Metastatic spinal cord compression

NICE quality standard

Draft for consultation

September 2013

This quality standard covers the diagnosis and management of metastatic spinal cord compression (MSCC) in adults (18 years and older), and the prevention of MSCC in adults at risk. For more information, see the topic overview.

Why this quality standard is needed

Spinal cord compression problems with potentially serious pathology (cauda equina syndrome, cancer of the spine [particularly metastatic disease] and spinal infection) need to be recognised and prioritised urgently[1]. These groups often present with similar signs and symptoms, and it is important to identify the cause in order to establish if the spinal cord compression is metastatic. MSCC is defined as spinal cord compression by direct pressure and/or the induction of vertebral collapse or instability by metastatic spread or direct extension of malignancy that threatens or causes neurological disability. MSCC is a complication of cancer, and is usually an oncological emergency.

MSCC requires a multidisciplinary approach. Early diagnosis and treatment are essential to prevent neurological damage, so early recognition and reporting of symptoms, simple and rapid referral pathways, urgent investigations, and prompt treatment are all integral.

People with breast, lung or prostate cancer account for more than 50% of MSCC diagnoses, but it can also be caused by other tumours or haematological cancers. Research has shown that 77% of people diagnosed with MSCC had an established

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[1] National Spinal Task Force (2013) Commissioning Spinal Services – Getting the service back on track

diagnosis of cancer, whereas 23% presented with MSCC as the first presentation of malignancy[2].

The incidence of MSCC in England is unknown because cases are not systematically recorded. However, postmortem evidence indicates that it is present in 5–10% of patients with advanced cancer. MSCC is estimated to affect approximately 3000 patients per annum in England[3]. The average age at the time of diagnosis is 65. It is important that care is delivered on an individualised basis and is not influenced by the age of the person.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2013/14
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Part 1 and Part 1A.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

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[2] Levack P, Graham J, Collie D et al. (2001) A prospective audit of the diagnosis, management and outcome of malignant spinal cord compression. Clinical Resource and Audit Group (CRAG) 97/08

[3] National Spinal Task Force (2013) Commissioning Spinal Services – Getting the service back on track

Table 1 NHS Outcomes Framework 2013/14

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** 1.4 Under 75 mortality rate from cancer* i One-and ii Five-year survival from all cancers iii One-and iv Five-year survival from breast, lung and colorectal cancer
4 Ensuring that people have a positive experience of care	Overarching indicator 4a Patient experience of primary care i GP services 4b Patient experience of hospital care Improvement areas Improving people's experience of outpatient care 4.1 Patient experience of outpatient services Improving hospitals' responsiveness to personal needs 4.2 Responsiveness to in-patients' personal needs Improving the experience of care for people at the end of their lives 4.6 Bereaved carers' views on the quality of care in the last 3 months of life Improving people's experience of integrated care Improving people's experience of integrated care 4.9 An indicator is under development***
5 Treating and caring for people in a safe environment and protect them from avoidable harm	Overarching indicator 5c Hospital deaths attributable to problems in care Improvement areas Reducing the incidence of avoidable harm 5.1 Incidence of hospital-related venous thromboembolism (VTE) 5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) *** Indicator shared with Adult Social Care Outcomes Framework	

Table 2 **Public health outcomes framework for England, 2013–2016**

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** *4.*5 Under 75 mortality rate from cancer

Coordinated services

The quality standard for MSCC specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole MSCC care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with MSCC.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality MSCC service are listed in related quality standards. [Link to section in web version]

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults with MSCC should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with MSCC. If appropriate, healthcare professionals and social care and public health practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

[In final web version hyperlink each statement to the full statement below.]

Statement 1. People at risk of developing metastatic spinal cord compression (MSCC) are given information that describes the signs and symptoms of MSCC and what to do if they develop signs and symptoms.

Statement 2. People at risk of developing metastatic spinal cord compression (MSCC), who present with either spinal pain or neurological symptoms or signs, have their diagnostic investigations coordinated by an MSCC coordinator.

