MSCC Guidelines for the Referral of Patients with Spinal Metastatic Disease & Suspected Metastatic Spinal Cord Compression

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline has been produced to support the prompt investigation, diagnosis and onward referral of patients with metastatic spinal cord compression (MSCC) and\or spinal metastases, to a defined team specialising in spinal assessment and management. It describes the steps necessary to ensure early diagnosis, appropriate investigation and coordination of treatment to prevent paralysis or other neurological damage which may adversely affect quality of life and prognosis.

Patients presenting with suspected spinal cord compression may be classified as either urgent or emergency referrals. The distinction is made based on the basis of the symptoms and signs and subsequent imaging confirmation of the compression of the neural elements within the spine.

This guideline is for use by the following staff groups

Lead Clinician(s)

Dr Tom Heafield	Consultant Neurologist & Neurology Clinical Lead
Approved by Divisional Management Board on:	7th July 2021
Review Date: This is the most current document and should be used until a revised version is in place	7th July 2024

Key amendments to this guideline

Date	Amendment	Approved by:
7th July 2021	New document approved	DMB
25th November 2021	Amendments to section 3.2 wording	Tom Heafield
23rd March 2022	Amendments to section 3 - minor change to clarify the times of expected results.	Dr I Nagra / Dr Heafield

Introduction

Metastatic spinal cord compression (MSCC) is a well-recognised complication of cancer and is usually an oncological emergency. Early diagnosis and treatment is essential to prevent irreversible neurological damage.

Some patients with spinal metastases are at risk of developing spinal cord compression and need to be assessed by a specialist team to reduce the likelihood of permanent loss of function.

To ensure early detection and responsive management of MSCC a clear pathway for referrals in line with the recommendations of the NICE Guidance (2008 and 2014) is necessary. This requires MSCC referrals to be discussed with the designated MSCC co-ordinator for the Trust. The responsibility of the MSCC coordinator is to ensure the required information is available and collated so that senior clinical advisors can decide on the most appropriate management for the patient avoiding unnecessary delays.

1. Clinical Presentation

1.1 Urgent presentation

1.1.1 Patients presenting with the following clinical symptoms and signs of spinal metastatic disease and should be dealt with as urgent (i.e. treatment planning within one week of presentation).

- pain in the middle (thoracic) or upper (cervical) spine progressive pain in the lower (lumbar) spine
- 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 or requiring opiate analgesia
- developing limb weakness
- abnormal neurological signs
- abnormal reflexes and or a sensory level to examination (pin prick)

1.1.2 See section 6.5 for the clinical management of patients classed as urgent.

1.2 Emergency presentation

1.2.1 Patients presenting with clinical symptoms suggesting cord compression should be dealt with as an emergency (i.e. treatment planning should be within 24 hours of presentation or sooner if clinically indicated). This means patients with any of the clinical symptoms outlined in 3.1 plus neurological symptoms including:

- radicular pain
- any limb weakness, abnormal reflexes
- difficulty walking (including falls)
- sensory loss or bladder or bowel dysfunction, ***especially a sensory level***

1.2.2 **Please note:** neurological signs of spinal cord or cauda equina compression develop late in the evolution of spinal cord compression.

1.2.3 **The following is commonly used as a guide to indicate which patients require emergency referral:**

Metastatic cancer\suspected cancer (common in breast, prostate, lung, renal, myeloma)

Severe suspicious pain, band like chest pain, shooting nerve pain, nocturnal pain, progressive spinal pain, sensory impairment

Continence- difficulty in controlling bladder or bowels

Cannot work legs / arms, loss of power

1.2.4 See section 6.6 for the management of patients classed as emergency.

2. Imaging

2.1 MRI of the whole spine should be performed in patients with suspected MSCC, unless there is a specific contraindication. This should be done in time to allow definitive treatment to be planned within:

- 1 week of the suspected diagnosis in the case of spinal pain suggestive of spinal metastases or sooner if there is a pressing clinical need for emergency surgery

