Anglia Cancer Network

Agenda Item: **10**

From: **Tonia Dawson, Nurse Director**

BOARD REPORT **Acute Oncology Service – Project Closure Report**

1. Purpose

To provide the AngCN Network Board with:

- An Acute Oncology Service implementation update and closure report from an AngCN perspective, which includes a current position statement against the Key Performance Indicators identified in 2010, and
- A summary of the key work and recommendations necessary to take this work forwards within the new structure.

2. Background

The fundamental need for Acute Oncology as a structured service across England and Wales was newly introduced within the NHS in the August 2009 NCAG report.

This was in response to serious concerns being raised in the following reports:-

1. National Cancer Peer Review Programme 2004-2007, Overview of the findings from the second national round of peer reviews of cancer services in England. NCAT June 2008.
2. *"For better, for worse?".* National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) report. Nov 2008.

In addition to this, the 2007 Cancer Reform Strategy (CRS) placed significant emphasis on the need for cancer inpatient stays to be reduced, inpatient cancer care being the most expensive care setting, accounting for approximately half of all cancer expenditure and 12% of all acute inpatient bed stays. Inpatient admissions for cancer had risen by 25% in the eight-year period leading up to the publication of the NCAG report, 60% of which related to emergency admissions.*

In the 2006/7 period this equated to approximately 273,000 cancer emergency admissions per annum (750 per day) nationally, representing a 30% increase compared with 1997/98. For an average Trust this meant five cancer admissions per day.*

In parallel with the rising cost impact the demand on Chemotherapy services had also increased but the infrastructure to support the existing service and its anticipated growth of 25% between 2010 and 2025 was not in place. Therefore, whilst patients were benefiting from the improvements in the drugs and services, difficulties started to arise in the NHS' ability to sustain an optimal service.

A UK-wide review of Chemotherapy services was undertaken, resulting in the 27 NCAG Report key recommendations, one of which was that:-

> *"All hospitals with emergency departments should establish an Acute Oncology Service and/or a pathway to ensure the rapid and appropriate management of patients presenting with previously undiagnosed cancer [and that these services] will also have a major role in the effective management of patients admitted with complications during a course of chemotherapy and with the urgent complications of malignancy."*

**Sources:*
- *Cancer Reform Strategy (CRS) – 2007*
- *NCAG Report – August 2009*
- *DoH Cancer Commissioning Guidance - 2009*

3. The Approach Taken in the AngCN

3.1 The Implementation Approach

In response to the publication of the *draft* NCAG report in August 2008 the Network, working with the Trusts and Commissioners, established the following in order to implement a robust service across the Network's nine acute Trusts:

Date	Activity	Purpose
Sept 2009 to Jan 2010	Carried out an Acute Oncology and Chemotherapy Pathway Mapping exercise.	To establish current service gaps and pre-existing areas of good practise.
January 2010 to March 2010	Defined and gained clinical agreement to the implementation of the following key elements of the service within each Trust: • A fully-constituted Acute Oncology Team, • A&E and acute medical pathways and protocols, • 24/7 patient telephone advice service in place, supported by the 24/7 Triage Protocol, • 24/7 consultant helpline services, • Fast track clinic processes, • An IT flagging system, • Standard patient alert card	Consistent implementation within all Trusts and thereby equity of Network AOS service provision.
March 2010	Set a Network target implementation date of March 2011, ahead of the national December 2011 target.	To establish a robust baseline service by the March 2011 date, enabling the Trusts to fine tune the services, ensuring increased compliance with the AOS quality standards.
March 2010 to February 2012	A focused implementation monitoring process with the use of the RAG sheets and risk plans, 2-monthly reviews and quarterly Network Board reporting.	Consistent implementation focus, Identification of further good practise and shared learnings, Board buy-in and continued support.
	Co-developed the following national initiatives: • 24/7 Triage Protocol, • Patient Alert Card, • National Emergency Protocols, • National spread of the AngCN RAG implementation monitoring framework.	Consistency and equity of national service provision.
	Developed NAOG-agreed Network-wide minimum specifications for Trust adherence to the following services: • The 24/7 Patient Helpline, • 24/7 Consultant Advice, • Acute Oncology Induction Training.	Safe and equitable service provision across the Network Trusts.
January 2011	Set up the AOS Nurse Forum.	To provide the CNS' with a robust support network within this new service.
January 2011 to March 2013	Set up the AOS KPI and Trust Data Collection Benefits Analysis process.	To measure the impact of the implemented service on: • Emergency cancer admissions rates, • Length of stay for emergency/unplanned cancer patients, • Neutropenic Sepsis mortality and door-to-needle time rates.
July 2011	Provided Network funding for AOS Nurses within each Trust until 31 March 2013.	To demonstrate tangible Network support for the service and fundamental need for the CNS role within each local Acute Oncology Team and Service.
December 2010 and December 2011	Set up distinct MSCC and CUP Implementation Teams (both of which form a part of Acute Oncology).	Increased focus on these service areas during the implementation phase, to be reviewed as appropriate for merging into the NAOG.