Statement 3. People with suspected metastatic spinal cord compression (MSCC), who present with neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Statement 4. People with suspected metastatic spinal cord compression (MSCC), who do not present with neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Statement 5. People with metastatic spinal cord compression (MSCC) have their care pathway coordinated by an MSCC coordinator.

Statement 6. People with metastatic spinal cord compression (MSCC) have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Questions about the individual quality statements

Question 1 For draft quality statement 1: Is it possible to define ‘at high risk of developing bone metastases’?

Question 2 For draft quality statement 2: Is it possible to define ‘at high risk of developing bone metastases’?

Question 3 For draft quality statement 6: would it be more appropriate to refer to a management plan for people with MSCC rather than a discharge plan for people with MSCC who are admitted to hospital?

Quality statement 1: Information about recognising the signs and symptoms of metastatic spinal cord compression

Quality statement

People at risk of developing metastatic spinal cord compression (MSCC) are given information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Rationale

It is important that people at risk of developing MSCC recognise its signs and symptoms so they can seek help to ensure prompt diagnosis and treatment. If people have information, they can feel empowered to manage their condition, which can lead to early detection and improved outcomes.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that people at risk of developing MSCC are given information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-1E-105y (Network Information on Early Detection of MSCC) and 11-3Y-311 (Patient Information on Early Detection of MSCC) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

Process

Proportion of people at risk of developing MSCC who receive information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Numerator – the number of people in the denominator who receive information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Denominator – the number of people at risk of developing MSCC.

Data source: Local data collection. NICE audit support for Metastatic spinal cord compression (NICE clinical guideline 75).

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people at risk of developing MSCC to be given information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Healthcare professionals give people at risk of developing MSCC information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms.

Commissioners ensure that they commission services that give people at risk of developing MSCC information that describes the signs and symptoms of MSCC and what to do if they develop signs or symptoms

What the quality statement means for patients, service users and carers

People at risk of MSCC are given information that describes the signs and symptoms to watch out for and advice on what to do if they develop signs or symptoms.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendation 1.3.1.1 (key priority for implementation).

Definitions of terms used in this quality statement

People at risk of MSCC

People with cancer who have, or who are at high risk of developing bone metastases, and people with cancer who present with spinal pain.

Signs and symptoms of MSCC

The signs and symptoms of MSCC are described in NICE clinical guideline 75 in the following recommendations:

1.3.2.1 Contact the MSCC coordinator urgently (within 24 hours) to discuss the care of patients with cancer and any of the following symptoms suggestive of spinal metastases:

- pain in the middle (thoracic) or upper (cervical) spine
- progressive lower (lumbar) spinal pain
- severe unremitting lower spinal pain
- spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing)
- localised spinal tenderness
- nocturnal spinal pain preventing sleep.

1.3.2.2 Contact the MSCC coordinator immediately to discuss the care of patients with cancer and symptoms suggestive of spinal metastases who have any of the following neurological symptoms or signs suggestive of MSCC, and view them as an oncological emergency:

- neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction
- neurological signs of spinal cord or cauda equina compression.

Information that describes the signs and symptoms of MSCC

Information for patients may be in the form of, for example, a leaflet listing the early warning signs and symptoms of MSCC, together with clear advice on what action to take if any signs or symptoms develop. The full guideline includes a patient information leaflet in appendix 2 (see Metastatic spinal cord compression [NICE clinical guideline 75]). In addition, other examples of patient information are available from a number of sources.

Healthcare professionals should give careful consideration to the timing of giving information, because people with cancer receive a wide variety of supporting information about the disease. The importance of information about MSCC, and its signs and symptoms, should be communicated clearly.

Question for consultation

Is it possible to define ‘at high risk of developing bone metastases’?

Quality statement 2: Coordinating care for people at risk of metastatic spinal cord compression

Quality statement

People at risk of developing metastatic spinal cord compression (MSCC), who present with either spinal pain or neurological symptoms or signs, have their diagnostic investigations coordinated by an MSCC coordinator.