  OR

- 24 hours in the case of spinal pain suggestive of spinal metastases and neurological symptoms or signs suggestive of MSCC and occasionally sooner if there is a pressing clinical need for emergency surgery.
- MRI is the imaging modality of choice to demonstrate the extent of soft tissue and bone involvement, and the extent and degree of neurological compromise. ***The option of a neurological opinion in difficult cases should be considered.***

2.2 When MRI is contraindicated other imaging such as CT of the spine with contrast may assist with the diagnosis.

2.3 In addition to MRI, it is wise to request an up to date CT chest, abdomen and pelvis staging scan and particularly if the overall clinical situation suggests surgery may be appropriate. CT is more appropriate to define the potential for structural spinal failure. A targeted CT scan with multi-planar bone reconstruction (MPR) can be reconstructed from the whole body CT to assess spinal stability and to plan spinal surgery in patients with MSCC. The need for the dedicated MPR should be indicated on the request information.

2.4 This information above will facilitate decisions about stability and suitability for vertebroplasty. (NB: this should not delay referral of emergency cases i.e. deteriorating neurology)

3. Access to imaging and reporting

3.1 Radiology departments have configured lists to allow examination of patients with suspected MSCC at short notice during the hours of 9-5pm during weekdays and 8-4pm only on the Worcester site or selected weekend days at other sites seven days a week. In-patient MSCC scans are done within 24 hours of the request 7 days a week and reported same day. Out-patient studies are done within 7 days of the request and reports are expedited to be completed within One working day of the scan being done.

3.2 MRI is available at WAHT during the hours of 9-5pm on weekdays and 8-4pm on weekends and bank holidays, for those patients presenting with the symptoms outlined above or when there is an intention to proceed to immediate treatment as an in-patient.

3.3 If MRI is not available within the required time frame deemed clinically necessary at the referring hospital i.e. after 5pm, the patient with suspected MSCC and rapidly evolving deficit should be transferred to a unit with out of hours capability if there is a pressing clinical need for surgery.

3.4 If MSCC is confirmed the imaging examination should be transferred via the Image Exchange Portal (IEP) to the centre to which the clinician will refer the patient via an intranet 'blue light' request. The timeframe for this will depend upon clinical need; however, there should be the facilities for image transfer 24/7 via the PACS department or MRI radiographers.

3.5 Image transfer via the Image Exchange Portal may require further training of radiographic staff at referring centres to enable transfer of images outside normal office hours. There may be instances where some referring centres send the images by CD Rom or other means if IEP is not possible.

4. Assessment of spinal instability

4.1 Spinal instability refers to potential or actual mechanical spinal failure possibly leading to neurological damage as a result of movement. It is a major concern in management of traumatic spinal injury. Spinal column infiltrated by metastatic tumour is likely to be weakened and therefore potentially less stable. However, in metastatic spine disease, whether the spine is stable or not can be difficult to decide.

4.2 Spinal Stability in metastatic disease is dependent on:

- *Site of disease(cervical, thoracic or lumbar):* For example, in the thoracic spine the presence of ribs and chest wall provide added support to the spinal column affected by metastatic disease, whereas this is lacking in the cervical spine and below the tenth thoracic vertebra
- *Extent of tumour infiltration:* In general, the greater the tumour involvement of the vertebrae (particularly of the vertebral body), the more likely it is that stability is compromised. Collapsed vertebrae are also less likely to be stable.
- *Co-morbidity:* For example, pre-existing osteoporosis of the vertebrae (related to old age, chronic steroid use etc) will lead to weakened bones, which when infiltrated by tumour is likely to be less stable.

- *Effect of open surgery or disease progression:* Decompressive surgery without stabilisation (in the form of instrumentation, vertebroplasty or both) may reduce spinal stability. Spinal stability may also be compromised in some patients managed non-surgically, due to tumour progression.

4.3 An assessment of the risk of spinal instability should be made in each patient by the medical/surgical team, based upon clinical and radiological information (derived from both MRI and CT imaging see section 4 above). If the spine is thought to be unstable inform the patient's oncologist who may ask for a surgical opinion prior to and in order to discuss treatment options. If in doubt, obtain a surgical opinion from spinal surgeon on call.

