medicine use to reflect best practice and clinical effectiveness.
- Other members of RSCH Pharmacy staff in particular clinical practitioners from other specialties, aseptic services and clinical trials staff
- External stakeholders and customers relating to oncology services, district nurses, general practitioners, external suppliers of chemotherapy provision.

Job Statement
- The post holder will work as a highly specialist practitioner helping to deliver a comprehensive clinical pharmacy service to oncology, haematology and palliative care patients in accordance with objectives set by the Deputy Chief Pharmacist (Cancer, Aseptic & Research Services).
- The post-holder will be an active member of the oncology clinical services team and will focus on the delivery of pharmaceutical care to oncology, haemato-oncology and palliative care patients on the ward, day unit and outpatients.
- To support the provision of a Trust Wide Medicines Management service.

Scope of Job
- Contributes to the provision of Oncology Clinical Pharmacy services to Cancer patients treated at St Luke’s Cancer Centre (SLCC). As a Cancer Centre SLCC serves a population of 1.2 Million patients, of all tumour sites, from across the St Luke’s Cancer Alliance.
- Works with the Deputy Chief Pharmacist (Cancer, Aseptic & Research Services) to provide pharmaceutical input into the management of oncology drugs
- Overall responsibility for oncology services to Onslow Ward
- Responsible for the day to day management of oncology pharmacists, pre-registration pharmacists and students.
- Contributes to the implementation of protocol guidelines, specifying drug doses and clinical details required for the safe administration of chemotherapy drugs for all tumour sites treated at SLCC, i.e. Breast, Colorectal & and gastro-intestinal, Lung, Gynaecological tumours, Urological tumours, Brain, Head & neck tumours and haematological malignancies.
Onology Pharmacy Operations Manager (Helen Kimber)

Liaises with:
- Medical, nursing and other staff involved in the care of oncology, haematology and palliative care patients within the St. Luke’s Cancer Centre (SLCC) at the Royal Surrey County Hospital and the St Luke’s Cancer Alliance.
- Other members of RSCH Pharmacy staff in particular clinical practitioners from other specialties, aseptic services and clinical trials staff
- External stakeholders and customers relating to oncology services, district nurses, general practitioners, external suppliers of chemotherapy provision
- The Aseptic Services Manager and Deputy Chief Pharmacist (Cancer, Aseptic & Research Services), to ensure the provision of adequate staff for the Satellite pharmacy and clinical trial work
- External Clinical Research Associates, company representatives and organisations conducting clinical trials

Job Statement
- Manage the running and strategic development of the SLCC Satellite Pharmacy.
- Act as lead pharmacist for the management of aseptic clinical trials for oncology products and other specialities.
- Deputise for the Aseptic Services Manager for all professional aspects of the Pharmacy Aseptic Service and undertake duties within the licensed Aseptic Services Department.
- Work as a highly specialist practitioner helping to deliver a comprehensive clinical pharmacy service (with particular reference to clinical trials) to oncology, haematology-oncology and palliative care patients in accordance with objectives set by the Deputy Chief Pharmacist (Cancer, Aseptic & Research Services).

Scope of Job
- Contribute to the provision of Oncology Clinical Pharmacy services to Cancer patients treated at St Luke’s Cancer Centre (SLCC). As a Cancer Centre SLCC serves a population of 1.2 Million patients, of all tumour sites, from across the St Luke’s Cancer Alliance.
- Work with the Deputy Chief Pharmacist (Cancer, Aseptic & Research Services) to provide pharmaceutical input into the management of oncology drugs.
- Responsible for the line management
- Overall responsibility for oncology services to the Oncology Outpatient Department
- Overall responsibility for the pharmaceutical management of oncology clinical trials
- Be responsible for the final check and release of aseptically prepared products.
Senior Specialist Pharmacist, Aseptic Services (Nicola Hughes)

Liaises with:
Patients, External Customers, Medical, Nursing and Pharmacy Staff, Finance, Engineering, Estates, IT staff, Company Representatives, Stakeholders in the Cancer Network, District Nurses, Transport Staff, Porters, Quality Assurance Staff and Support Staff.