Rationale

Some people with cancer are at risk of developing MSCC, for example, people who have, or who are at high risk of developing, bone metastases. When people at risk present with spinal pain or neurological symptoms or signs it is important that diagnostic investigations are undertaken promptly. Providing an MSCC coordinator service, available at all times, to liaise with healthcare professionals and coordinate necessary investigations, will help to ensure that care is both comprehensive and timely.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people at risk of developing MSCC, who present with either spinal pain or neurological symptoms or signs, have their diagnostic investigations coordinated by a MSCC coordinator.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-3Y-304 Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

b) Evidence of local arrangements for the identification of individuals responsible for performing the role of MSCC coordinator.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-3Y-304 Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

Process

Proportion of people at risk of developing MSCC, who present with either spinal pain or neurological symptoms or signs, who have their diagnostic investigations coordinated by an MSCC coordinator.

Numerator – the number of people in the denominator who have their care pathway coordinated by an MSCC coordinator.

Denominator – the number of people at risk of developing MSCC, who present with either spinal pain or neurological symptoms or signs.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people at risk of developing MSCC, who present with either spinal pain or neurological symptoms or signs, to have their diagnostic investigations coordinated by an MSCC coordinator.

Healthcare professionals ensure that people at risk of developing MSCC, who present with either spinal pain or neurological symptoms or signs, have their diagnostic investigations coordinated by an MSCC coordinator.

Commissioners ensure that they commission services that provide an MSCC coordinator to organise diagnostic investigations for people at risk of developing MSCC who present with either spinal pain or neurological symptoms or signs.

What the quality statement means for patients, service users and carers

People at risk of developing MSCC (that is, people with cancer that has spread, or is at risk of spreading to the bones of the spine, who also have symptoms or signs that suggest they may be developing a spinal problem), have their investigations for diagnosis arranged by a coordinator.

Neurological symptoms and signs are set out in NICE clinical guideline 75, recommendation 1.3.2.2:

- neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction
- neurological signs of spinal cord or cauda equina compression.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendations 1.1.2.3.

Definitions of terms used in this quality statement

MSCC coordinator

An MSCC coordinator should coordinate the care pathway of people with MSCC and the diagnostic investigations of people at risk of developing MSCC who present with relevant symptoms. An MSCC coordinator should be available 24 hours a day, 7 days a week, with an identified point of contact available to liaise with healthcare professionals.

The MSCC coordinator's responsibilities and the support they should receive are described in NICE clinical guideline 75 recommendations 1.1.2.3 and 1.1.2.5.

The Manual for cancer services: acute oncology – including metatastic spinal cord compression measures (2011; measure 11-3Y-304) lists the criteria that the MSCC coordinator service should fulfil.

People at risk of MSCC

People with cancer who have, or who are at high risk of developing bone metastases, and people with cancer who present with spinal pain.

Question for consultation

Is it possible to define 'at high risk of developing bone metastases'?

Quality statement 3: Imaging and treatment plans for people with suspected metastatic spinal cord compression and neurological symptoms or signs

Quality statement

People with suspected metastatic spinal cord compression (MSCC), who present with neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Rationale

People with suspected MSCC, who present with neurological symptoms or signs, need rapid access to imaging that will accurately identify spinal cord compression. MRI is central to the diagnosis, staging and planning of treatment. Neurological deficit at initial presentation is an important predictor of long-term functional outcome. To reduce the risk of avoidable disability for people with suspected MSCC, it is important that both MRI is performed and definitive treatment is planned with the agreement of senior clinical advisers within 24 hours of the suspected diagnosis.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that people with suspected MSCC who present with spinal pain and neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-1E-110y (The MSCC Case Discussion Policy) and 11-1E-111y (The Audit of Timeliness of the Investigation of MSCC) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

Process

Proportion of people with suspected MSCC who present with spinal pain and neurological symptoms or signs, who receive an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Numerator – the number of people in the denominator who receive an MRI of the whole spine, and have a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Denominator – the number of people with suspected MSCC, who present with spinal pain and neurological symptoms or signs.