4.4 Spinal Neoplastic Instability Score (SINS)

4.4.1 This scoring tool specifically designed for assessment of potential for instability by radiology and oncology teams and will give a guide as to whether referral for surgical stabilisation should be considered prior to oncological treatment. (Appendix 1). (***The option of a neurological opinion in difficult cases should be considered)***

5. Immediate management

5.1 If spinal instability is suspected at diagnosis of cord compression:

- Ensure patient is nursed on flat bed and log rolled (with appropriate pressure care and VTE management being mindful that patients may require urgent surgery).
- If cervical lesion is suspected, immobilise with neck blocks, tape and fit a hard collar (Miami J or Philadelphia).
- Obtain an urgent surgical opinion from spinal surgeons as per referral guideline.

5.2 Spinal instability should be considered if there are new neurological symptoms/signs and/ or significant pain on vertical loading on initial attempts at mobilisation of the patient. Patients with cord compression, who have received radiotherapy, may subsequently develop instability due to tumour progression or fracture.

5.3 All patients with metastatic spine disease, considered initially stable, need to be educated with respect to the warning signs of progression to instability and cord compression. Patients should be given a copy of patient information leaflet and alert card if not already given. This is available from the Macmillan Cancer Support website.

6. Referral for specialist opinion

6.1 The process for referral for a specialist opinion is dependent upon the severity of symptoms at presentation, and referrers should follow the appropriate route for emergency or urgent referrals.

6.2 If there are issues with the interpretation of neurological findings, then an urgent neurology consultation should be sought via ward referrals or advice and guidance:

wah-tr.neurologyadvice@nhs.net or wah-tr.wrh.neurologyreferrals@nhs.net

The option of a neurological opinion in difficult cases should be considered.

6.3 Emergency referrals should be discussed with the on call MSCC co-ordinator for the Trust.

6.4 Involve the Acute Oncology Team to ensure early oncology opinion and immediate advice for care and management of suspected MSCC patients. If out of hours discuss with oncology on-call at the local provider hospital.

6.5 Urgent referrals

6.5.1 Patients presenting with spinal metastases, but with the absence of signs of cord compression are also classed as **urgent**.

6.5.2 Oncologist opinion

Following MRI all patients should be referred for initial opinion by an oncologist. This should be done within a timescale that enables treatment planning within 1 week of diagnosis:

- Patients already known to an oncology team should be referred, where possible, directly to that team via their registrar/consultant.
- If patients are not known to an oncology team, or the team is unavailable, the on-call oncologist should be contacted.

6.5.3 Surgical opinion

The Consultant oncologist (in consultation with the patient) will decide whether onward referral for a surgical opinion should take place.

The Oncologist is responsible for determining whether a surgical opinion is required. The secondary care clinician, making the referral, is responsible for contacting the surgical team.

All urgent (**non-emergency**) patients with spinal metastatic disease requiring a spinal surgical opinion are to be referred to the appropriate locally agreed spinal service.

6.6 Emergency referrals

Patients with spinal metastases and clinical symptoms suggesting cord compression are classed as emergency referrals. **An immediate opinion is required in this instance and the following steps are to be taken**:

6.6.1 Primary care clinicians, including hospice and care home staff, should immobilise the patient (with appropriate pressure care precautions) and transfer him\her to the nearest accident & emergency department or equivalent medical admissions unit (MAU) with a copy of the patient alert guide if available.

6.6.2 Where possible contact should be made with the local Acute Oncology team\MSCC Coordinator advising them of the transfer.

6.6.3 The option of a neurological opinion should be considered in any or difficult cases.

6.6.4 Oncologist Opinion

Following MRI patients should be referred for initial oncology opinion. This should be done within a timescale that enables treatment planning within 24 hours of diagnosis:

- Patients already known to an oncology team should be referred directly to that Acute Oncology Service.
- If the Acute Oncology Team is unavailable, the on-call oncologist should be contacted.

6.6.5 Surgical opinion

The Consultant oncologist, (in consultation with the patient) will decide whether onward referral for a surgical opinion should take place.

