Birmingham Women's and Children's NHS Foundation Trust

Policy for the administration of systemic anti-cancer therapy (SACT) for malignant disease

Site: Applies to BCH

Version:	4
Approved by:	Systemic Anti-Cancer Therapy Review Group
Date Approved:	April 2024
Ratified by:	Policy Review Group
Date ratified:	June 2024
Name of originator/author:	Brian Carey / Kate Hong / Laura Fletcher
Name of responsible committee/individual:	Systemic Anti-Cancer treatment Review Group
Date issued:	June 2024
Review date:	April 2027
Target audience:	All Trust clinical staff

Contents

1. Summary of Key Points

- To support the safe and effective administration of SACT
- To outline staff who are authorised to administer SACT

2. Introduction

This policy outlines the staff who are authorised to administer SACT, the training they have undertaken to enable them to do so and the designated areas for the administration of SACT. Pre-treatment checks and potential reasons for not proceeding with SACT are also covered. The policy covers administration of SACT via a variety of routes.

3. Duties

This Systemic Anti-Cancer Therapy Review Group will be responsible for the subsequent monitoring and review of policies.

To ensure all Trust clinical staff has a clear understanding of who can administer SACT and guidance on where administration can take place at BCH. This policy should be used in conjunction with:

- Policy for the use of personal protective equipment (PPE) when administering, handling and managing a spillage of bodily waste and/or clinical samples from patients receiving cytotoxic therapy.
- • Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy
- • Policy for the Care and Management of Central Venous Catheters
- Policy for the Care and Management of Ports
- Policy for the care and management of peripheral cannulae (PVC)
- Policy for minimising the risk and management of extravasation and phlebitis

4. Identification of Stakeholders

4.1 Within BWCH:

All BCH Trust clinical staff involved in administration of SACT for malignant disease.

4.2 Outside BWCH:

Expert Advisory Group on Children's Cancer to the West Midlands Cancer Alliance.

5. Method for development

5.1 Consultation and Communication with Stakeholders

Systemic Anti-Cancer Therapy Review Group

Brian Carey (Chair)	Chemotherapy Advanced Nurse Practitioner
Dave Hobin	Consultant Oncologist
Dave Hobin	Consultant Oncologist/IT Lead
Jason Patel	Lead Cancer Pharmacist
Harpreet Marwaha	Quality Lead for Cancer
Jane Cooper	Research Sister Oncology/Haematology
Elaine Carrolan	Quality, Accreditation and Data Manager
Samarah Ahmed	ChemoCare Pharmacist
Abigail Conway	Ward 18 Manager
Victoria King	Lead Cancer Nurse
Sabah Iqbal	Service Manager - Blood, Stem Cell & Cancer

6. Content

6.1 Areas of administration

Designated areas for administration of in-patient SACT are ward 18 and ward 19 and Outpatients 3, Waterfall House (Manual for cancer services 2013, 11-7B-101).

In addition SACT may be administered on:

- Ward 10 for patients whose neurosurgical care dictates this is their best place of care
- PICU for patients requiring ICU care
- Operating theatres for patients: receiving intrathecal chemotherapy (where the administration cannot be carried out in the Outpatients 3, Waterfall House Oncology Theatre without the need for an additional anaesthetic), or patients receiving intravitreal or intra-arterial chemotherapy. For the latter patients the interventional radiology suite may also be used.

If there is a clinical need to administer SACT in any other area due to exceptional circumstances (e.g. surgical needs for care on a surgical specialist ward, unwell emergency admission requiring urgent treatment) there must be a discussion with the appropriate clinical teams which should include the Chemotherapy Lead Clinician or Pharmacist, Advanced Nurse Practitioner and SACT Team or Lead Cancer Nurse.

Whenever possible, administration of SACT should occur during standard working hours, which are defined as 8.00am to 5.30pm, Monday to Friday, excluding Bank and statutory holidays (Manual for cancer services, 2013)

Consideration should be given to whether the patient could be transferred temporarily to Outpatients 3, Waterfall House for their treatment.

In the case of emergency admissions or urgent clinical need for SACT being initiated out-of-hours on Ward 18 or on an outlying ward the on-call Consultant must be involved in the

decision. A record of the discussion and decision rationale must be documented in the patient's case notes.