Data source: Local data collection. NICE audit support for Metastatic spinal cord compression (NICE clinical guideline 75). Department of Health Acute Oncology Measures 11-1E-111y (The Audit of Timeliness of the Investigation of MSCC) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011). British Spine Registry Spinal tumour data (2013).

Outcome

a) Rates of paraplegia within 3 months of treatment.

Data source: Local data collection.

b) Rates of mortality within 30 days of treatment.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-1E-113y Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011). British Spine Registry Spinal tumour data (2013).

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people with suspected MSCC who present with spinal pain and neurological symptoms or signs, to have an

MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Healthcare professionals ensure that people with suspected MSCC, who present with spinal pain and neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

Commissioners ensure that they commission services that give people with suspected MSCC who have spinal pain and neurological symptoms or signs, an MRI of the whole spine, and develop a definitive treatment plan if there is a confirmed diagnosis of MSCC, within 24 hours of the suspected diagnosis.

What the quality statement means for patients, service users and carers

People with suspected MSCC (who have spinal pain and nervous system symptoms, such as numbness or tingling in their arms or legs) have an MRI of their whole spine and a plan for their treatment developed within 24 hours of the suspected diagnosis.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendation 1.4.3.3 (key priority for implementation).

Definitions of terms used in this quality statement

Neurological symptoms and signs are set out in NICE clinical guideline 75, recommendation 1.3.2.2:

- neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction
- neurological signs of spinal cord or cauda equina compression.

Treatment plan

A definitive treatment plan for people with MSCC should be agreed by senior clinical advisers and should be documented. The full clinical guideline, Metastatic spinal cord compression, states that treatment planning must take account of:

- the degree of neurological disability
- the general health of the patient
- the primary site of tumour
- the presence of other spinal and extraspinal metastases
- the likely response of the tumour to radiotherapy or other adjuvant therapy.

Senior clinical advisers

Include clinical oncologists, spinal surgeons and radiologists with experience and expertise in treating patients with MSCC.

Suspected MSCC

NICE clinical guideline 75 recommendation 1.3.2.1 includes the following signs and symptoms suggestive of spinal metastases:

- pain in the middle (thoracic) or upper (cervical) spine
- progressive lower (lumbar) spinal pain
- severe unremitting lower spinal pain
- spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing)
- localised spinal tenderness
- nocturnal spinal pain preventing sleep.

Quality statement 4: Imaging and treatment plans for people with suspected metastatic spinal cord compression and no neurological symptoms or signs

Quality statement

People with suspected metastatic spinal cord compression (MSCC), who do not present with neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Rationale

People with suspected MSCC, who present with spinal symptoms but no neurological symptoms or signs, need timely access to imaging that will accurately identify spinal cord compression. MRI is central to the diagnosis, staging and planning of treatment. If MSCC is suspected, it is essential that investigation, planning, and treatment take place before any loss of neurological function occurs. To reduce the risk of avoidable disability for people with suspected MSCC, it is important that an MRI is performed and that treatment is planned by senior clinical advisers within 1 week of the suspected diagnosis.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that people with suspected metastatic spinal cord compression (MSCC), who do not present with neurological symptoms or signs, have an MRI of the whole spine, and a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-1E-110y (The MSCC Case Discussion Policy) and 11-1E-111y (The Audit of Timeliness of the Investigation of MSCC) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

Process

Proportion of people with suspected MSCC, who present with spinal pain but no neurological symptoms or signs, who receive an MRI of the whole spine, and have a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Numerator – the number of people in the denominator who receive an MRI of the whole spine, and have a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Denominator – the number of people with suspected MSCC who present with spinal pain but no neurological symptoms or signs.

Data source: Local data collection. NICE audit support for Metastatic spinal cord compression (NICE clinical guideline 75). Department of Health Acute Oncology Measures 11-1E-111y (The Audit of Timeliness of the Investigation of MSCC) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011). British Spine Registry Spinal tumour data (2013).

Outcome

a) Rates of paraplegia in people with suspected MSCC.

Data source: Local data collection.

b) Rates of mortality within 30 days of treatment.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-1E-113y Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011). British Spine Registry Spinal tumour data (2013).

