

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	
Service	Children’s Cancer Operational Delivery Network – Paediatric Oncology Shared Care Unit [INDIVIDUAL PROVIDER NAME TO BE INSERTED AT CONTRACT STAGE] COMPLETE AT CONTRACT STAGE: [Standard / Enhanced A / Enhanced B]
Commissioner Lead	NHS England
Provider Lead	INDIVIDUAL PROVIDER NAME TO BE INSERTED AT CONTRACT STAGE

1. Scope
<p>1.1 Prescribed Specialised Service</p> <p>This Service Specification (the “Specification”) covers the provision of Children’s Paediatric Oncology Shared Care Units (POSCUs) involved in the delivery of children’s cancer services (≤ 16 years of age) in England. POSCUs operate as part of a Children’s Cancer Operational Delivery Network (“Network”) which is led by a Principal Treatment Centre (PTC). In order to ensure access to age appropriate shared care, some POSCU services may flex the upper age limit to 18 years. This must be agreed by both the Children’s Cancer Network and Teenage and Young Adult Cancer Network locally.</p> <p>1.2 Description</p> <p>The scope of specialised services is set out in the Prescribed Specialised Services Manual (the “Manual”). The provision described within the Manual relates to children and young people up to the age of 24 years.</p> <p>The Manual states that “specialist cancer services for children and young people include:</p>

- All specialist care for children within children’s Principal Treatment Centres (PTCs);
- All specialist care for teenagers and young adults within Teenage and Young Adult PTCs including transitional care (service provision covered by other published NHS England Service Specifications);
- All shared care overseen by PTCs;
- All cancer chemotherapy and radiotherapy;
- All specialist cancer palliative care services; and
- Planning after care (as part of the survivorship initiative)”.

The Specification covers the provision of paediatric oncology shared care services and must be read in conjunction with:

- The Children’s Cancer Operational Delivery Network – Principal Treatment Centre Service Specification, together with other published NHS England Service Specifications (Appendix 1); and
- NHS England Clinical Commissioning Policies and Policy Statements.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

NHS England commissions all specialist cancer services for children at specified centres. Clinical Commissioning Groups (CCGs) do not commission any elements of this service.

2. Care Pathway and Clinical Dependencies

2.1 Service Overview

Shared care enables children with cancer to receive supportive care and, where agreed, specified chemotherapy treatment(s) as close to home as possible and importantly, facilitates appropriate access to local community support services.

The Specification has been developed, as part of a suite of Children’s Cancer Network Service Specifications, to implement the recommendations of the Cancer Taskforce and the NHS Long Term Plan. Specifically, it aims to sustainably:

- Improve integration between different children’s cancer services;
- Improve the experience of care;
- Increase participation in clinical trials, which is currently at around two thirds of patients;
- Increase tumour banking rates;
- Improve the transition between children’s and TYA services, in particular ensuring that there is no age gap between different services; and
- Embed genomic medicine within children’s cancer services.

Securing improved experience, greater pathway integration and increased clinical trial participation may mean that existing shared care arrangements in some Networks in England need to be both/either consolidated in number and/or expanded in terms of scope of practice. It is expected that the PTC, through the Children’s Cancer

Operational Delivery Network, will drive this change, reflecting the unique needs of each Network within the agreed service configuration.

2.2 Children's Cancer Operational Delivery Network

All POSCUs must be part of a Children's Cancer Operational Delivery Network. In particular geographies and for some supra-network services, POSCUs may work with more than one PTC. Where this occurs, the POSCU is required to form part of one Network only, which must be the PTC with whom they provide the most shared care.

All POSCUs are expected to:

- Agree and sign a Memorandum of Understanding, or other written agreement, setting out the role of the Network and each constituent member, together with the agreed governance arrangements;
- Participate fully in the Children's Cancer Operational Delivery Network;
- Provide regular data to the Children's Cancer Operational Delivery Network to support the operational delivery and improvement of Children's Cancer Network services. This will include, but not be limited to:
 - Compliance against Network agreed pathways and protocols;
 - Clinical and quality outcomes across the network, including any incidents or safety concerns;
 - Workforce indicators; and
 - Patient experience survey results.

2.3 POSCU Core Service Requirements

All children with cancer must have access to emergency paediatric care within a travel time of one hour of their home, in order to access antibiotics quickly and safely. Therefore, all POSCUs must be commissioned providers of children's Emergency Units.

