

Metastatic spinal cord  
compression

**Implementation advice**

2009



This implementation advice accompanies the clinical guideline: 'Diagnosis and management of adults at risk of and with metastatic spinal cord compression' (available online at: [www.nice.org.uk/CG75](http://www.nice.org.uk/CG75)).

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**This implementation advice is aimed at the person responsible for supporting the implementation of NICE guidance in the organisation (NICE manager) and the clinical lead for the topic.**

**This is a support tool containing suggested steps towards implementing our guidance informed by your local baseline assessment.**

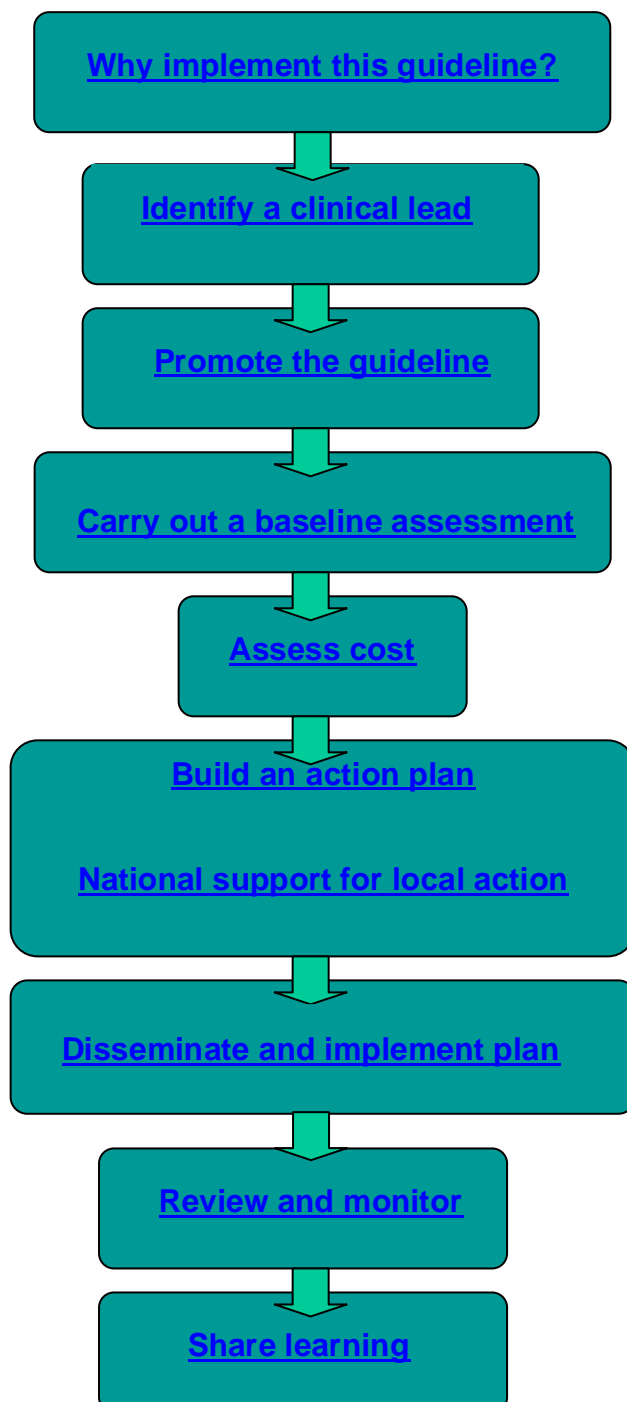
**It is not NICE guidance.**

**Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.**

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## Steps to implementing NICE clinical guidelines

The algorithm below outlines the process for implementing NICE clinical guidelines. When using this advice online, hold down the 'Ctrl' button and click on the hyperlinks in the boxes to go directly to the advice you need. The advice has been developed in consultation with a range of experts from patient and professional groups. A list of these contributors is available [here](#).



## Why implement this guideline?

The true incidence of metastatic spinal cord compression (MSCC) is unknown. Postmortem evidence indicates that MSCC affects 5–10% of patients with advanced cancer. Patients with breast, lung and prostate cancer account for more than 50% of MSCC cases, but it can be caused by any solid tumour.

A Scottish audit<sup>1</sup> showed that there were significant delays between patients first developing symptoms, and general practitioners and hospital doctors suspecting MSCC and making an appropriate referral. The median times from the onset of back pain and nerve root pain to referral were 3 months and 9 weeks, respectively. Nearly half of all patients with MSCC were unable to walk at the time of diagnosis, and the majority (67%) of these patients had recovered no function after 1 month. Of those who could walk unaided at the time of diagnosis, 81% were able to walk (either alone or with aid) at 1 month. The ability to walk at diagnosis was significantly related to overall survival.