Job Statement
- Delivery of a comprehensive Pharmacy Aseptic Unit service to the Trust and external customers (including chemotherapy, TPN, CIVAS and clinical trial medication).
- Performing the professional role of a Registered Pharmacist within the Aseptic Unit, including the provision of advice, supervision and training.
- Ensuring compliance with principles of Good Manufacturing Practice (GMP), Good Clinical Practice (GCP), and legislative requirements for all activities within the Aseptic Unit.
- Responsible for the development and ongoing management of the Aseptic Unit service to outreach chemotherapy sites and external customers (NHS and non-NHS), managing Service Level Agreements (SLAs), Key Performance Indicators (KPIs) and monitoring income generation.
- Ensuring benefits of Information Technology (IT) systems are maximised to enhance efficiency and safety within the Aseptic Unit – including the introduction, development and validation of new IT systems.
- Management of new technologies within the Unit e.g. gene therapy trials – including their safe and timely introduction into clinical practice.
- Working with the Deputy Chief Pharmacist, CARS and Pharmacy Aseptic Services Manager in the development of:
  - A long-term strategy for the Aseptic Unit service;
  - Service improvement initiatives to improve both staff and patient experience.

Scope of Job
- Delivery of the MHRA licensed Pharmacy Aseptic Service preparing..
- The department prepares a wide range of aseptically prepared products including cytotoxics, parenteral nutrition, antibiotics, monoclonal antibodies and investigational medicinal products in a ready to use form for end users at RSCH and external customers in order to minimise health and safety risks, infection risks and medication errors.
- Line management of the Aseptic Services Manager and junior Pharmacists.
- Provide an aseptic service to external NHS and private customers, generating annual revenue for the Trust of £800K.
- Guided by Medicines Act 1968, GMP, GCP, and external audit recommendations.
- Devise aseptic services training programmes for all levels of staff including pharmacists, pre-registration pharmacists, pharmacy technicians, pharmacy assistants, domestic staff and other trainees.
Lead Pharmacist, Clinical Trials (Gaybrielle Livingstone)

Liaises with:
- Medical, nursing and other staff involved in the care of inpatients at the Royal Surrey County Hospital.
- Other members of RSCH Pharmacy staff in particular Outpatient Oncology Pharmacy Manager & Oncology Clinical Trials Lead, clinical practitioners from other specialities, and clinical trials staff.
- Patients, carers and relatives.
- Trust Research and Development (R&D) Team, research nurses and doctors regarding all aspects of clinical trial set up and management.
- External Clinical Research Associates, company representatives and organisations conducting clinical trials.
- The Deputy Chief Pharmacist (CARS) to ensure the provision of adequate staff for clinical trial work.

Job Statement
The post holder will:
- Manage all pharmacy aspects of clinical trials and the clinical trials team.

Scope of Job
- Responsible for the Pharmacy feasibility assessment, set up, running, closure and archiving of all clinical trials within the Royal Surrey County Hospital.
- Organisation of all financial issues relating to trials within Pharmacy, including setting fees, negotiating with commercial sponsors, costing drug treatments and monitoring clinical trial income.
- Line manager to Chief Pharmacy Technician, Clinical Trials Operational Manager.
- Tutor for a junior pharmacist on the Joint Programme Board (JPB) Pharmacy Practice Diploma.
Appendix 11: ITC Accountability Agreement (B15/S/a/itc-16-002)

Royal Surrey County Hospital NHS

Intrathecal Chemotherapy

Accountability Agreement

The Trust Intrathecal Chemotherapy Lead is Dr John de Vos, Consultant Haematologist.

The Trust Intrathecal Lead is accountable to the Trust Chief Executive for compliance with the national intrathecal chemotherapy guidance (HSC 2008/001) and the intrathecal chemotherapy measures.

Signed: J de Vos  Date: 23.08.19.

Trust Intrathecal Chemotherapy Lead:
Lead Consultant Haematologist
Dr John de Vos

Signed: L Stead  Date: 19.11.19.