Each POSCU will offer either 'Standard' or 'Enhanced' services:

- **Standard POSCUs:** Will provide the full range of supportive care but will **not** provide SACT services; and
- **Enhanced POSCUs:** Will provide the same services as Standard POSCUs and, in addition, will also provide SACT services. Enhanced POSCUs will be sub classified into two groups: (i) Level A Enhanced POSCUs who provide out-patient and daycare bolus or infusional chemotherapy; and (ii) Level B Enhanced POSCUs who also provide in-patient chemotherapy.

All POSCUs must comply with the standards for the level of its designation, as agreed with the Network and must demonstrate that:

- The shared care service exists within a sustainable Children's Services department that can deliver care in line with national guidance for acute paediatric services (*Facing the Future: Standards for Acute General Paediatric Services*, Royal College of Paediatrics and Child Health (RCPCH), 2015);
- The necessary infrastructure, staffing and competencies (including facilities for education provision, staff, staff competencies) exist at the POSCU to provide the agreed level of service;

- Paediatric cancer patients are cared for on a single named children's ward where this is agreed as part of the ward's regular activity and to which patients are admitted in preference to other wards;
- There is sufficient and appropriate expertise in medical and nursing cover throughout each 24 hour period regardless of the level (if any) of chemotherapy provided and including robust arrangements for absence, holidays, out of hours and emergencies to ensure continuity of service;
- There is access to at least Critical Care Level 1 at every POSCU (*High Dependency Care for Children - Time to Move On*, RCPCH, 2014);
- Expert oncology and haematology medical advice is available by telephone throughout each 24 hour period either through the PTC or the POSCU. This must include a robust process for access to oncology team advice/review at weekends which must be demonstrated in the POSCU operational policy and in Network agreements;
- There is sufficient access to services from Allied Health Professionals (AHPs), such as pharmacy, dietetics, physiotherapy, occupational therapy, speech and language therapy;
- There is adequate access to psychology services;
- A robust research governance framework is in place with the PTC delivering appropriate elements of the trial activity; and
- Patient and family experience is used to guide service improvement.

Where the POSCU is providing shared care services in partnership with another PTC and supra-regional services, the POSCU must follow the individual supportive care protocol for the PTC overseeing the patient's care.

Standard POSCUs:

Standard POSCUs must only provide the following services:

- Assessment of children referred to paediatric services on the cancer immediate or urgent referral pathway;
- Outpatient supportive care and follow-up;
- Emergency management of paediatric oncology patients (e.g., febrile neutropenia emergency treatment) and inpatient supportive care (e.g., pain management and symptom control); and
- Sign-posting to local paediatric services.

Each Standard POSCU will be expected to comply with the following staffing requirements:

- All Standard POSCUs must have a lead consultant clinician with cancer experience and a deputy lead clinician. The relevant sessions should reflect the size on the unit/responsibility. The lead clinician's continuing professional development (CPD) must include cancer specific elements;
- The lead consultant should be a member of the Children's Cancer and Leukaemia Group (CCLG) in order to enable access to best practice guidelines and training;
- Ward and Day Care nurse staffing levels and training must be specified by the Manual for Cancer Services (2014) (see Appendix 3);

- The Lead Nurse and Deputy Lead Nurse must both be trained at the 'external' level as defined by the Manual for Cancer Services (2014) (see Appendix 3);
- The Lead and Deputy Lead Nurse must have allocated time (programmed activities (PAs)) in their job plans to allow for them to participate and lead in educational activities;
- AHPs must be available within the Network;
- Lead advanced level pharmacist and designated deputy trained to provide a clinical supportive care service for children with cancer, and sufficient staffing in place to ensure there is a safe and effective service; and
- Lead consultant clinicians, lead nurses and lead pharmacists and their deputies should all be trained in Good Clinical Practice (GCP) to allow them to support treatments that are part of clinical research trials.

Some Standard POSCUs may be able to provide more complex supportive care. This must be agreed by the Network and may require access to 24 hour imaging including CT scans, Critical Care Level 2 (High Dependency Unit, HDU) facilities, nutritional support / Total Parenteral Nutrition (TPN) and expert pain control and other paediatric subspecialty expertise (e.g. paediatric surgery).

Enhanced POSCUs - Level A

Level A Enhanced POSCUs must provide all of the following services in addition to the services expected of Standard POSCUs, in line with Network guidelines:

- Outpatient bolus chemotherapy;
- Infusional day case chemotherapy; and
- Acute lymphoblastic leukaemia (ALL) Maintenance chemotherapy - adjustment of 6-Mercaptopurine and Methotrexate dosing.