Intrathecal chemotherapy will only be given in areas specified in the Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy.

Out-Patient Chemotherapy is administered in the Outpatients 3, Waterfall House Oncology Clinic in the following specified rooms;

- Treatment Rooms Day Care Beds Isolation Cubicles
- Consulting Rooms that have been allocated as over-flow isolation rooms due to demand on the day by the nurse in charge
- Oncology Theatre (N.B. Intrathecal Drugs only as per the Intrathecal Chemotherapy Policy)

Out-patient SACT for patients in Phase I, II or III clinical trials may also be administered in the Wellcome Clinical Research Facility in the following rooms:

- Treatment Rooms
- Isolation / Consulting Rooms designated on the day by the nurse-in- charge
- Day Care Beds
- Ward 18 (for out-patient treatment out-of-hours, e.g. patients due out- patient treatment at the weekend)

Rationale for initiating treatment out-of hours must be recorded in the patient's case notes following discussion with relevant personnel.

SACT items to be administered in non-designated locations, with the exception of oral SACT, will be stored in pharmacy and should be collected when required to prevent SACT being unnecessarily handled.

Note: The requirements for the storage of items for intrathecal administration are set out in the Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy.

All areas in which SACT are administered must have the following equipment available and are routinely checked, to ensure suitability (e.g. within expiry date) and function. Where administration is to take place in a non-designated area any items on the list below that are

not routinely available must be provided before administration may proceed (Manual for cancer services, 2013 (11- 7B-103)

- Emergency bell/telephone Resuscitation equipment
- Drugs for the management of emergencies – cardiac arrest and anaphylaxis
- Extravasation kit and SACT spillage kit and access to running water
- Disposal equipment e.g. appropriate sharps bins
- Access to relevant policies and procedures

6.2 Staff training in checking and administering of SACT

Staff administering SACT must have completed The Children's Cancer and Leaukaemia Group (CCLG) SACT passport (2022) or the Expert Advisory Group on Children's Cancer to the West Midlands Cancer approved competency based training programme or be covered by the exceptions for the administration of SACT (Manual for cancer services 2013, 11- 7A-134) and work within professional and local guidelines and protocols for the checking and administration of both the prescription and the drugs.

As per the Manual for cancer services (2013) (11- 7B-141) treatment records should be held for each individual patient fulfilling the following minimum criteria including:

- Patients identification Weight, height, surface area disease type
- Regimen and doses (including all cytotoxic SACT drugs to be used and elective essential supportive drugs other than antiemetic's); trial name or number if applicable
- Route of administration (oral, IV, IV Infusion, IM, SC) Number of cycles intended
- Frequency of cycles and of administration within a cycle Investigation necessary prior to starting the whole course
- Investigation to be performed serially during the course (to detect / monitor both toxicity & response) and their intended frequency
- Number of cycles
- Planned attendances managed by agreed non-medical staff, for example, nurse-led attendances
- Site of administration (PTC, POSCU, Community)

6.3 Patient and treatment identification (Manual for cancer services, 2013 (11- 7B-144)

Prior to the administration of any dose of SACT, whether on the first day, or any subsequent day, of a treatment cycle the nurse preparing to administer the dose(s) should ensure:

- That the patient's identification is confirmed according to Trust policy and that the details on any and all prescription charts and prepared drug doses are consistent and without ambiguity. If there is any doubt over the patient's identity and/or whether the drugs doses supplied are intended for a particular patient administration should not proceed until all uncertainties or ambiguities have been addressed and removed.
- All critical test results have been documented and the patient is fit for treatment to proceed.
- The treatment course, cycle, including cycle number, and individual administration(s) within the cycle are identified and the individual drug doses provided are consistent with them and the prescription.
- That any supportive drugs, including hyper-hydration, have been prescribed as appropriate for the treatment cycle/administration and given according to the prescription.
- That the administration route and duration are clearly stated on the prescription.
- That any and all diluents and dilution volumes are clearly stated on both the prescription and the individual drug doses supplied, and correspond.
- Clinical assessment criteria prior to administering SACT.