Trust Chief Executive:
Louise Stead
Aim

The aim of this document is to provide guidance on the admission of haemato-oncology patients to the Royal Surrey County Hospital. It covers pathways for acute emergency admissions, acute emergency transfers from other trusts, elective admissions and patient transferred from other teams within the hospital. The aim is always for patients to be admitted to Onslow ward, the designated haemato-oncology and oncology ward. Admission to other wards might be necessary in emergencies. The patient will be under the care of the haematology team whichever ward they are on (as opposed to the ward based care of patients under medical and surgical teams). Onslow ward has 34 beds, 15 beds in bays (2 six bedded bays and one bay with 3 beds) and 19 side rooms. Side rooms are prioritized for haemato-oncology patients and neutropaenic patients.

Acute Emergency Admissions

This applies to all emergency admissions to the hospital which are not planned. Note that there are cases where the haematology team has been informed by the patient/relative/GP that the patient is coming to hospital, but these patients remain emergency admissions and do not constitute ‘elective’ admissions.

- All haemato-oncology patients are given strict instructions to seek medical attention if unwell; contact details are provided to all patients to liaise directly with the team during working hours, either via the haematology CNS, ward, or haematology SpR. Out of hours the oncology SpR is contacted directly. If patients are unwell they will be advised to come to A&E as soon as possible. As stated above these are not ‘elective’ admissions. Though the term ‘expected admissions’ is sometimes used, this is confusing terminology as it has a significant risk of undermining/underestimating the acuteness of the situation. ‘expected emergency admission’ is more appropriate terminology. If patients contact the haematology/oncology team directly and require attending A&E, then the A&E department will be informed of the ‘expected emergency admission’.

- Most patients however will present directly to A&E when unwell as they are instructed to do. They all will have been given information on their diagnoses and treatment. Most of these patients will be on chemotherapy.

- On A&E they will be triaged, though chemotherapy patients will be prioritized due to the high risk of patients having neutropenic sepsis.

- Between 9AM and 5PM, Monday to Friday, the haematology team (SHO/SpR) will be contacted upon arrival of the patient. If possible the haematology team will review the patient directly and admit from there if appropriate. If no immediate review is possible due to ward emergencies, the A&E team will review and assess the patient as normal. The patient will be seen by the haematology as soon as possible thereafter.
- Between 5PM-9PM, the oncology SHO on site will be contacted and if possible review the patient. Same conditions as above apply.
- Out of hours (9PM-9AM) the A&E and Medical team on take will review and manage the patient. The haematology doctor on-call can be contacted via switch-board for advice if required.
- If admission is required, this will be organized through the (medical) bed manager/Site Nurse Practitioner (SNP). It will be clearly stated whether the patient is neutropenic and requires a side room, or whether there is another reason a side room is required.
- All attempts will be made for the patient to be admitted to Onslow ward directly, though on occasions admissions to another ward (i.e. Acute Admissions Unit) might be necessary. All patients will remain under the care of the haematology team, whichever ward they are on.

**Acute Emergency Transfers**

This applies to newly diagnosed Acute Myeloid Leukaemia (AML) patients as well as newly diagnosed Primary Central Nervous System Lymphoma (PCNSL). Both conditions are medical emergencies that invariably require *EMERGENCY* treatment which is life-saving. This treatment can NOT be given at the referring centers, hence immediate transfer is required. In both conditions in most patients time is of the essence. All attempts will be made to transfer patients during ‘day-light’ hours if clinically possible.

- The new AML or PCNSL patients at other centers will need to be discussed directly with the Haematology SpR or consultant and accepted before transfer.
- The haematology SpR/consultant will liaise directly with the Site Nurse Practitioner/bed manager regarding the transfer, stating the urgency of said transfer.
- All attempts will be made for the patient to be transferred to Onslow ward, as they will require emergency chemotherapy. It will be made clear whether the patient will require a side room.
- In rare situations temporary admission to another ward (i.e. Acute Admissions Unit) might be required if no beds are available on Onslow ward. All attempts will be made for urgent transfer to Onslow ward; this might require another patient being moved to an outlying ward.
- The nursing staff on Onslow will liaise directly with the ward staff at the referring hospital once a bed is identified and the patient can be transferred.
- It can not be stressed highly enough that these patients require urgent attention and that they should be prioritized for transfer/admission.