Level A Enhanced POSCUs are expected to see, on average over a 5 year period, at least 10 new patients per year. The arrangements for this must be agreed by the PTC and overseen by the Network.

Each Level A Enhanced POSCU will be expected to comply with the following staffing requirements:

- New lead consultant clinician must have at least 1 full year of tertiary paediatric cancer experience and their deputy must have tertiary cancer experience. For existing lead clinicians and where a POSCU changes level of service, previous clinical experience and expertise should be taken into account and competency to act as lead POSCU clinician approved by the ODN;
- Number of PAs for the lead consultant and their deputy should reflect the level of activity at that POSCU;
- CPD for medical staffing must include cancer specific training;
- Lead consultant and deputy should be a member of the CCLG;
- Ward and Day Care nurse staffing levels and training must be as specified in the Manual for Cancer Services (2014) (see Appendix 3);
- There should be a Lead Nurse for the service who has identified time and responsibility in their job role for paediatric oncology and is trained at the

'External' level as defined in Appendix 3. There should be a Deputy Lead Nurse to provide cover in the absence of the Lead Nurse who should be trained at external level as defined in the Manual for Cancer Services (2014) (see Appendix 3);

- The Lead Nurse should be a Core Member of the POSCU MDT. The Deputy Lead Nurse should be an extended member of the POSCU MDT and provide cover to the Lead Nurse;
- The Lead and Deputy Lead Nurse must have allocated time in their job plans for this role which also allows for them to participate in and lead educational activities. This should reflect the level of activity within the POSCU;
- There should be named Nurse Trainer for the service, with responsibility for training in chemotherapy administration. See Appendix 3 for details of training and role;
- AHPs to be affiliated members of the MDT and involved in MDT meetings & decisions as appropriate;
- Patient and families should have guaranteed access to AHP services either locally or within a network solution if appropriate;
- There must be access to Health Play Specialist(s);
- Lead advanced level pharmacist and designated deputy for the service, trained to provide a clinical service for children with cancer. Sufficient staffing should be in place to ensure a safe and effective services. Time must be allocated to their job plans to allow them to liaise with the PTC and participate in educational activities; and
- Lead consultant clinicians, lead nurses and lead pharmacists and their deputies should all be GCP-trained to allow them to support treatments that are part of clinical research trials.

Level A Enhanced POSCUs must have a regular MDT meeting (see Appendix 2) and should work to establish MDT links with the PTC. Besides the regular meetings to discuss individual patients the team must meet at least annually to discuss, review, agree and record at least some operational policies.

Enhanced POSCUs – Level B

Level B Enhanced POSCUs must provide the following service in addition to the services expected of Standard and Level A Enhanced POSCUs:

- Inpatient infusional chemotherapy.

Level B Enhanced POSCUs may also provide the following service, where there is an explicit agreement with the Network to do so:

- Intrathecal chemotherapy (in line with the National Guidance on the Safe Administration of Intrathecal Chemotherapy, *Department of Health*, 2008).

Level B Enhanced POSCUs are expected to see, on average over a 5 year period, at least 20 new patients per year. The arrangements for this must be led and overseen by the Network.

Each Level B Enhanced POSCU will be expected to comply with the following staffing

requirements:

- New lead consultant clinician must have at least 2 years of paediatric cancer experience of which 1 year must include tertiary cancer experience in a PTC or equivalent and their deputy must have at least 1 year of paediatric oncology experience. For existing lead clinicians and where a POSCU changes level of service, previous clinical experience and expertise should be taken into account and competency to act as lead POSCU clinician approved by the ODN;
- Number of PAs for the lead consultant and their deputy should reflect the level of activity at that POSCU;
- CPD for medical staffing must include cancer specific training;
- The lead consultant and their deputy should be members of the CCLG;
- Ward and Day Care nurse staffing levels and training must be as specified by the Manual for Cancer Services (2014) (see Appendix 3);
- There should be a Lead Nurse for the service who has identified time and responsibility in their job role for paediatric oncology and is trained at the 'External' level as defined in Appendix 3. There should be a Deputy Lead Nurse to provide cover in the absence of the Lead Nurse who should be trained at external level as defined in the Manual for Cancer Services (2014) (see Appendix 3);
- The Lead Nurse should be a Core Member of the POSCU MDT. The Deputy Lead Nurse should be an extended member of the POSCU MDT and provide cover to the Lead Nurse;
- The Lead and deputy Lead Nurse must have allocated time in their job plans to allow them to participate in and take a leader in educational activities. The allocated time in their job plans must reflect their level of activity;
- There should be named Nurse Trainer for the service, with responsibility for training in chemotherapy administration. See Appendix 3 for details of training and role;
- AHPs must be affiliated members of the MDT situated at the POSCU and involved in MDT meetings & decisions as appropriate;
- AHPs need to have experience in paediatrics and oncology;
- AHPs must have allocated time in their job plans to allow them to participate in education and training across the Network;
- Staffing levels will need to ensure that there are cover arrangements in place for holiday and study to ensure patient access to AHP services;
- There must be access to Health Play Specialist(s);
- All patients must have access to local psychology services;
- Lead advanced level pharmacist and designated deputy for the service, trained to provide a clinical service for children with cancer. Sufficient staffing should be in place to ensure a safe and effective services. Time must be allocated to their job plans to allow them to liaise with the PTC and participate in educational activities; and
- Lead consultant clinicians, lead nurses and lead pharmacists and their deputies should all be GCP-trained to allow them to support treatments that are part of clinical research trials.