3.2 The Anticipated Cost Savings Guideline

In June 2010 the AngCN set a guideline target for Acute Oncology (for programme budgeting purposes) to limit bed days for emergency cancer admissions to 40% of total cancer bed days, as part of the Transforming Inpatient Care Programme.

Using anonymised data from the six Network PCTs for the period 1 April 2009 to 30 June 2009, all cancer admissions (Primary Diagnosis code only) were analysed for emergency admissions and length of stay, resulting in an anticipated saving of 20,591 bed days, providing an annual cost saving of £4,149k across the Network, a potential saving of £159k per 100,000 cancer adjusted population. This potential for cost savings through reduction in bed days (as a proportion of total bed days) underlined the much greater cost under PbR tariff for emergency admissions compared to planned admissions.

4. Benefits Analysis

To monitor whether this could be achieved, as outlined in the table in section 3.1 above, the Network has therefore, since January 2011 been working with the Trusts and Commissioners to measure the impact of the Acute Oncology Service on:

4.1.1 Emergency cancer admissions rates, and
4.1.2 Length of stay for emergency/unplanned cancer patients,

As well as,

4.1.3 Neutropenic Sepsis mortality rates and door-to-needle times,
4.1.4 An analysis of Trust emergency calls and presentations.

The following provides a summary analysis of progress to date against each of the above key performance indicators.

4.1.1 Emergency Cancer Admissions Rates

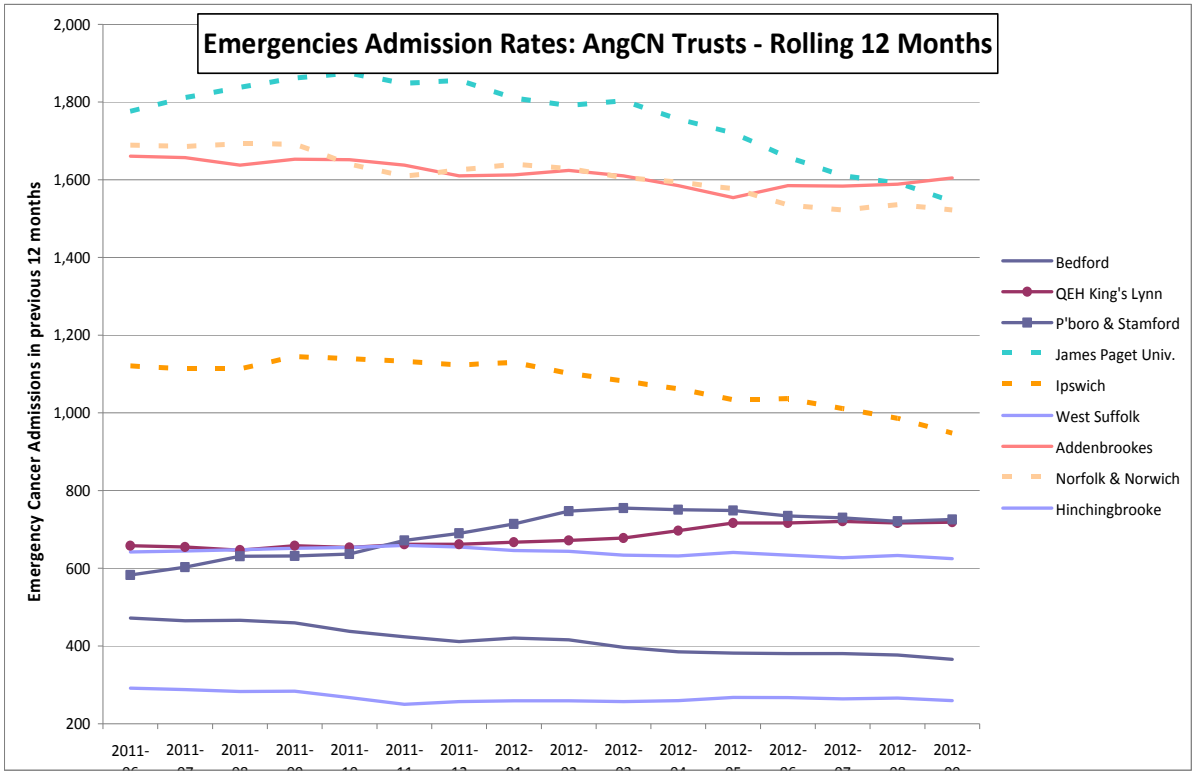
A baseline of PCT SUS data was established using an average of the four quarters between 1 July 2010 and 30 June 2011. Quarterly reports against this baseline have been produced for the 5-quarter period up to and including Q2 (Jul-Sep) 2012/13. Within this the following trends can be identified:

Ipswich and Hinchingbrooke show a drop in admission rates for the third quarter in succession, with Hinchingbrooke showing the most substantial drop in Q2 (-21%). JPUH shows a continuing drop for the fifth successive quarter.

West Suffolk and Addenbrooke's show admission rates that are equal to the baseline for Q2 where in previous quarters rates below the baseline had been demonstrated.

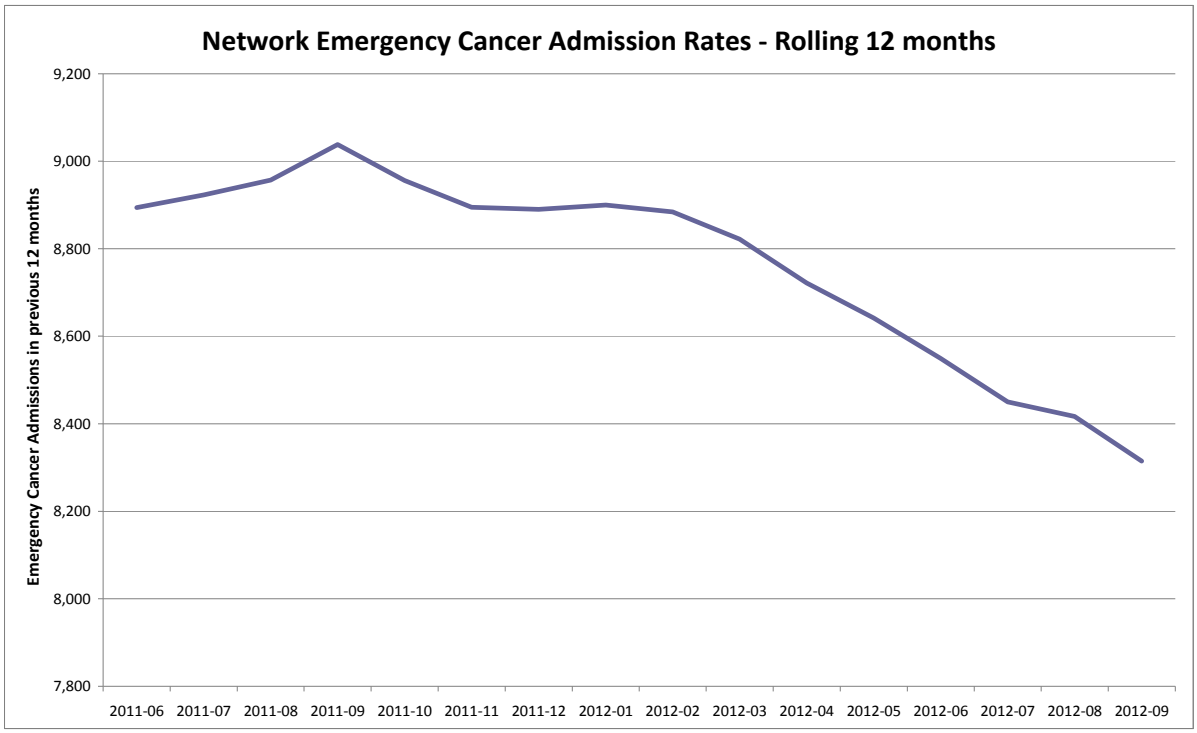
Where QEH had previously shown reductions from the baseline, it is now showing marked increases, starting with Q4 and continuing into Q2. Peterborough has demonstrated a trend of increased emergency admission rates across all reported quarters, in Q2 reporting a 32% increase. The Network has begun to look at this data in more detail to determine the reasons behind the increases at both Trusts, with the initial assessment being that this may be due to inaccurate coding. The Network is currently working with the Trusts to confirm this.