The Oncologist is responsible for determining whether a surgical opinion is required. The secondary care clinician, making the referral, is responsible for contacting the surgical team.

6.6.6 Staff in A&E/MAU should ensure that:

- Immediate clinical and full neurological assessment is carried out MRI whole spine is performed within 24 hours of the patient presenting (or sooner if clinically indicated)
- Oral dexamethasone 16mg od is commenced as soon as possible if there are signs of neurological compromise, unless lymphoma is strongly suspected when it is preferable to obtain a biopsy. If it is felt that steroids may be necessary please discuss this with the spinal surgery team before commencement if it is thought surgery may be indicated.

In addition, the A&E\MAU staff should liaise with the acute oncology team\MSCC coordinator to ensure that:

- Imaging is completed
- Where possible all clinical information is available
- The patient is discussed with an oncologist as described above
- If appropriate the patient is referred for surgical opinion (as described above)
- ***The option of a neurological opinion in difficult cases should be considered***

6.6.7 The referring clinician must be in a position to provide clinical details of the patient to the respective on call senior clinical advisors to enable appropriate case discussion; this should involve availability to view images.

6.7 MSCC case discussion policy

6.7.1 All cases of confirmed or suspected MSCC should be assessed by local clinicians and be referred for initial discussion with a clinical oncologist.

6.7.2 Based on the opinion of the clinical oncologist, patients who might potentially benefit from surgery should be referred for senior surgical opinion from a specialist with experience of treating MSCC.

6.7.3 The referring clinician should be able to provide the clinical details of the case to each senior clinical advisor.

6.7.4 The case discussion should take place whenever it is needed, urgently as individual cases newly present. Case discussion should involve oncologist, spinal surgeon and if required radiologist.

6.7.5 Each senior clinical advisor should be able to view the patient's imaging during the case discussion.

6.7.6 The outcome of the case discussion should be recorded in the patient's medical notes.

6.8 Management: Percutaneous vertebroplasty and radio frequency ablation

6.8.1 Percutaneous vertebroplasty and radio frequency ablation are available within the Network for patients deemed suitable (this may include patients with non-malignant conditions e.g. osteoporosis). Patients should be referred to the appropriate centre for an opinion.

6.8.2 Both the spinal surgeon and interventional radiologist should agree the suitability and feasibility of this form of treatment at the spinal MDT.

APPENDIX 1

Spinal Instability Neoplastic Score (SINS)

Location
- 3 points: Junctional (C0-C2, C7-T2, T11-L1, L5-S1)
- 2 points: Mobile spine (C3-C6, L2-L4)
- 1 point: Semi-rigid (T3-T10)
- 0 points: Rigid (S2-S5)

Pain relief with recumbency and/or pain with movement/loading of the spine
- 3 points: Yes
- 1 point: No (occasional pain but not mechanical)
- 0 points: Pain free lesion

Bone lesion
- 2 points: Lytic
- 1 point: Mixed (lytic/blastic)
- 0 points: Blastic

Radiographic spinal alignment
- 4 points: Subluxation / translation present
- 2 points: De novo deformity (kyphosis / scoliosis)
- 0 points: Normal alignment

Vertebral body collapse
- 3 points: >50% collapse
- 2 points: <50% collapse
- 1 point: No collapse with >50% body involved
- 0 points: None of the above

Posterolateral involvement of the spinal elements (facet, pedicle or costovertebral joint fracture or replacement with tumor)
- 3 points: Bilateral
- 1 point: Unilateral
- 0 points: None of the above

Interpretation
- **Sum score 0-6:** stable
- **Sum score 7-12:** indeterminate (possibly impending) instability
- **Sum score 13-18:** instability