Early diagnosis and treatment is essential to prevent disability and premature death. Therefore, it is important that appropriate services are commissioned and in place to enable early recognition and reporting of symptoms, simple and rapid referral pathways, urgent and appropriate investigations, and prompt treatment.

The national annual net savings arising from implementing the guideline recommendations on MSCC are estimated at £3.5 million. If patients have surgery before they lose the ability to walk, the costs associated with these patients becoming paraplegic are likely to be avoided, resulting in estimated savings of £17.5 million. These savings represent the difference in health service costs included in the full guidance for care of patients who can walk compared with the care of patients who are unable to walk.

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<sup>1</sup> Levack P et al (2001) A prospective audit of the diagnosis, management and outcome of malignant cord compression (CRAG 97/08). Edinburgh: CRAG.

The Healthcare Commission assesses the performance of NHS organisations in meeting core standards set by the Department of Health in 'Standards for better health' issued in July 2004. Core standard C5 says that NHS organisations should take into account national agreed guidance when planning and delivering care. Full implementation of this guideline is likely to take several years.

If the guideline is not relevant to your organisation, remember to record it.

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## Identify a clinical lead

If you are responsible for supporting the implementation of NICE guidance on a day-to-day basis (NICE manager) you should identify a clinical lead to begin putting the guideline into practice.

The settings covered in the guideline are primary care, including referral, rehabilitation, continuing care and follow-up; secondary care, including diagnosis, treatment and rehabilitation; tertiary care in cancer centres, neurosurgical units and spinal surgery units; specialist rehabilitation centres; and palliative care services. As implementation issues cross many care settings, it may be helpful to identify multiple leads to share the implementation work. The clinical leads should be selected from medically qualified clinicians, for example, clinical oncologists, spinal surgeons or other healthcare professionals with experience and expertise in the treatment of MSCC.

Every cancer network should have a network site specific group (NSSG) for MSCC, including representatives from primary, secondary and tertiary care.

It is important that group membership enables effective awareness raising among clinicians responsible for 'at-risk' groups of patients. An overarching lead should be identified. This may be the NICE manager, who can provide leadership and accountability for the overall implementation of the guideline.

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## Promote the guideline

The NICE manager should ensure that all relevant groups are aware of the guideline and have copies of the Quick Reference Guide. With this guideline, it is also important that at-risk groups of patients have appropriate information provided to support early recognition of symptoms of MSCC. [A local patient information template](#) is provided to support this.

The [slide set](#) provided by NICE should help you raise awareness of the guideline.

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## **Carry out a baseline assessment**

Using the published guideline, the clinical lead should work with the relevant specialist group to compare current activity with the recommendations. This information could be gathered through informal discussions or by using a more formal questionnaire. This baseline assessment will help identify exactly what your organisation and others are doing now and what needs to change in light of the guideline.

Consider, for example, how the recommendations will have an impact on:

- configuration of services
- staffing
- training.

The NICE [audit criteria](#) may help you with this process.

### ***Who should be involved?***

Once the baseline assessment has identified what needs to change, the next stage is to identify which groups will need to alter their current way of working and to consider the best way to engage them in the development and implementation of the action plan. In most cases there may be existing groups or networks such as the local cancer network that could fulfil this function.

These groups are likely to include:

- clinical oncologists
- spinal surgeons
- radiologists
- radiographers and medical physicists
- palliative care teams
- occupational therapists
- other healthcare professionals with experience and expertise in the treatment of MSCC



- key workers allocated to cancer patients
- commissioners
- service planners
- network patient partnership and support groups
- healthcare professionals responsible for the care of at-risk patients.

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## **Assess cost**

The NICE manager should work with the clinical lead to assess how much it will cost to implement the guideline using the [costing template](#) provided by NICE. It might be possible to make some of the required changes using existing resources, and there may be potential for savings to be achieved, or capacity freed up to be used for other things.

Click here to view NICE's [costing report](#).

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## **Build an action plan**

If your organisation is not meeting the recommendations, the NICE manager (the person who is responsible for supporting the implementation of NICE guidance on a day-to-day basis) and the clinical lead should work together to develop an action plan. The details of your action plan will depend on the results of your baseline assessment and your local circumstances.

The local cancer network and the network lead for MSCC can play a major role in the development of the action plan.

In consultation with a range of experts in MSCC we have identified key areas to address for the successful implementation of this guideline:

- raising awareness
- coordination of services
- commissioning.

### ***Suggested actions for healthcare professionals***

#### **Raising awareness**

Early diagnosis and treatment is essential to prevent paralysis. Therefore, it is very important that patients with cancer who are at risk of developing MSCC, their families and carers, and their healthcare professionals are aware of the symptoms of MSCC.