To demonstrate the trends by Trust, the following graph provides a rolling 12 month comparison of emergency admission rates, covering the June 2011 to September 2012 period:-

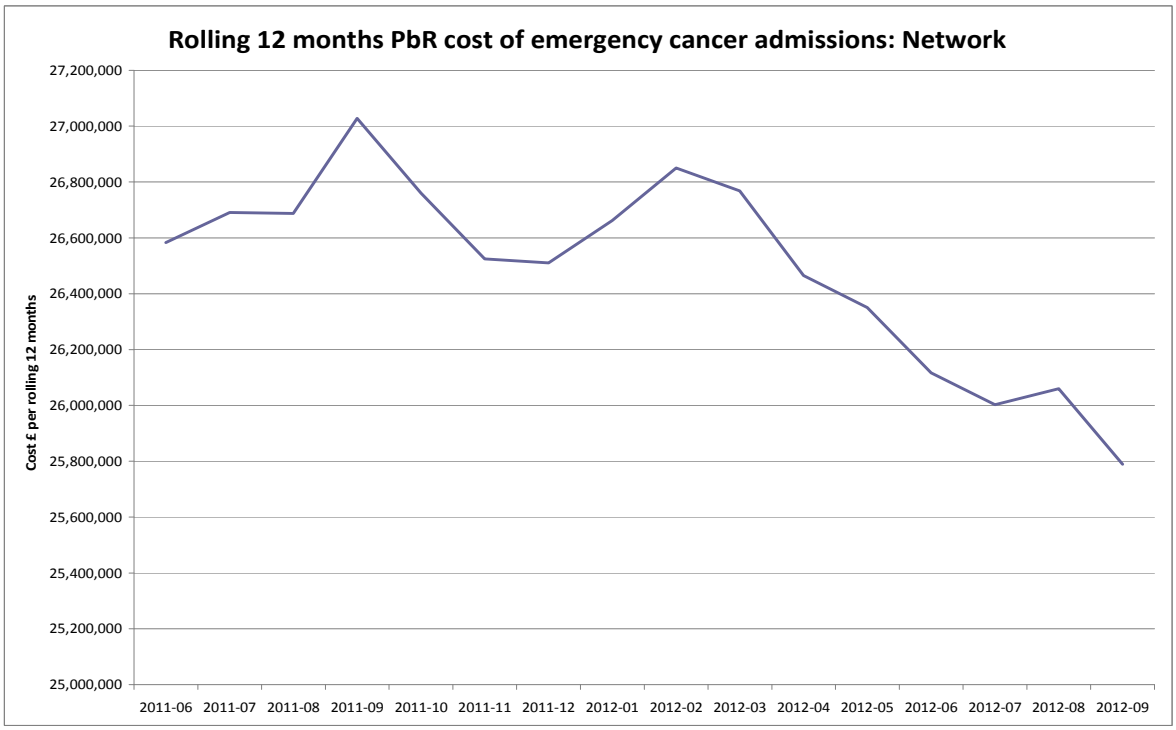


At a Network level the total number of admissions is lower (-7%) than the baseline for the fourth consecutive quarter which is a fair indication that the AOS programme is having the desired effect.

The following graph, providing a rolling 12-month comparison of emergency cancer admission rates, demonstrates this downward trend:-



In line with this the following graph reflects the associated PbR cost reduction across the Network.



4.1.2 Length of Stay (LoS) for Emergency/Unplanned Cancer Patients

Using the same established baseline as in the analysis for emergency cancer admission rates, LoS has fluctuated above and below the average for the previous year and for Q2 is 1% below that of the baseline period across the Network. Considering the reduction in same day discharges for the same period (-14% compared to baseline), which would tend to increase average LoS, this represents a significant improvement.

Ipswich and Hinchingbrooke have achieved reductions in admissions at the same time as reductions in average length of stay, meaning a real reduction in bed days. Addenbrooke's has reduced average LoS in Q2 (-17%), but the increased number of same day discharges (+47%) may account for this fall. QEH and Peterborough did reduce average LoS but because of increases in admissions the number of bed days has not fallen relative to baseline.

To roll this up to a Network level comparison across the reporting period, in Q1 (Apr-Jun) 2009 there were 37,903 inpatient bed days, 20,309 of which were unplanned, whereas in Q2 (Jul-Sep) 2012 these rates had decreased to 30,619 and 16,967 respectively.