6.4 Pre-treatment checks/investigations

Before a course of SACT, by any route, the patient must be clinically assessed to ensure:

- Haematology parameters, particularly neutrophil and platelet counts are sufficient for treatment to proceed – as set out in the Treatment Protocols.
- Clinical chemistry parameters, appropriate to the treatment and as set out in the Treatment Protocol, are sufficient for the treatment to proceed.
- Any other investigations e.g. renal function, audiology or cardiology, that impact on whether the treatment can be given and/or at what dose, have been performed, reported and reviewed.
- Investigations listed on the front of ChemoCare prescriptions or as detailed in the clinical trial protocol or national guideline. These investigations should be listed in the case notes for patients following individualised treatment plans.

- The patient is clinically well.
- Weight documented (throughout treatment weight is likely to fluctuate. It is essential to check documented weight is current).
- All females of childbearing age who have started their periods require a check of their pregnancy status prior to SACT. If the patient's last menstrual period (LMP) is within 30 days and the patient states she could not be pregnant, pregnancy testing is not required.
- Appropriate and functioning venous access
- Prior to administration of any SACT the patient and carers should be advised of safe handling practices, side effects and any possible systemic adverse reactions and asked to immediately report these should they occur.

The above should be confirmed by a SACT prescriber and the patient be documented to be fit for chemotherapy prior to administration of any SACT.

6.5 Reasons not to start administration of SACT:

SACT should not be administered by the competent practitioner if there is any issue with any of the above.

6.6 Reasons to stop administration of SACT:

Administration of SACT should be stopped if:

- If questions are raised by the patient and their family/carers. These concerns should be discussed with the Nurse in Charge/Senior Nurse/ANP or patient's medical team
- The patient demonstrates unexpected side effects or complications which are not routinely managed with planned supportive care, particularly signs of hypersensitivity reaction or anaphylaxis.
- The equipment fails to function

6.7 Dispensing

All pharmacy staff involved with dispensing oral SACT should have access to copies of the relevant protocols. Requests for information and/or clarification should be made to the Lead Cancer Pharmacist in the first instance.

Wherever possible oral SACT will be supplied in blister or foil packed tablets or capsules.

Tablets or capsules should not be handled directly, all staff should use a non-touch technique to minimise the risks of exposure.

Liquid medicines should be handled in such a way as to minimise contamination of the outside of the bottle. Any evidence of contamination should be removed using a damp paper towel whilst wearing gloves. The paper towel must be disposed of as cytotoxic waste.

6.8 Administration and Checking of SACT

As a minimum the person administering SACT should wear PPE as per the Guideline for the use of personal protective equipment (PPE) when handling Cytotoxic Therapy, Cytotoxic Waste or managing spillage of cytotoxic waste. The assistant or checker should at a minimum wear gloves and apron but for maximum protection should wear the full PPE including, gloves, armlets, plastic apron and safety glasses.

6.8.1 Peripheral Intravenous SACT

Consideration should be given to changing the cannula site after 24 hours. However, if the fluid runs freely, there is good blood return and there are no signs of erythema, pain or swelling at the site the existing cannula may be used, with careful monitoring of the treatment site, particularly immediately after treatment is commenced. Observation of a peripheral administration site should be maintained at regular intervals. Signs of infiltration, extravasation must be addressed immediately according to the BWC Extravasation Policy.

If treatment is to be administered through a cannula consideration should be given to giving the most irritant or vesicant drug first. Vesicant drugs should be given via a newly established cannula wherever possible. This should be delivered as a slow bolus manually using a regular flashback technique.

6.8.2 Central Intravenous SACT

Intravenous bolus injections should be given slowly, over approximately 5 minutes. Luer-lock syringes must be used for the bolus administration of all intravenous SACT.

Patency of central venous access devices (CVADs) should be confirmed prior to use by aspirating the CVAD and flushing. Patency of ports should be re- checked during administration of every few millilitres during the administration of a vesicant using the flashback technique as there is increased risk of needle dislodgment.

Giving sets should be primed to check integrity (and flushed on completion of infusion) with a suitable compatible intravenous solution. Intravenous administration sets should have Luer lock fitting. Using an aseptic non-touch technique, carefully insert the giving set into the cytotoxic infusion at waist height to minimise the risk of personal contamination in the event of a spillage. Used equipment should be disposed of in a purple lidded cytotoxic sharps bin.

The infusion site should be checked according to the BWC Extravasation policy and the patient monitored for systemic adverse reactions.