Level B Enhanced POSCUs must provide sufficient beds for paediatric oncology patients on the paediatric ward to support the planned inpatient chemotherapy service as well as the unplanned admissions for patients requiring supportive care. This will facilitate each Level B Enhanced POSCU to transfer fewer patients out.

Level B Enhanced POSCUs must have a regular MDT meeting (see Appendix 2) and should work to establish MDT links with the PTC. Besides the regular meetings to discuss individual patients the team must meet at least annually to discuss, review, agree and record at least some operational policies.

Level B Enhanced POSCUs should have robust methods to facilitate communication with network providers and other ad hoc clinical forums e.g. video conferencing.

2.4 Systemic Anti-Cancer Therapy (SACT) – For Enhanced POSCUs Only

Systemic anti-cancer therapy (SACT) plays an important role in the treatment of children's cancers. It includes conventional chemotherapy, monoclonal antibodies/targeted therapies, intravenous, subcutaneous, intrathecal, intraventricular, and oral chemotherapy; hormonal treatment is excluded. All SACT delivered to children should be initiated by the PTC and agreed by one of the PTC MDTs.

All SACT services must:

- Have a professional head for the service that is directly responsible for the development, management and ultimate clinical accountability and responsibility for the service. This professional head of service must hold an appropriate qualification to practice and be registered with the Health Professions Council;
- Have a single named designated pharmacist for the aseptic chemotherapy preparation facilities of the pharmacy service;
- Utilise an approved list of treatment regimens which is updated annually and all treatments must be given in accordance with agreed treatment protocols. This list must be held by the relevant PTC;
- Assess all new treatments prior to their introduction and agree these with the Network in advance to ensure that they fit with strategic plans;
- Ensure that treatment is given in accordance with agreed Network treatment protocols;
- Have a policy defining the steps required for use of regimens not on the approved protocol list. Deviations must be directed and approved by the PTC and should be recorded and audited on a regular basis;
- Agree arrangements for the delivery of urgent SACT treatment prior to MDT discussion;
- Put in place a robust system of clinical governance and ensure that all staff are fully familiar with the treatments employed within the service and be trained and deemed competent to deliver them;
- Ensure that chemotherapy is prescribed using an e-prescribing system (Contract particulars, Schedule 4 – National Quality Requirements). It is acknowledged that some providers may be working towards compliance with

this requirement and will therefore have implementation plans in place which have been agreed with local commissioners;