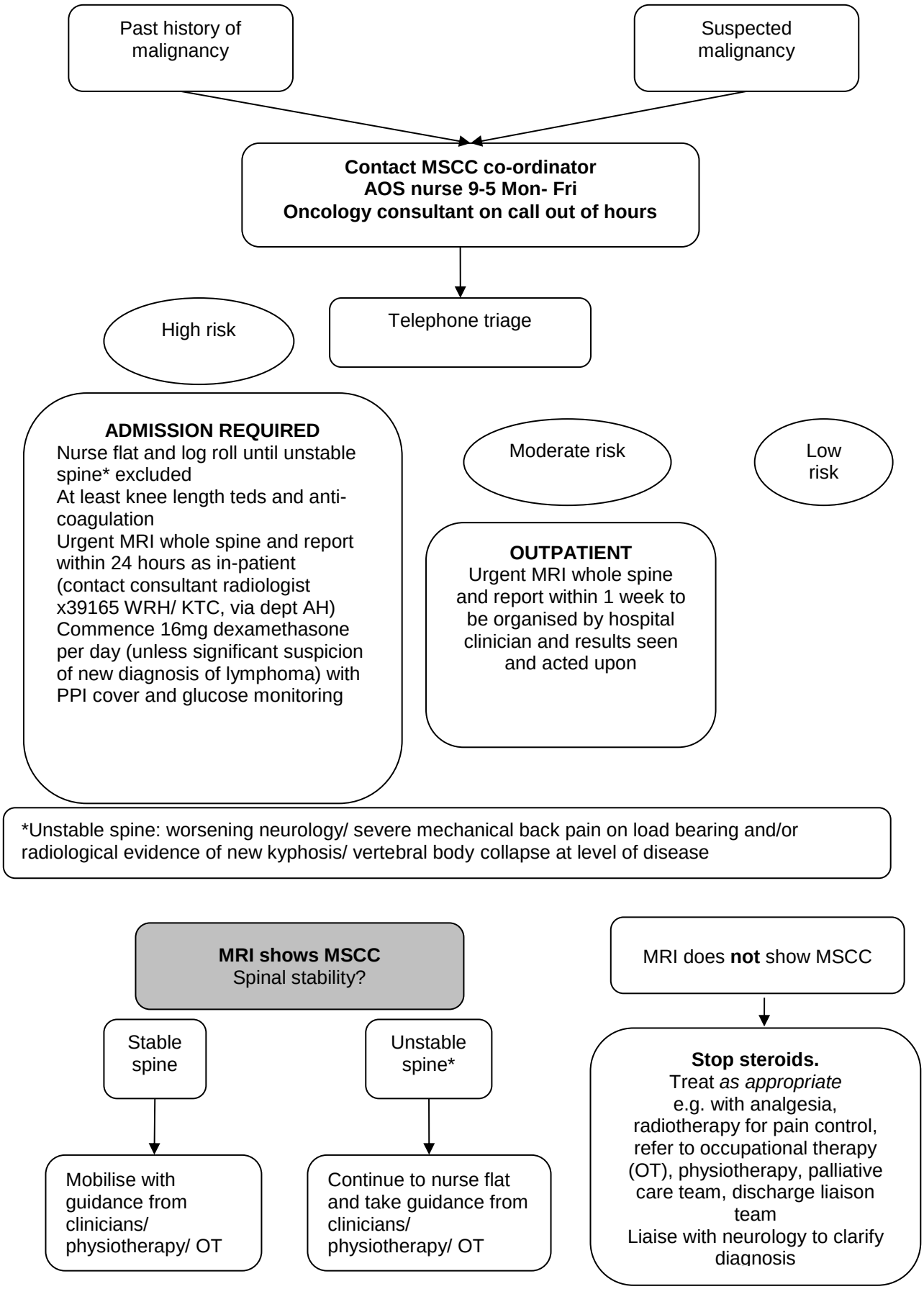
SINS scores of 7 to 18 warrant surgical consultation.