Although James Paget continues to have a significantly higher number of same day discharges relative to total admissions (In Q2 55% of total admissions were same day discharges), this is reducing when compared to the JPUH baseline of 68%. This ratio of same day discharges compared to total admissions varies considerably between the Trusts, the lowest being Bedford at 4% for Q2, with both Ipswich and Addenbrooke's at 26%.

It is important to understand that this variation is likely to be a result of how each Trust treats and codes AOS presentations. This can have a significant effect on the cost to commissioners.

Q2 analysis vs. the Baseline is summarised in the following Length of Stay and Same Day Discharge tables:-

Average Length of Stay	Average July 2010 to June 2011 Baseline	Q2 Variation vs. Baseline
Network	**8.2 days**	**- 1%**
Bedford	10.1	+8%
CUHFT	9.1	- 17%
HHT	10.7	- 5%
IHT	9.0	- 4%
JPUH	3.0	+43%
NNUH	9.8	+1%
PCH	9.5	- 13%
QEHKL	9.3	- 8%
WSH	9.9	+3%

Average LoS – PbR Cost	Total Cost July 2010 to June 2011 (Baseline)	Total Cost July 2011 to June 2012	Total Cost Oct 2010 to Sept 2011	Total Cost Oct 2011 to Sept 2012
Network Total Cost	£26.6m	£26.1m (-2% compared to baseline)	£27.1m (+2% compared to baseline)	£25.8m (-£796k compared to baseline, representing a 3% reduction) (-£1.3m compared to the previous 4 quarters, representing a 5% reduction)

Same Day Discharges – Volumes	Average July 2010 to June 2011 Baseline	Q2 Variation vs Baseline
Network	**550**	**- 14%**
Bedford	10	**- 61%**
CUHFT	75	**+47%**
HHT	9	**- 35%**
IHT	59	**- 11%**
JPUH	300	**- 35%**
NNUH	32	**- 29%**
PCH	23	**+93%**
QEHKL	30	**- 26%**
WSH	10	**+23%**

Same Day Discharges – Costs	Total Cost July 2010 to June 2011 (Baseline)	Total Cost July 2011 to June 2012	Total Cost Oct 2010 to Sept 2011	Total Cost Oct 2011 to Sept 2012
% of all emergency admissions	25%	26.6%	25.8%	25.5%
Network Total Cost	£2.1m	£2.1m (- £27k compared to baseline, representing a 1.3% reduction)	£2.2m (+£106k compared to baseline, representing a 1.1% increase)	£1.9m (-£211k compared to baseline, representing a 10% reduction) (-£317k compared to the previous 4 quarters, representing a 14% reduction)

4.1.3 Neutropenic Sepsis Mortality Rates and Door-to-Needle Times

Trusts across the Network are required to carry out an annual Neutropenic Sepsis audit, covering a consecutive six-month period.

Each Trust reported its 2012 Neutropenic Sepsis audit results in July 2012. NAOG analysis of "Door-to-Needle time" rates (that all patients with suspected Neutropenic Sepsis should be initially treated with antibiotics within 60 minutes of presentation), show the following results by Trust:-

Trust	6-Month Period Audited	Number of Patients with Suspected NS	Percentage meeting the DTN time target
Bedford	1 April 2011 to 31 March 2012	35	66%
CUHFT	1 October 2011 to 31 March 2012	130 (63 of whom has been analysed as of July 2012)	10/63 (16%)
HHT	1 July 2011 to 31 March 2012	24	58%
IHT	1 June 2011 to 31 May 2012	54	18%
JPUH	1 June 2011 to 31 January 2012	47	81%
NNUH	1 January 2012 to 7 July 2012	69	61%
PCH	1 January 2012 to 30 June 2012	89	25%
QEHKL	1 August 2011 to 31 January 2012	85	38%
WSH	31 August 2011 to 2 July 2012	93	25%

Each Network Trust also reported its local action plan to improve upon the above rates, with some Trusts now reporting a significant improvement. For example, the WSH put a Patient Group Directive (PGD) in place which has seen the overall percentage of patients receiving antibiotics within an hour increase from the 25% outlined above, to 55%.

Not all Trusts provided sufficiently robust Neutropenic Sepsis mortality recording within the data collection, to make it possible to provide a Network Neutropenic Sepsis mortality overview in this paper. This will be taken forward as a key recommendation within section 7.