- Ensure that SACT is only be prescribed by staff that have demonstrated their competency and are authorised and registered to prescribe SACT by the PTC and/or Children's Cancer Network;
- Ensure that all SACT prescriptions are checked by a cancer pharmacist who has undergone specialist training, demonstrated their appropriate competence and is locally/authorised. Where a pharmacist non -medical prescriber prescribes SACT a second children's cancer pharmacist is still required to verify the prescription;
- Undertake pre-chemotherapy treatment assessments to ensure:
 - Accurate pre-SACT assessment to enable variation from the patient's baseline to be detected;
 - Pre-course and pre-cycle records meet all requirements of the relevant SACT; and
 - The patient is confirmed to be fit to proceed and all pre-cycle/course investigations are within the limits defined in the protocol.
- Ensure that all female patients of child bearing age have a pregnancy test prior to initiation of SACT;
- Put in place local arrangements to ensure that, as far as is practicable, high cost items are only reconstituted after the patient's blood results are known. All SACT must be prepared in accordance with locally approved policies and protocols;
- Ensure that there are on-site facilities for the management of central venous access devices with defined surgical support at the POSCU site, so that the administering practitioner can ensure appropriate venous access for the chemotherapy to be administered;
- Commence SACT treatment during standard 'working hours' wherever possible when support services and expert advice are available; there should be a local policy to this effect. The policy must state in which, and only which, exceptional circumstances the initiation of administration of chemotherapy may be allowed outside "normal working hours" and the arrangements for administering SACT which then apply;
- Ensure that the SACT service is delivered safely and that it conforms to appropriate standards, guidance and best practice, in particular the:
 - Manual for Cancer Services: Children's Cancer Measures (National Cancer Action Team, 2013);
 - Improving Outcomes in Children and Young People with Cancer (NICE, 2005);
 - National standards set following National Patient Safety Agency (NPSA) oral and vinca-alkaloid alerts (2008);
 - Systemic Anti-Cancer Therapy: For Better or Worse (National Confidential Enquiry into Patient Outcomes and Death (NCEPOD), 2008);
 - Chemotherapy Services in England: Ensuring quality and safety (National Chemotherapy Advisory Group (NCAG), 2009); and
 - Guidance on the administration of intrathecal chemotherapy

(Department of Health, 2008).

- On the Right Course: A review of the quality of care provided to patients receiving systemic anti-cancer therapy. (National Confidential Enquiry into Patient Outcome and Death (NCEPOD), 2018).
- Ensure that nurses who administer chemotherapy to children have been assessed as competent to do so in line with the relevant quality measures;
- Maintain a register of staff that have completed competency-based training;
- Ensure that all staff responsible for reconstituting SACT must have undergone training in line with:
 - Health and Safety Commission approved Code of Practice, The Control of Substance Hazardous to Health (COSHH, 2008);
 - Aseptic dispensing for NHS patients: a guidance document for pharmacists in the United Kingdom (Department of Health, 1993);
 - Rules and Guidance for Pharmaceutical Manufacturers and Distributors (the 'Orange Guide') (MRHA, 2017); and
 - Quality Assurance of Aseptic Preparation Services 5th Edition (Beaney, AM. 2017).
- Put in place a policy detailing the safe reconstitution of cytotoxic drugs. Manipulating and reconstituting cytotoxics poses the greatest risk, for this reason, cytotoxics should only be reconstituted in an accredited and regulated/audited pharmacy aseptic unit by appropriately trained and experienced staff;
- Following treatment with SACT, the responsible clinician should confirm to both the patients GP and the referring clinician; what treatment has been delivered, the patient's condition and any post treatment arrangements; and
- Submit data to the national SACT database.

SACT preparation, in particular chemotherapy, may receive its pharmacy support from a pharmacy which has previously been reviewed as part of the peer review of adult cancer services. If, at such a previous review, there was compliance with the measures regarding preparation facilities and the Control of Substance Hazardous to Health (COSHH) they will be regarded as compliant for the review of children's cancer services provided it is within the timeframes stated in those measures. The remaining preparation measures, as outlined in this Specification, should be applied specifically and separately with regards to the children's service. The responsibility for review purposes for these measures lies with the lead pharmacist.

2.5 Patient Information and Consent

Patient and Carer Information must be provided which covers generic and tumour specific information for children with cancer.

Each provider and health care practitioner must comply with the relevant legislative framework and relevant guidance governing consent. Accordingly, each provider and health care practitioner must ensure that all children and young people who use services are:

- Fully informed about their care, treatment and support and information must be age-appropriate;

- Able to take part in decision making to the fullest extent possible; and
- Asked if they agree for their parents or guardians to be involved in decisions they need to make.

([Guidance for providers on meeting the regulations. Care Quality Commission. 2015](#)).

Further guidance on children's consent can be found through the [General Medicine Council](#).

It is important that patients, parents and carers receive clear written guidance when consenting to treatment, this must include the following:

- Treatment intent;
- Prognosis and potential complications associated with their treatment;
- Clear instructions who to contact if they need advice outside working hours including phone numbers for 24/7 advice lines (either at the PTC or POSCU);
- How to proceed in the event of a medical emergency, in particular following SACT; and
- Information on how to manage and care for a central line (where appropriate).