**Elective Admissions for Intensive Chemotherapy**

This includes elective admissions for in-patient chemotherapy for AML, Mantle Cell Lymphoma (MCL), Salvage high grade Lymphoma Chemotherapy and PCNSL. These patients require multiple cycles of intensive chemotherapy, though they are often discharged between cycles. Upon discharge or upon decision of initiation of treatment in the Out-patient clinic, a clear plan will be made with the patient and Onslow ward for admission and treatment. It is clinically of the utmost importance to avoid delays in treatment as this will affect treatment outcome and prognosis.

- The Haematology team will enter the patient’s details into the Onslow Ward Desk Diary for elective admissions.
- The patient is also informed of the planned date of admission.
- The Ward diary is checked by the nurse in charge on a daily basis which will allow forward planning.
- On the day of admission, or the night before a bed is allocated to the patient.
- The patient is instructed to ring the ward in the morning of the admission to find out when the bed will be available. If the bed is available early in the morning the ward staff or haematology team can ring the patient and inform them.
- In the situation where no elective beds are available or too many elective patients are booked into the Ward Desk Diary, the senior clinicians in charge of the planned patients should prioritise the admissions on a clinical basis.
- If no bed is available the patient will be admitted as soon as there is, usually the next day.
- At all points should the patient be kept informed of any delays if they were to occur.
Patients transferred from other teams within the RSCH (both medical and surgical)

A significant number of patients with haematological malignancies (mainly acute leukaemia, lymphoma and myeloma patients) will be diagnosed after admission under other teams, both medical and surgical. These patients will most likely be on the Acute Admissions Unit, but can be on any of the medical or surgical wards.

- Once a haemato-oncological diagnosis is made (most often on the basis of diagnostic tests such as blood tests, imaging or biopsies) the team looking after the patient will refer to the haematology team directly. This has to be a doctor to doctor referral and will lead to the patient being reviewed by the haematology team before acceptance of the transfer.
- Once accepted the SNP will be informed and if possible the patient will be transferred to Onslow ward. The nursing staff of both wards will liaise directly with regards to when the bed is ready.
- If no immediate transfer is possible the haematology team can still take over the care of the patient (if appropriate) and will continue to review the patient on the outlying ward.

Contact details

Onslow ward: extension 6858
Medical SNP: 71-0129
Haematology CNS: 71-6322
Haematology SHO: 71-4184/4178
Haematology Consultant: on-call via switchboard
A&E: extension 4156
Appendix 13: Sample Consultant Haematologist On-Call Rota (B15/S/a/itc-16-chi-003)