- Gain knowledge and awareness of the symptoms and signs of MSCC.
- Offer an information leaflet to patients (and their families and carers) which explains:
  - the symptoms of MSCC
  - advice on what to do and who to contact if they develop these symptoms
  - who to contact if their symptoms progress while they are waiting for urgent investigation of suspected MSCC.

## **Coordination of services**

Efficient diagnosis and management of patients with MSCC or suspected MSCC can be achieved through a clear care pathway and alignment and management of services.

- The network lead for MSCC should:
  - advise the network about the organisation of services.
  - ensure that there are appropriate points of telephone contact to an MSCC coordinator and senior clinical advisers
  - ensure that the local care pathway is documented, agreed and consistent
  - carry out regular audits of the care pathway.
- The MSCC coordinator should:
  - perform an initial telephone triage by assessing requirement for, and urgency of, investigations, transfer and treatment
  - coordinate the care pathway and advise clinicians
  - liaise with the acute receiving team and organise admission and mode of transport.
- The senior clinical advisers should give advice and support to the MSCC coordinator and other clinicians, inform the decision-making process and undertake treatment where necessary.
- The lead healthcare professional identified by secondary or tertiary care centres should:
  - carry out regular audits of the care pathway
  - ensure good communication between all healthcare professionals involved in the care of patients with MSCC.

## ***Suggested actions for commissioners***

### **Commissioning**

Timely access to services is crucial in meeting the needs of patients with MSCC. Appropriate services, equipment and facilities should be

commissioned to ensure timely referral, imaging and treatment, and to provide adequate supportive care and rehabilitation for patients with MSCC.

Commissioners should:

- work jointly with councils to provide equipment and support to meet the individual needs of patients with MSCC and their families and carers
- ensure the following are made available:
  - access to an MSCC coordinator at all times
  - access to senior oncology opinion and senior surgical opinion at all times
  - out of hours MRI scanning
  - access to spinal surgery as an emergency
  - access to urgent radiotherapy
  - nursing and rehabilitation services

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## National support for local action\* [[Back to build an action plan](#)]

There have been a number of developments over recent years in policy on cancer services. These policies have focused on enhancing the quality of cancer services.

Document	Relevance
<a href="#">Holistic common assessment of supportive and palliative care needs for adults with cancer</a> Department of Health (2007)	<ul style="list-style-type: none"> <li>• Report and accompanying guidance presenting a national specification for a holistic health and social care assessment undertaken to identify supportive and palliative care needs of an individual and to trigger any specialist assessment that may be required.</li> <li>• The guidance enables healthcare teams to use the national specification as a benchmark against which current processes of assessment (and the tools used in support of this) can be appraised.</li> </ul>
<a href="#">Getting it right for people with cancer</a> National Cancer Director, Department of Health (2007)	<ul style="list-style-type: none"> <li>• Outlines how services are being configured to meet the needs of cancer patients. States that no single factor accounts for the progress made so far but highlights five areas where configuration of services plays a key role in improving cancer services for patients:                         <ul style="list-style-type: none"> <li>• better coordination of care – team working and cancer networks</li> <li>• centralisation of complex services – more specialisation</li> <li>• moving some services closer to patients – more convenience</li> <li>• adapting the roles of different staff – more flexibility</li> <li>• using hospital beds better – reinvesting savings in other areas of cancer care.</li> </ul> </li> </ul>
<a href="#">Cancer reform strategy</a> Department of Health (2007)	<ul style="list-style-type: none"> <li>• Builds on progress made since the publication of the NHS Cancer Plan in 2000.</li> <li>• Sets a clear direction for cancer services for the next 5 years.</li> <li>• Shows how by 2012 our cancer services can and should become among the best in the world.</li> </ul>