2.6 Training / Education

All staff should be subject to annual performance appraisal and a policy should be in place to govern this. Clear training policies should be in place to ensure that staff maintain and develop their specialist skills and knowledge which should include:

- Nurse training in line with the Network's internal and external training programme including training in chemotherapy skills and management of its consequences in line with the staff members role. It is recognised in national guidance that the nursing contribution in cancer teams is critical to the success of these services;
- Medical training in line with above where applicable for chemotherapy;
- Specialist pharmacy training in order to enable (i) clinical screening of supportive care prescriptions and for the enhanced POSCU (ii) chemotherapy prescription verification; (iii) safe implementation of clinical trials and new drugs; (iv) safe implementation of electronic prescribing of SACT;
- Access to specialist resource materials; and
- "Good Clinical Practice" in Clinical Trials training.

Time must be allocated for mandatory training and to maintain and develop cancer skills for all staff disciplines.

2.7 Interdependencies with Other Services

Each POSCU must have a co-located:

- Acute general paediatric services;
- Paediatric pharmacy service;
- Paediatric Critical Care - Level 1; and
- POSCUs that undertake higher-risk interventions (as defined by the Network) must also have Paediatric Critical Care - Level 2 (HDU).

Other related co-dependent services include:

- Local authority based services for education and social services;
- Child and adolescent mental health services;
- Primary Care;
- Community services; and
- Palliative care services.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

This Specification is for children resident in England* or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays? Establishing the responsible commissioner and other Department of Health guidance relating to Patients entitled to NHS care or exempt from charges).

This Specification covers children and teenagers aged 0 to 15 years, up to the 16th birthday. However, older teenagers may wish to be treated within the service and younger teenagers may be treated within TYA services if they so wish and where this is consistent with Network agreements. Hence this specification should be read in conjunction with the relevant specifications for Teenage and Young Adult Cancer Services.

*Note: for the purposes of commissioning health services, this EXCLUDES Patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES Patients resident in Wales who are registered with a GP Practice in England.

3.2 Population Needs

Childhood cancer is rare and, in the UK, around 1,600 children (under 15 years) are diagnosed with cancer every year (CCLG). The incidence of cancer in adolescents is less certain due to data collection problems, but rates calculated by Birch (2003), and endorsed by the CCLG, suggest about 1:7000 per year among adolescents 15-19 years. Across the 0-19 age range, the highest incidence of cancer is among children 0-4 years, reducing among children 5-14, and rising again among teenagers over 15 years. The incidence of childhood cancer in each region is similar across the UK.

Childhood cancers are different to cancers affecting adults and tend to occur in different parts of the body. Children are diagnosed with a wide range of cancers in the UK; around 41% are leukaemias and lymphomas, 25% brain tumours, with the remaining conditions comprising a wide range of solid tumours. As the age of the patient increases, bone sarcoma and epithelial tumours, which are more commonly seen in adults, are found.

In the past 40 years, treatment for children with cancer has greatly improved. Cure rates for children with cancer are much higher than adults. On average, 82% (over 8 in 10) of all children can now be completely cured. For some types of children's cancer, the cure rate is much higher (CCLG).

3.3 Expected Significant Future Demographic Changes

The incidence of paediatric cancer is expected to continue to increase in line with current trends, i.e. approximately 10% more children diagnosed per million population with every decade. The increases are likely to occur in particular tumour types including bone tumours and germ cell tumours, in line with recent trends (Cancer Science 2018, in press). Increased incidence and improved survival rates are expected to continue to increase the number of patients using adult late effects services.

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

The Specification aims to:

- Improve cancer treatment outcomes and survival for children with cancer;
- Reduce physical, emotional and psychological morbidity arising from treatment for childhood cancer;
- Support equitable, integrated and timely shared care across the Network;
- Ensure appropriate entry of patients to clinical trials;
- Deliver age appropriate care, in age appropriate settings;
- Delivery and support palliative care services across the pathway;
- Deliver a long-term follow-up model;
- Facilitate transition to TYA and/or adult services;
- Support the patient and family throughout their cancer journey; and
- To develop high quality data to enable review of performance of services and share learning to continuously demonstrate improvements in the quality of services and patient experience.

NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

4.2 Indicators Include:

No.	Indicator	Data source	Domain(s)	CQC Key Question
POSCU Clinical Outcomes				
101	Median time from onset of fever to administration of antibiotics in neutropenic fever.	Provider (NCRAS dataset)		Safe, Effective

Patient Experience				
201	There is information for patients and families.	Self declaration	4	Responsive, Caring
202	There is a mechanism in place to obtain feedback from patients and families.	Self declaration	4	Responsive, Caring
Structure and Process				
001	There is specialist paediatric oncology staffing.	Self declaration	1,3,5	Well led, Safe
002	There are agreed shared care arrangements with the PTC and Network.	Self declaration	1,3,5	Well led, Safe
003	There is a 24/7 resident medical on call rota.	Self declaration	1,3,5	Safe, Effective
004	There are treatment planning meetings (applicable to Enhanced POSCU Level A and Level B).	Self declaration	1,3,5	Effective
005	There is a Network agreed competency-based training programme (applicable to Enhanced POSCU Level A and Level B).	Self declaration	1,3,5	Safe, Effective
006	There are specified wards for administration of SACT (applicable to Enhanced POSCU Level A and Level B).	Self declaration	1,3,5	Safe, Effective
007	There are Network agreed clinical guidelines including SACT regimens and protocols in place (applicable to Enhanced POSCU Level A and Level B).	Self declaration	1,3,5	Safe, Effective
008	There are policies in place for the safe administration of SACT (applicable to Enhanced POSCU Level A and Level B).	Self declaration	1,3,5	Safe, Effective
009	There is a process in place for national SACT submission.	Self declaration	1,3,5	Safe, Effective, Well Led.
010	There are Network agreed patient pathways in place.	Self declaration	1,3,5	Safe, Effective
011	There is a policy in place for transition.	Self declaration	1,3,5	Safe, Effective

NOTE – Some metrics are developmental and will require refinement over 2021-23 – such metrics should be included within Trust Data Quality Improvement Plans.

Detailed definitions of indicators, setting out how they will be measured, is included in schedule 6.

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Designated Providers (if applicable)

The designated providers for the **[INSERT INDIVIDUAL CHILDREN'S CANCER NETWORK NAME AT CONTRACT STAGE]** are as follows:

[DRAFTING NOTE – AT CONTRACT STAGE SELECT A SINGLE CHILDREN'S CANCER NETWORK CONFIGURATION]

6. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

<please list, explaining each abbreviation and acronym>

Date published: *<insert publication date>*

Appendix 1

NHS England Service Specification	
SUPRA-NETWORK SERVICES	
Service Specification Title	NHS England Reference
Paediatric Radiotherapy Services	TBC
Proton Beam Therapy Service (all ages)	170071S
Proton Beam Therapy Service - Overseas Programme (adults and children)	170012/S
Haematopoietic Stem Cell Transplantation (Children)	B04/S/b
Retinoblastoma Service (Children)	E04/S(HSS)/a
Stereotactic Radiosurgery and Stereotactic Radiotherapy (Intracranial) (All Ages)	D05/S/a
Primary Malignant Bone Tumours Service (Adults and Adolescents)	B12/S(HSS)/a
CAR T-cell Therapy	TBC
NETWORK SPECIALIST SERVICES	
Service Specification Title	NHS England Reference
Children's Cancer Networks - Principal Treatment Centres	TBC
Teenage and Young Adult Cancer Services	TBC
Chemotherapy (Children, Teenagers and Young Adults)	B15/S/b
Paediatric Medicine: Endocrinology & Diabetes	E03/S/e
Paediatric Neurosciences: Neurosurgery	E09/S/a
Paediatric Neurosciences: Neurology	E09/S/b
Paediatric Neurosciences: Neurodisability	E09/S/c
Paediatric Neurosciences: Neurorehabilitation	E09/S/d
Paediatric Medicine: Renal	E03/S/a
Paediatric Medicine: Immunology and Infectious Diseases	E03/S/d
Paediatric Medicine: Palliative Care	E03/S/h
Craniofacial service (All Ages)	E02/S(HSS)/d
Paediatric Surgery (& Surgical Pathology, Anaesthesia & Pain)	E02/S/a
Paediatric Surgery Chronic Pain	E02/S/b
Paediatric Surgery Neonates	E02/S/c
NHS Genomic Laboratory Services	TBC
Child and Adolescent Mental Health Services (CAMHS) Tier 4 : General adolescent services including specialist eating disorder services	170022/S
Tier 4 Child and Adolescent Mental Health Services (CAMHS): Children's Services	C07/S/b

Appendix 2: Enhanced POSCU MDT Membership

The core team specific to the POSCU MDT should include:

- Lead clinician of the POSCU;
- Deputy Lead clinician of the POSCU (N.B. the Lead and Deputy Lead clinicians could cover for each other);
- The POSCU lead cancer nurse;
- Designated pharmacist from the cancer pharmacy service supporting the POSCU chemotherapy service. Pharmacy input is required for all chemotherapy treatment decisions; however, membership can be through direct attendance at the MDTs or through access to the MDT outcomes and direct attendance at other multidisciplinary team meetings where SACT treatment planning is undertaken. This must be agreed by the Children's Cancer Network; and
- MDT co-ordinator/secretary;

An NHS-employed member of the core team should be nominated as having specific responsibility for users' issues and information for patients and carers.