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people with suspected MSCC who present with spinal pain but no neurological symptoms or signs to receive an MRI of the whole spine, and have a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Healthcare professionals ensure that people with suspected MSCC who present with spinal pain but no neurological symptoms or signs, receive an MRI of the whole spine, and have a definitive treatment plan developed if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

Commissioners ensure that they commission services that give people with suspected MSCC, who present with spinal pain but no neurological symptoms or signs, an MRI of the whole spine, and a definitive treatment plan if there is a confirmed diagnosis of MSCC, within 1 week of the suspected diagnosis.

What the quality statement means for patients, service users and carers

People with suspected MSCC (who have spinal pain only) have an MRI of their spine, and a plan for their treatment organised within 1 week of the suspected diagnosis.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendation 1.4.3.3 (key priority for implementation).

Definitions of terms used in this quality statement

Neurological symptoms and signs are set out in NICE clinical guideline 75, recommendation 1.3.2.2:

- neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction
- neurological signs of spinal cord or cauda equina compression.

Suspected MSCC

NICE clinical guideline 75 recommendation 1.3.2.1 includes the following signs and symptoms suggestive of spinal metastases:

- pain in the middle (thoracic) or upper (cervical) spine
- progressive lower (lumbar) spinal pain
- severe unremitting lower spinal pain
- spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing)
- localised spinal tenderness
- nocturnal spinal pain preventing sleep.

Treatment plan

A definitive treatment plan for people with MSCC should be agreed by senior clinical advisers and should be documented. The full clinical guideline, Metastatic spinal cord compression, states that treatment planning must take account of:

- the degree of neurological disability
- the general health of the patient
- the primary site of tumour
- the presence of other spinal and extraspinal metastases
- the likely response of the tumour to radiotherapy or other adjuvant therapy.

Senior clinical advisers

Include clinical oncologists, spinal surgeons and radiologists with experience and expertise in treating patients with MSCC.

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Quality statement 5: Coordinating care for people with metastatic spinal cord compression

Quality statement

People with metastatic spinal cord compression (MSCC) have their care pathway coordinated by an MSCC coordinator.

Rationale

People may present with MSCC to a variety of specialists and may require involvement from a number of specialties including oncology, surgery and radiography. It is important that investigations and treatments are undertaken promptly because early intervention has a positive effect on MSCC outcomes. Providing an MSCC coordinator service, available at all times, with a point of contact to liaise with healthcare professionals and coordinate the care pathway, will help to ensure that care is both comprehensive and timely.

Quality measures

Structure

a) Evidence of local arrangements to ensure that people with MSCC have their care pathway coordinated by an MSCC coordinator.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-3Y-304 (The MSCC Coordinator Service) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

b) Evidence of local arrangements for the identification of individuals responsible for performing the role of MSCC coordinator, with 24-hour availability.

Data source: Local data collection. Department of Health Acute Oncology Measures 11-3Y-304 (The MSCC Coordinator Service) Manual for cancer services: acute oncology - including metatastic spinal cord compression measures (2011).

Process

Proportion of people with MSCC who have their care pathway coordinated by an MSCC coordinator.

Numerator – the number of people in the denominator who have their care pathway coordinated by an MSCC coordinator.

Denominator – the number of people with MSCC.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people with MSCC to have their care pathway organised by an MSCC coordinator.

Healthcare professionals ensure that people with MSCC have their care pathway organised by an MSCC coordinator.

Commissioners ensure that they commission services that provide an MSCC coordinator to organise the care pathway of people with MSCC.

What the quality statement means for patients, service users and carers

People with MSCC have their treatment and care plan organised by a coordinator.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendations 1.1.2.1 and 1.1.2.2.

Definitions of terms used in this quality statement

MSCC coordinator

An MSCC coordinator should coordinate the care pathway of people with MSCC and the diagnostic investigations of people at risk of developing MSCC who present with relevant symptoms. An MSCC coordinator should be available 24 hours a day, 7 days a week, with an identified point of contact available to liaise with healthcare professionals.