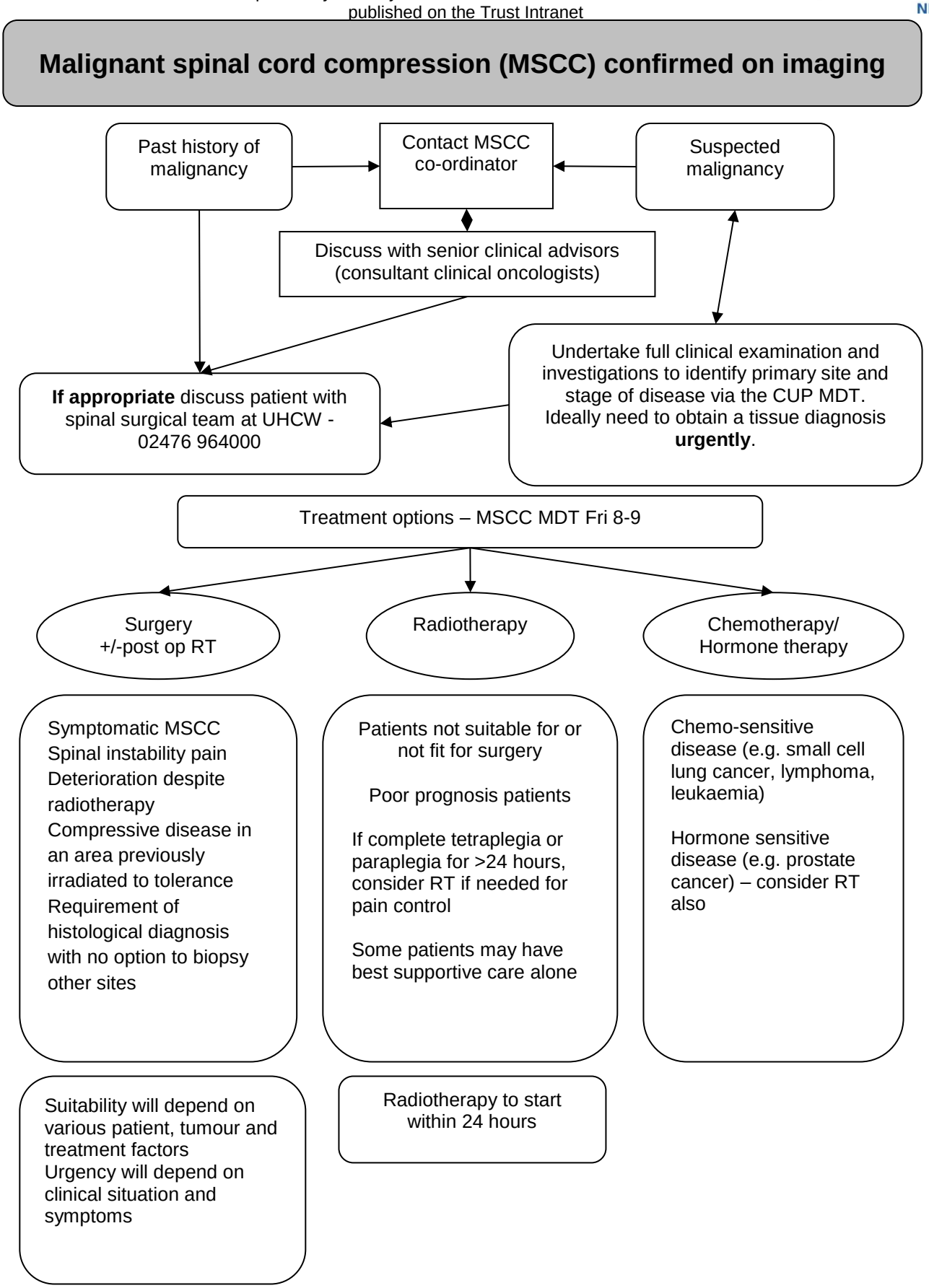
Reference

Fisher CG, DiPaola CP, Ryken TC, Bilsky MH, Shaffrey CI, Berven SH, et al. A novel classification system for spinal instability in neoplastic disease: an evidence-based approach and expert consensus from the Spine Oncology Study Group. Spine 2010; 35:E1221-9.