Appendix 3: Standards for Children's Nursing

The Network should agree a nurse training programme in oncology skills and chemotherapy administration covering certain core competencies specified below (internal training). The Network may or may not choose to extend this programme to provide more comprehensive training, but it is not primarily intended, by these measures, to initiate new, university accredited courses in paediatric oncology.

Where additional training beyond the internal training is required for compliance with these measures it is intended that the Network should use these currently existing courses (external training). There should be named and experienced paediatric oncology nurses for each Network who should be responsible for the internal training and assessing the core competencies of staff. The Network may choose to share the provision of such an internal training programme and the employment of trainers and assessors with one or more Networks.

External training

- University accredited course in children's cancer care and/or chemotherapy to 20 credits at first degree or 15 credits at Masters level. Individuals may follow a modular pathway based on local provision. Reviewers should exercise judgement over this.

Internal training

- Network agreed, RCN competency based
 - 'Full' – chemotherapy administration and oncology skills.
The competencies should include at least those specified in "*Competencies: an education and training competency framework for administering medicines intravenously to children and young people*" (Royal College of Nursing; publication code 003 005 Domains 1-5) and "*Competencies: an integrated competency framework for training programmes in the safe administration of chemotherapy to children and young people*" (Royal College of Nursing; publication code 002 501);
 - 'Foundation' – oncology skills for nurses not administering chemotherapy.
The competencies should cover at least the following: (i) management of central venous access devices; (ii) care of a child who is febrile and neutropenic; and (iii) administration of blood products.
 - 'Low Risk' – chemotherapy competencies focused only on administration of Network agreed limited list of low-risk regimens.

External is intended to be at greater depth than internal, to provide exemption from 'full internal' training and also from foundation and low risk training. Full internal encompasses and provides exemption from foundation and low risk training.

Foundation and low risk are tailored to their specific nurse roles and of themselves provide no exemption from another complete training type. However, nurses should be able to move between roles within the internal training programme by acquiring, and being assessed for, just those additional competencies which would then complete the required training type.

Standard POSCU Nursing Standards

There should be a minimum of 2 nurses during each shift, trained at least to the '*foundation* internal' level.

Enhanced Level A POSCU Nursing Standards

Minimum of two, day and night, nurses working on the in-patient ward should be trained at least to the '*foundation* internal' training level.

A minimum of 2 nurses on duty during each shift of each working day that the day care facility is open for chemotherapy should be trained at least to the '**full** internal' training level.

On days that the facility is open but not for chemotherapy, there should be a minimum of 2 nurses during each shift, trained at least to the '*foundation* internal' level.

There must be a named Lead Nurse at the POSCU. The role of the Lead Nurse is to provide professional and clinical leadership and support to nursing staff within the PTC. Post-holders should be responsible for all elements of the nursing service and will be expected to contribute to the strategic development of the whole service in line with the individual hospital trust and relevant national targets and quality measures.

Level B Enhanced POSCU

Minimum of two, day and night, nurses working on the in-patient ward should be trained at least to the '**full** internal' training level specified.

A minimum of 2 nurses on duty during each shift of each working day that the day care facility is open for chemotherapy should be trained at least to the '**full** internal' training level.

There must be a named Lead Nurse at the POSCU. The role of the Lead Nurse is to provide professional and clinical leadership and support to nursing staff within the PTC. Post-holders should be responsible for all elements of the nursing service and will be expected to contribute to the strategic development of the whole service in line with the individual hospital trust and relevant national targets and quality measures.

Nurse Trainer

There must be a named chemotherapy nurse for the chemotherapy service with responsibility for training in chemotherapy administration for both Level A and Level B Enhanced POSCUs. The nurse should be qualified to 20 credits at first degree level in paediatric oncology including one module or more in chemotherapy administration (external training) and the nurse should be currently administering chemotherapy for part of the time, with a minimum of two years previous experience in chemotherapy administration. The named nurse trainer should have an agreed list of responsibilities which include:

- Choosing nurses who are initially judged able to act as assessors of competence in chemotherapy administration;
- Ensuring that staff administering chemotherapy in the service are trained and assessed for competence according to the competencies specified in the introduction; and

- Have an agreed minimum time allowed for those responsibilities in their weekly timetable.