The MSCC coordinator's responsibilities and the support they should receive are described in NICE clinical guideline 75 recommendations 1.1.2.3 and 1.1.2.5.

The Manual for cancer services: acute oncology – including metatastic spinal cord compression measures (2011; measure 11-3Y-304) lists the criteria that the MSCC coordinator service should fulfil.

Quality statement 6: Supportive care and rehabilitation

Quality statement

People with metastatic spinal cord compression (MSCC) have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Rationale

Rehabilitation and supportive care are integral to the promotion of independence and quality of life in people with cancer. Survival rates at 1 year for people with MSCC have been reported as being less than 20%. Because of this, MSCC should be regarded as a life-limiting disease, and considerable attention needs to be paid to ensuring high-quality, individualised support for people when they return home after a hospital admission. Emphasis should be on a coordinated, person-centred discharge planning process, led by a key worker, and which should take into account other existing cancer treatment pathways, if relevant.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that people with MSCC have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Data source: Local data collection.

Process

Proportion of people with MSCC who have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Numerator – the number of people in the denominator who have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Denominator – the number of people with MSCC who are discharged from hospital.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers ensure that systems are in place for people with MSCC to have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Healthcare professionals ensure that people with MSCC have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

Commissioners ensure that they commission services that make sure people with MSCC have a discharge plan that includes an assessment of ongoing care and rehabilitation needs.

What the quality statement means for patients, service users and carers

People with MSCC have a plan of the care they will receive after they have been discharged from hospital, which will include plans for rehabilitation.

Source guidance

- Metastatic spinal cord compression (NICE clinical guideline 75), recommendation 1.6.5.4 (key priority for implementation).

Definitions of terms used in this quality statement

Discharge planning and ongoing care

For patients with MSCC, this should start on admission. It should involve the patient and their families and carers, their primary oncology site team, rehabilitation team and community support, including primary care and specialist palliative care, as needed.

Key worker

Person who, with the patient’s consent and agreement, takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice.

Equality and diversity considerations

Survival times for people with MSCC vary from just a few weeks to over a decade. The person's prognosis and age should not affect the content of the discharge plan or their access to rehabilitation services.

Question for consultation

Would it be more appropriate to refer to a management plan for people with MSCC rather than a discharge plan for people with MSCC who are admitted to hospital?

Status of this quality standard

This is the draft quality standard released for consultation from 11 September to 9 October 2013. It is not NICE's final quality standard on MSCC. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 9 October 2013. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from March 2014.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, health professionals and social care practitioners, patients, service users and carers alongside the documents listed in Development sources [Link to section in web version]

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments [add correct link] are available.

Good communication between healthcare professionals and people with MSCC is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with MSCC should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide on the NICE website.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Metastatic spinal cord compression. NICE clinical guideline 75 (2008).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- National Spinal Taskforce (2013) Commissioning Spinal Services – Getting the service back on track.
- Department of Health (2011) Commissioning Cancer Services.
- Department of Health (2011) Improving outcomes: a strategy for cancer.
- National Cancer Peer Review Programme (2011) Manual for cancer services: acute oncology – including metatastic spinal cord compression measures.
- Department of Health (2010) A guide to practice-based commissioners in developing good cancer care services.
- Department of Health (2007) Cancer Reform Strategy.
- NICE Cancer Service Guidance (2004) Improving outcomes in supportive and palliative care for adults with cancer.

Definitions and data sources for the quality measures

- National Cancer Peer Review Programme (2011) Manual for cancer services: acute oncology – including metatastic spinal cord compression measures.
- NICE clinical guideline 75 (2008) Metastatic spinal cord compression: audit support.

Related NICE quality standards

Published

- Lung cancer. NICE quality standard 17 (2012).
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Breast cancer. NICE quality standard 12 (2011).

In development

- Faecal incontinence. Publication expected February 2014.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Haematological malignancies.
- Neurological problems.
- Pain management (young people and adults).
- Prostate cancer.
- Radiotherapy services.
- Referral for suspected cancer.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

Hugh McIntyre (Chair)

Consultant Physician, East Sussex Healthcare Trust

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Julia Thompson

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The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

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