Malignant spinal cord compression (MSCC) ADULTS
as per NICE guidance CG 75

APPENDIX 2




Malignant spinal cord compression (MSCC) confirmed on imaging
Past history of malignancy
Contact MSCC co-ordinator
Suspected malignancy
Discuss with senior clinical advisors (consultant clinical oncologists)
Undertake full clinical examination and investigations to identify primary site and stage of disease via the CUP MDT. Ideally need to obtain a tissue diagnosis **urgently**.
If appropriate discuss patient with spinal surgical team at UHCW - 02476 964000
Treatment options – MSCC MDT Fri 8-9
Surgery +/-post op RT
Radiotherapy
Chemotherapy/ Hormone therapy
Symptomatic MSCC
Spinal instability pain
Deterioration despite radiotherapy
Compressive disease in an area previously irradiated to tolerance
Requirement of histological diagnosis with no option to biopsy other sites
Patients not suitable for or not fit for surgery
Poor prognosis patients
If complete tetraplegia or paraplegia for >24 hours, consider RT if needed for pain control
Some patients may have best supportive care alone
Chemo-sensitive disease (e.g. small cell lung cancer, lymphoma, leukaemia)
Hormone sensitive disease (e.g. prostate cancer) – consider RT also
Suitability will depend on various patient, tumour and treatment factors
Urgency will depend on clinical situation and symptoms
Radiotherapy to start within 24 hours

APPENDIX 3

SPINAL METASTASES WITHOUT MSCC
Urgent Referral Fast Track

Symptoms

- Metastatic cancer \ suspected cancer
- Pain in spine (new \ persistent)
- Nerve root pain

Referral to patient Oncologist, if patient not known to an oncologist, or the team is unavailable the on-call oncologist at the appropriate Trust should be contacted.

Imaging performed within a week of suspected spinal disease

Following Initial discussion with oncologist / oncology review determine appropriate treatment i.e Radiotherapy/systemic therapy (where surgery not indicated)

Onward referral to locally agreed spinal surgical centre for opinion if appropriate

Oncology opinion/ treatment / Rehabilitation

Surgery/ vertebroplasty/ stabilisation/ Rehabilitation

Palliative care referral Rehabilitation

Oncology opinion/ systemic treatment / Rehabilitation

Metastatic Spinal Cord Compression (MSCC) EMERGENCY REFERRAL TODAY

Metastatic cancer\suspected cancer (common in breast, prostate, lung, renal, myeloma)

Severe suspicious pain, band like chest pain, shooting nerve pain, nocturnal pain, progressive spinal pain, sensory impairment

Continence- difficulty in controlling bladder or bowels

Cannot work legs \ arms, loss of power

Think red flag! Think MSCC! Early diagnosis and treatment can prevent paralysis!

GP | Community Clinician | Hospice | Patient

A&E/MAU WITH ALERT GUIDE
ADMIT, ACT, ADVICE

- Immobilise and
- nurse flat
- Neurological
- assessment
- MRI whole spine within 24 hours or sooner if immediate intervention intended Dexamethasone 16mg od (if signs of neurological compromise unless lymphoma strongly suspected) Commence local MSCC Care Pathway

Clinical information

Imaging

Phone MSCC Co-ordinator\Acute Oncology Team

Rehabilitation referral

Contact patient's oncologist if available or the on-call oncologist. Onward surgical referral will be made on the advice of the oncology team if appropriate

Oncology opinion/ treatment / Rehabilitation

Surgery/ vertebroplasty/ stabilisation/ Rehabilitation

Rehabilitation\palliative care

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

Guidelines based on: West Midlands Strategic Clinical Network MSCC, Acute Oncology and Cancer of Unknown Primary Expert Advisory Group Guideline for the Referral of Patients with Spinal Metastatic Disease and Suspected Metastatic Spinal Cord Compression 15th February 2019