<table>
<thead>
<tr>
<th>Date</th>
<th>06/06/19</th>
<th>06/06/19</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun</td>
<td>25/06/19</td>
<td>25/06/19</td>
<td>LH</td>
</tr>
<tr>
<td>Mon</td>
<td>26/06/19</td>
<td>26/06/19</td>
<td>LH</td>
</tr>
<tr>
<td>Tues</td>
<td>27/06/19</td>
<td>27/06/19</td>
<td>LH</td>
</tr>
<tr>
<td>Wed</td>
<td>28/06/19</td>
<td>28/06/19</td>
<td>LH</td>
</tr>
<tr>
<td>Thurs</td>
<td>29/06/19</td>
<td>29/06/19</td>
<td>LH</td>
</tr>
<tr>
<td>Fri</td>
<td>01/07/19</td>
<td>01/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sat</td>
<td>02/07/19</td>
<td>02/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sun</td>
<td>03/07/19</td>
<td>03/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Mon</td>
<td>04/07/19</td>
<td>04/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Tues</td>
<td>05/07/19</td>
<td>05/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Wed</td>
<td>06/07/19</td>
<td>06/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Thurs</td>
<td>07/07/19</td>
<td>07/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Fri</td>
<td>08/07/19</td>
<td>08/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sat</td>
<td>09/07/19</td>
<td>09/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sun</td>
<td>10/07/19</td>
<td>10/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Mon</td>
<td>11/07/19</td>
<td>11/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Tues</td>
<td>12/07/19</td>
<td>12/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Wed</td>
<td>13/07/19</td>
<td>13/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Thurs</td>
<td>14/07/19</td>
<td>14/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Fri</td>
<td>15/07/19</td>
<td>15/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sat</td>
<td>16/07/19</td>
<td>16/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sun</td>
<td>17/07/19</td>
<td>17/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Mon</td>
<td>18/07/19</td>
<td>18/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Tues</td>
<td>19/07/19</td>
<td>19/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Wed</td>
<td>20/07/19</td>
<td>20/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Thurs</td>
<td>21/07/19</td>
<td>21/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Fri</td>
<td>22/07/19</td>
<td>22/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sat</td>
<td>23/07/19</td>
<td>23/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sun</td>
<td>24/07/19</td>
<td>24/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Mon</td>
<td>25/07/19</td>
<td>25/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Tues</td>
<td>26/07/19</td>
<td>26/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Wed</td>
<td>27/07/19</td>
<td>27/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Thurs</td>
<td>28/07/19</td>
<td>28/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Fri</td>
<td>29/07/19</td>
<td>29/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sat</td>
<td>30/07/19</td>
<td>30/07/19</td>
<td>LH</td>
</tr>
<tr>
<td>Sun</td>
<td>31/07/19</td>
<td>31/07/19</td>
<td>LH</td>
</tr>
</tbody>
</table>

**Consultant**

- **Dr Andrew Laurie**
- **Dr Louise Hendry**
- **Dr Madhu Rangaiah**
- **Dr John de Vos**
- **L Rogers**
- **E Grey-Davies**

**Distribution List**

- **Al**
- **LH**
- **AL**
- **JH**
- **RW**
- **JV**

**Reg cover weekend**

- **MRA 1**
- **MRA 2**
- **MRA 3**
- **MRA 4**
- **MRO 1**
- **MRO 2**
- **MRO 3**
- **MRO 4**
- **REG/MRA 1**
- **REG/MRA 2**
- **REG/MRA 3**
- **REG/MRA 4**
- **REG/MRA 5**
- **REG/MRA 6**

**Security Notice:** The information in this rota should not be disclosed to any third party without the rota members' permission.

---

81
### MICROBIOLOGISTS ONCALL ROTA (CONSULTANTS ONLY)
**OUT OF HOURS & WEEKENDS**
**(FOR FRIMLEY PARK & ROYAL SURREY SITES)**

<table>
<thead>
<tr>
<th>Date</th>
<th>2018</th>
<th>1ST CONTACT</th>
<th>2nd CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon 12th August</td>
<td></td>
<td>Dr Meda</td>
<td></td>
</tr>
<tr>
<td>Tue 13th August</td>
<td></td>
<td>Dr Fernando</td>
<td></td>
</tr>
<tr>
<td>Wed 14th August</td>
<td></td>
<td>Dr Campisi</td>
<td>Dr Garner</td>
</tr>
<tr>
<td>Thu 15th August</td>
<td></td>
<td>Dr Hutley</td>
<td></td>
</tr>
<tr>
<td>Fri 16th August</td>
<td></td>
<td>Dr Varghese</td>
<td></td>
</tr>
<tr>
<td>Sat 17th August</td>
<td></td>
<td>Dr Fernando</td>
<td></td>
</tr>
<tr>
<td>Sun 18th August</td>
<td></td>
<td>Dr Fernando</td>
<td></td>
</tr>
</tbody>
</table>

**Consultant Microbiologist contact numbers for Frimley Park & Royal Surrey County Hospitals**

<table>
<thead>
<tr>
<th>Consultant</th>
<th>Contact Method</th>
<th>1. Mobile</th>
<th>2. Pager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Garner</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pager not working at present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Hutley</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only mobile available at the moment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Groves</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pager not working at present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Meda</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only mobile available at the moment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Clayton</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Mobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Pager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Varghese</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Mobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Pager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Fernando</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Mobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Pager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Giannatou</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Mobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Campisi</td>
<td>Via switchboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Mobile</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>