4.1.4 An analysis of Trust emergency calls and presentations

Since 1 July 2011 each of the Network Acute Trusts has submitted Calls and Presentations data to the Network against a defined set of criteria. The key aims of this work were to:

- Establish and monitor service demand for calls received into the Trusts and emergency presentations, both in- and out-of hours,
- Monitor clinical data trends, e.g., patient symptoms and diagnosis,

- Enable the Trusts to report on and review AOS working practices within the Trust AOS Service, for continuous review and improvement of local services,
- Provide data to inform variation of patient management and decision making between those patients seen by the AOS and in the EDs,
- Provide data to inform tumour site-specific Acute Oncology activity,
- Provide data to potentially inform the development of community services.

Analysis of this data demonstrates the following findings:

Network Calls- Service Demand	Q2 (July to Sept 2011)	Q3 (Oct to Dec 2011)	Q4 (Jan to March 2012)	Q1 (Apr to June 2012)	Q2 (July to Sept 2012)
• Call Volumes	1126	1833	1921	1888	2758
• Percentage of out-of-hours calls	51%	53%	49%	48%	45%

Notes
- Call volumes across the quarters have been consistent across all reporting periods, a significant jump in Q2 to 2758 for the quarter is most likely attributable to the fact that this is CUH's first complete quarter for data submissions, having recorded 761 calls within the Q2 period.
- Out of hours calls constitute approximately 50% of total call volume for each quarter

Network Calls- Clinical Data Trends	Q2 (July to Sept 2011)	Q3 (Oct to Dec 2011)	Q4 (Jan to March 2012)	Q1 (Apr to June 2012)	Q2 (July to Sept 2012)
The top 3 call reasons are:-					
• Pain (including chest pain)	189 (17%)	327 (18%)	348 (18%)	157 (8%)	422 (15%)
• Fever	164 (15%)	364 (20%)	291 (15%)	123 (7%)	417 (15%)
• Nausea and Vomiting	118 (10%)	164 (9%)	161 (8%)	109 (6%)	295 (11%)
The top 4 diagnoses are:-					
• Breast	58 (5%)	333 (18%)	397 (21%)	231 (12%)	590 (21%)
• Lung	28 (2%)	231 (13%)	266 (14%)	189 (10%)	321 (12%)
• Colorectal	25 (2%)	229 (12%)	227 (12%)	178 (9%)	301 (11%)
• Lymphoma	28 (2%)	148 (8%)	183 (9%)	81 (4%)	211 (8%)
Patients on Curative Treatment	N/A	N/A	N/A	N/A	1210 (44%)

Notes
- Comparison of the Q2 12/13 data with the previous quarters highlights an increase in the volumes reported against the Call Reasons and Diagnoses. This is due entirely to improved data quality in Q2 due to simplified reporting. The percentages however, remain consistent.
- The reduction in reported volumes in Q1 is due to the level of unknown or unrecorded records reported in that period (39% of Q2 call reasons and 40% of Q2 diagnoses) compared to 1% across the board for all other quarters.
- An assessment of the number of patients on curative treatment was not recorded prior to Q2 2012.

Network Calls- Working Practice/Actions Taken	Q2 (July to Sept 2011)	Q3 (Oct to Dec 2011)	Q4 (Jan to March 2012)	Q1 (Apr to June 2012)	Q2 (July to Sept 2012)
The top 4 actions taken were:					
• Total patients referred into the Trust, *of which*	565 (50%)	807 (44)%	880 (45%)	434 (23%)	1158 (42%)
• *Percentage referred to the AOS team*	*57%*	*51%*	*59%*	*44%*	*48%*
• Referred to GP	134 (12%)	266 (15%)	285 (15%)	208 (11%)	414 (15%)
• Advice/Self Management	289 (26%)	494 (27%)	593 (31%)	302 (16%)	855 (31%)