<p><a href="#">Our health, our care, our say: a new direction for community services</a> Department of Health (2006)</p>	<ul style="list-style-type: none"> <li>• Acknowledges the need for additional investment to improve end-of-life care and pledges to increase choices for patients by: <ul style="list-style-type: none"> <li>• doubling investment in palliative care services, including end-of-life care networks</li> <li>• ensuring all staff who work with patients who are dying are properly trained to look after them and their carers</li> <li>• building on coordinated multi-agency assessments, ensuring health, education and social care services are organised around the needs of dying patients and their families</li> <li>• providing rapid response (hospice at home) services to patients in need by investing in community-based specialist palliative care services.</li> </ul> </li> </ul>
<p><a href="#">Manual for cancer services</a> 2004 Department of Health (2004)</p>	<ul style="list-style-type: none"> <li>• As an integral part of the NHS cancer plan and modernisation of cancer, supports quality assurance of cancer services and enables quality improvement. Provides a mechanism for cancer services to demonstrate they are meeting the healthcare standards.</li> </ul>
<p><a href="#">The NHS cancer plan: a plan for investment, a plan for reform</a> Department of Health (2000)</p>	<ul style="list-style-type: none"> <li>• Sets out the government's programme for investment in and reform of cancer services in England, which aims to reduce death rates and improve survival and quality of life for cancer patients by improving prevention, promoting early detection and effective screening practice, and guaranteeing high-quality treatment and care throughout the country.</li> </ul>
<p><a href="#">A policy framework for commissioning cancer services</a>: a report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales The Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales (1995)</p>	<ul style="list-style-type: none"> <li>• Aims to create a network of care in England and Wales that will ensure patients, wherever they live, will receive treatment and care of a uniformly high standard. A strategic framework, rather than a blueprint, to help commissioners and providers of cancer services to make well informed decisions.</li> <li>• Includes general principles that should govern the provision of cancer care.</li> </ul>

## Related NICE guidance [[Back to build an action plan](#)]

Document	Relevance
<p><a href="#">Faecal incontinence: the management of faecal incontinence in adults</a> NICE clinical guideline 49 (2007)</p>	<ul style="list-style-type: none"> <li>• Offers best practice advice on the care of adults with faecal incontinence.</li> </ul>
<p><a href="#">Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery</a> NICE clinical guideline 46 (2007)</p>	<ul style="list-style-type: none"> <li>• Examines the risk of venous thromboembolism in inpatients undergoing surgical procedures.</li> </ul>
<p><a href="#">Service guidance for improving outcomes for people with brain and other central nervous system tumours</a> NICE cancer service guidance (2006)</p>	<ul style="list-style-type: none"> <li>• Aims to improve delivery of services for patients with brain and other central nervous system tumours in England and Wales.</li> </ul>
<p><a href="#">Improving outcomes for people with sarcoma</a> NICE cancer service guidance (2006)</p>	<ul style="list-style-type: none"> <li>• Outlines how to improve the care of all patients with bone sarcomas and adults with soft tissue sarcomas.</li> <li>• The guidance provides advice to those who develop and deliver cancer services on the planning, commissioning and configuration of services.</li> </ul>
<p><a href="#">Pressure ulcers: the management of pressure ulcers in primary and secondary care</a> NICE clinical guideline 29 (2005)</p>	<ul style="list-style-type: none"> <li>• This guideline makes evidence-based recommendations on the management of pressure ulcers in primary and secondary care.</li> </ul>



<p><a href="#">Referral guidelines for suspected cancer</a> NICE clinical guideline 27 (2005)</p>	<ul style="list-style-type: none"> <li>• Helps GPs make decisions about when to refer people to specialists when they present with symptoms that could be caused by cancer. This guideline is not about treating cancer.</li> </ul>
<p><a href="#">Improving supportive and palliative care for adults with cancer</a> NICE cancer service guidance (2004)</p>	<ul style="list-style-type: none"> <li>• Outlines how supportive and palliative care services should be provided for adults with cancer.</li> <li>• Advises those who develop and deliver cancer services on how to make sure that patients, families and carers are well informed, cared for and supported.</li> </ul>
<p><a href="#">Pressure relieving devices: the use of pressure relieving devices for the prevention of pressure ulcers in primary and secondary care</a> NICE clinical guideline 7 (2003)</p>	<ul style="list-style-type: none"> <li>• Makes recommendations about how the risk of developing a pressure ulcer can be assessed and how pressure ulcers can be prevented by using devices designed to reduce pressure</li> </ul>

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## **Disseminate and implement plan**

Once the action plan and assessment of cost have been approved by the NICE manager the work of implementing the action plan begins. To ensure effective implementation all relevant organisations should sign up to the action plan – for example, via a local area agreement.

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## Review and monitor

Implementation of the guideline should be reviewed and monitored, with results fed back to the relevant trust board.

One way to monitor implementation of the guideline is to audit current practice against the NICE guidance. The guideline is accompanied by [audit criteria](#) to help you with this.

### ***Implementation and uptake of NICE guidance***

The [ERNIE](#) (Evaluation and review of NICE implementation evidence) database is a source of information on the implementation and uptake of NICE guidance.

ERNIE will provide:

- a bank of guidance-specific NICE implementation uptake reports
- references to external literature
- a simple classification system summarising the uptake of NICE guidance.

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## Share learning

Have you got some tips to share with other organisations on implementing NICE clinical or public health guidance? Or would you like to learn from other people's experiences? If so, the NICE ['shared learning' database](#) can help.

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## Acknowledgements

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