References

- NICE guideline CG75 MSCC (November 2008) – (Quick Reference Guide) available at: http://guidance.nice.org.uk/CG75/QuickRefGuide/pdf/English
- The National Peer Review Programme Manual for Cancer Services Acute Oncology - Including Metastatic Cord Compression Measures (March 2011) available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125889.pdf
- British Association of Spinal Cord Injury Specialists SCI available at http://www.sci-link.org.uk/downloads/
- National Cancer Action Team Rehabilitation Pathways available at http://www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation
- ICE Clinical Pathway for Metastatic Cord Compression (January 2012) available at http://pathways.nice.org.uk/pathways/metastatic-spinal-cord-compression
- BMJ learning module MSCC http://learning.bmj.com/learning/module-intro/.html?moduleId=10032165
- Metastatic spinal cord compression in adults NICE quality standard [QS56] (February 2014) https://www.nice.org.uk/guidance/qs56
- Fisher CG, DiPaola CP, Ryken TC, Bilsky MH, Shaffrey CI, Berven SH, et al. A novel classification system for spinal instability in neoplastic disease: an evidence-based approach and expert consensus from the Spine Oncology Study Group. Spine 2010; 35:E1221-9.
- MacMillan Cancer Support: https://www.macmillan.org.uk/information-and-support

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Radiology Clinical Lead
Urgent Care Division (via the divisional governance team)
SCSD Division (via the divisional governance team)
Surgical Division (via the divisional governance team)

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Dr T. Heafield

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Dominique Thorn	Quality Governance Lead	Dominique.thorn1@nhs.net
Date assessment completed	22/07/21		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** MSCC Guidelines for the Referral of Patients with Spinal Metastatic Disease & Suspected Metastatic Spinal Cord Compression			
What is the aim, purpose and/or intended outcomes of this Activity?	Guideline for clinical staff to support the prompt investigation, diagnosis and onward referral of patients with metastatic spinal cord compression (MSCC) and\or spinal metastases, to a defined team specialising in spinal assessment and management.			
Who will be affected by the development & implementation of this	✓ ✓ ❑	Service User Patient Carers	❑ ❑ ❑	Staff Communities Other _____

activity?	❑	Visitors	❑	
Is this:	✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	• NICE guideline CG75 MSCC (November 2008) – (Quick Reference Guide) available at: http://guidance.nice.org.uk/CG75/QuickRefGuide/pdf/English • The National Peer Review Programme Manual for Cancer Services Acute Oncology - Including Metastatic Cord Compression Measures (March 2011) available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digita lasset/dh_125889.pdf • British Association of Spinal Cord Injury Specialists SCI available at http://www.sci-link.org.uk/downloads/ • National Cancer Action Team Rehabilitation Pathways available at http://www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation • ICE Clinical Pathway for Metastatic Cord Compression (January 2012) available at http://pathways.nice.org.uk/pathways/metastatic-spinal-cord-compression • BMJ learning module MSCC http://learning.bmj.com/learning/module-intro/.html?moduleId=10032165 • Metastatic spinal cord compression in adults NICE quality standard [QS56] (February 2014) https://www.nice.org.uk/guidance/qs56 • Fisher CG, DiPaola CP, Ryken TC, Bilsky MH, Shaffrey CI, Berven SH, et al. A novel classification system for spinal instability in neoplastic disease: an evidence-based approach and expert consensus from the Spine Oncology Study Group. Spine 2010; 35:E1221-9. • MacMillan Cancer Support: https://www.macmillan.org.uk/information-and-support			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	This is a local version of a guideline that is already in place regionally; further engagement is not considered necessary as the regional guideline has been in place for some time.			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		The guideline applies to adults only but has not particularly positive or negative effect based on age.
Disability		✓		The guideline does not adversely or otherwise impact on people with a disability – it applies to adults regardless of disability.
Gender		✓		The guideline does not adversely or otherwise

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Reassignment				impact on people with gender reassignment – it applies to adults regardless of gender.
Marriage & Civil Partnerships		✓		The guideline does not adversely or otherwise impact on people with gender reassignment – it applies to adults regardless of gender.
Pregnancy & Maternity		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Race including Traveling Communities		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Religion & Belief		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Sex		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Sexual Orientation		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		The guideline does not adversely or otherwise impact on people in this group – it applies to all adults.

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	.		

How will you monitor these actions?	
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	22/07/2021
Comments:	
Signature of person the Leader Person for this activity	Dr T. Heafield
Date signed	22/07/21 (electronic approval received via email)
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.