Presentation/Admissions Findings – Service Demand	**Q2 (July to Sept 2011)**	**Q3 (Oct to Dec 2011)**	**Q4 (Jan to March 2012)**	**Q1 (Apr to June 2012)**	**Q2 (July to Sept 2012)**
• Presentation volumes	341	769	759	709	1254
• In-hours presentations	88%	91%	84%	75%	77%
• AOS vs. ED admission rates	Not available	Not available	Not available	24% vs 95%	Not available
• Trust admission rates of presenting patients	63%	61%	63%	45%	48%
Notes • Presentation volumes are consistent across the quarters. The significant rise in presentation volumes in Q2 is attributed to an increase in the reported data from CUH, • The majority of presentations are in-hours, • For the Q1 period in which the data was collected, 24% of patients seen by the AOS were subsequently admitted, compared to 95% of those assessed in the emergency departments. • Trust admission rates show an apparent drop in Q1 and Q2. This may be due to improved quality in the Trusts data submissions for these 2 quarters but is likely also to be attributed to the actual drop in admission rates in line with the graphs in section 4.1.1.					
Presentation/Admissions Findings – Clinical Data Trends	**Q2 (July to Sept 2011)**	**Q3 (Oct to Dec 2011)**	**Q4 (Jan to March 2012)**	**Q1 (Apr to June 2012)**	**Q2 (July to Sept 2012)**
The top 4 presentation / admission reasons are:					
• Pain	42 (12%)	143 (19%)	112 (15%)	84 (12%)	157 (13%)
• Fever	39 (11%)	137 (18%)	122 (16%)	112 (16%)	236 (19%)
• Dyspnoea	30 (9%)	85 (11%)	117 (15%)	62 (9%)	121 (10%)
• Nausea & Vomiting	32 (9%)	28 (4%)	60 (8%)	52 (7%)	71 (6%)
The top 3 diagnoses are:					
• Breast	65 (19%)	162 (21%)	126 (17%)	127 (18%)	187 (15%)
• Colorectal	37 (11%)	60 (8%)	92 (12%)	100 (14%)	147 (12%)
• Lung	50 (15%)	125 (16%)	119 (16%)	112 (16%)	167 (13%)
Patients on Curative Treatment	N/A	N/A	N/A	N/A	456 (36%)
• An assessment of the number of presenting patients on curative treatment was not recorded prior to Q2 2012.					
Presentation/Admissions Findings – Working Practice/Actions Taken	**Q2 (July to Sept 2011)**	**Q3 (Oct to Dec 2011)**	**Q4 (Jan to March 2012)**	**Q1 (Apr to June 2012)**	**Q2 (July to Sept 2012)**
• Patient Admitted	215 (63%)	470 (61%)	481 (63%)	293 (45%)	608 (48%)
• Sent home after assessment	35 (10%)	201 (26%)	234 (31%)	21 (3%)	141 (11%)
• Consultant Assessment within 24 hrs of admission = Yes	N/A	N/A	396 (52%)	369 (57%)	629 (50%)
• Whether the patient has called the helpline within 48 hours prior to presentation.	N/A	N/A	N/A	N/A	Y = 494 (39%) N = 662 (53%
• Whether the patient has been discharged from a previous admission within 30 days of this presentation.	N/A	N/A	N/A	N/A	295 (24%) 799 (64%)
Note: The data completeness within the submissions resulted in it not being possible to accurately report against some of these areas until the quarters outlined above.					

5 How the Service is being sustained

The following areas have either been put in place or are required to ensure that the implemented service is sustained:

5.1 Continued Monitoring of Trust Neutropenic Sepsis rates

In place: An annual audit of Trust recording of Neutropenic Sepsis mortality rates and performance against the one-hour door-to-needle time targets. As agreed by the Network Acute Oncology Group members the audit for 2013, covering the 1 January 2013 to 30 June 2013 period and including NAOG-defined mandatory items including patient outcome, commenced on the 1 January 2013.

5.2 Continued funding for the AOS Nurse role

In progress: Substantive funding has been agreed at all Network Trusts with the current exceptions of:

- HHT, provisional funding approval has been given by the Trust Medical Director. Final approval anticipated 31 January 2013,
- JPUH, where the business case is scheduled for presentation to the Trust Investment Group. Interim funding has been identified to support the post from 01/04/13 until the Business Case has been agreed, and
- NNUH, where the business case will be submitted to the Trust Board in January 2013.

5.3 Trust adoption of the Network-developed AOS Nurse KSF career development framework

In progress: Trusts to adopt the AOS Nurse KSF framework, defined by the AOS Nurses Group, in order to continue to develop the AOS Nurse role within the Acute Trusts as a critical part of the Trust AOS team and service.

5.4 Acute Oncology Quality Standards

In place: Continuing compliance to the quality standards and ongoing review at the Network Acute Oncology Group of any gaps in compliance or good practice for sharing learnings across the Network.

5.5 The NAOG

In place: The ongoing function of the Network Acute Oncology Group, each Trust represented as a minimum by the Acute Oncology Team leads, having an overseeing and monitoring role for continued equitable and safe AOS services across the Network.

5.6 Continued adherence to the AOS Service Specifications

Continued Trust compliance to the Network-established minimum specifications, subject to annual review.

6 Lessons Learned

The following is a summary of the lessons learned from this programme, for continuing success both within the further development of Acute Oncology services across the Network and for taking forward into other programmes:

Areas that worked well

6.1 That good medical and nursing engagement was established from the outset and maintained throughout the implementation.

6.2 That focused Project Management was established upon publication of the draft NCAG report and maintained – the benefits of this being that all Trusts worked to the same plan, were clear on the objectives and target dates, common templates for the implementation and Trust data collection were in use, and a regular monitoring process was established.

6.3 That the target implementation date for the baseline service across the Network was set nine months ahead of the national target, a stretch goal that was achieved across the Network.

6.4 The importance of the detailed benefits monitoring process in enabling (a) the Trusts to fine-tune local implementation and (b) the Network to establish an understanding of the clinical and performance benefits of the service.

6.5 That the AOS Nurses were placed at the centre of the work within each Trust, both from an implementation and an ongoing operational perspective.

6.6 The Network funding of the AOS Nurses was a turning point in the success of the implementation.

6.7 That the Network linked the data collection to the AOS Nurse Funding for a more robust benefits analysis.

6.8 The engagement of robust financial and information support for the performance aspects of the benefits analysis activity.

Areas of Learning

6.9 That the Trust AOS Data Collection should have been made more minimal from the start of data collection – the initial scoping of the data collection for the calls and presentations made it too onerous for the Trust AOS Nurses to sustain. It was reduced in Q4 2011/12 and again in Q1 2012/13 to support the Trusts and to enhance data completeness.

7 Key Points and Recommendations, going forward

To enhance further the service already in place within each Trust, the following areas of future areas of development focus are strongly recommended:

7.1 Robust capture and reporting to the NAOG of Trust Neutropenic Sepsis mortality rates, for ongoing service improvement and improved outcomes.

7.2 Improvement against the Neutropenic Sepsis door-to-needle time target - those last reported in July 2012 demonstrate that work is required to improved the rates within the majority of Trusts.

7.3 In support of this, where not already in place, that each Trust implements a Patient Group Directive (PGD) to enable nurse-led prescribing of antibiotics for suspected Neutropenic Sepsis patients.

Note: Where the CCG leads have established good links with the GP cancer leads, Neutropenic Sepsis is already been monitored closely at a local level. This good practice is recommended for adoption across Anglia.

7.4 A continuous review of Acute Oncology working practices across all Trusts, with the aim of ensuring that the aims and objectives of the NCAG report are being achieved and improved upon.

7.5 That Trusts should continue to collect the AOS data locally from the 1 April 2013. The reported data has provided a valuable insight into Acute Oncology activity across the Network, and would provide Trusts with the data to inform on, for example:

- The above continuous review and improvement in working practices leading to the overall increased effectiveness of local AOS services,
- Identification of areas of good practice for innovation spread,
- The development of any future Acute Oncology-related business cases.

7.6 Continued focus on reducing unplanned admissions and length of stay, whilst the current downward trend is encouraging.

7.7 Further development of the Trusts IT flagging systems – whilst systems are in place the 2012 Peer Review visits highlighted inequity in the functionality across the Trusts. All Trusts have been requested to report any gaps in their current system compared to the quality standard and this is being reviewed at the January 2013 NAOG.

7.8 Carry out an assessment of the experience of the acute cancer patient compared with patients presenting as planned visits/admissions, to establish (a) variation between the two and (b) any variation in the acute patient's experience since the introduction of the AOS.

7.9 Agreed Service Level Agreements between CUH and the four affected units, for the provision of a 24/7 Consultant Helpline Service. The current status is that Bedford, the WSH and Hinchingbrooke's funding has now been agreed and the SLAs are in the process of being signed off. The SLA for QEH is currently being negotiated.

Further work to be done to develop the following:

7.10 Consideration of a 24/7 Network-wide Patient Helpline Advice Service, given that, as outlined in this paper out-of-hours calls represent approximately 50% of current call volumes across the Network.

7.11 CUP Key Performance Indicators. The Network CUP service is in its implementation phase and not yet at the point where the benefits of the service can be monitored and measured. This benefits analysis should be put in place at an appropriate point after completion of the implementation.

7.12 Assessment and analysis of the impact of the AOS on the Trust emergency departments and Palliative Care services.

8 Recommendations

The Board is asked to note the significant implementation progress made and to acknowledge and support the further work required for the continuing development of the Anglia Acute Oncology Service.

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