6.8.3 Oral SACT

Tablets should preferably not be crushed or capsules opened. If tablets are to be opened or crushed gloves and a surgical face mask should be worn (See BWCH Guideline for the use of personal protective equipment (PPE) when handling Cytotoxic Therapy, Cytotoxic Waste or managing spillage of cytotoxic waste, 2024). Tablets or capsules should not be handled directly, in the absence of suitable liquid formulations this may make it impossible to avoid handling SACT.

On wards or clinics, oral doses of chemotherapy should be dispensed into a disposable medicine pot or cup prior to administration to a patient. Dispose of medicine pots used as cytotoxic waste.

Liquid medicines should be handled in such a way as to minimise contamination of the outside of the bottle. Any evidence of contamination should be removed using a damp paper towel whilst wearing gloves. The paper towel must be disposed of as cytotoxic waste in a purple-lidded sharps bin.

Tablet crushers and splitters should be rinsed with water after use to remove any residue from the tablet. Avoid splashing as this may contaminate surrounding surfaces. The tablet splitter contains a sharp blade should be left to dry to avoid injury.

All oral chemotherapy should be taken with plenty of water and swallowed whole not chewed to avoid local irritation to the oral mucosa.

Please refer to the Haematology/Oncology Information Leaflet for Children/Young People before discharging a patient home with oral SACT.

6.8.4 Intrathecal SACT

Only staff who have been appropriately trained and accredited, and whose names appear in the appropriate Trust register are permitted to have involvement in the prescribing, dispensing, issue, checking and/or administration of intrathecal chemotherapy appropriate to their role and training.

All staff involved in the administration of intrathecal chemotherapy must comply at all times with the Trust's Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy (2020). This also includes intraventricular chemotherapy administered via an Ommayah reservoir or intrathecal chemotherapy administered via a lumbar port device.

6.8.5 Intramuscular and subcutaneous SACT

Should SACT be prescribed by this route normal practices for intramuscular and subcutaneous apply. Please seek guidance from the Lead Chemotherapy Pharmacist is required.

6.8.6 Intravitreal and Intra-arterial

This is administered specifically within the Retinoblastoma service; for which there is specific training. For guidance refer to Appendix F in the Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy (2020).

6.8.7 Topical

Topical cytotoxic drugs may be applied either directly to the skin or as ear or eye drops. Bleomycin, mitomycin C and 5-fluorouracil solutions are administered topically in the Operating department outside of the cancer service and are not covered in detail in this policy.

However, as guidance the principles in this policy around training, safe handling, documentation, assessment, patient information, monitoring etc. may be utilised. Cytotoxic eye or ear drops are rarely, if ever, administered at BWCH.

Gloves should be worn while handling or applying the product and using cotton buds rather than fingers is also advisable where the site makes this appropriate. It is important to protect the normal skin and avoid the eyes and other mucous membranes during administration.

The affected area should not be washed vigorously during the treatment. Although risks may be small, patients should be counselled regarding the toxicity to normal skin and the risks of contamination via direct contact or clothing to other areas of skin or to the skin of other people.

Patients and parents/carers should receive information and instructions regarding their treatment to ensure they are aware of the potential hazards to their family and environment.

6.8.8 Miscellaneous Routes of Administration

Other routes of administration of cytotoxic drugs include:

- Intrahepatic
- Intracranial
- Regional infusion (e.g. isolated limb infusion)

None of these are routinely used at Birmingham Children's Hospital.

Should the need arise appropriate policies and procedures will be created to support the administration of cytotoxic drugs by these routes.

7. Education and Training

All staff involved in administering SACT must be aware of the policies and procedures to ensure safe administration.

Only specialist Haematology-Oncology nurses who have undertaken and been assessed as competent by completing a CCLG SACT competency passport (2022) or the Expert Advisory Group on Children's Cancer to the West Midlands Cancer Alliance approved training programme (Manual for cancer services, 2013 pp.26) may administer SACT orally, or by the subcutaneous, intravenous (bolus and infusion) and intramuscular routes.

There are two exceptions to this requirement:

• There is a list of exemptions in the Manual for cancer services (2013 pp.26) which cover staff who were trained prior to the publication of the Measures.

• Administration of intra-arterial chemotherapy in the treatment of retinoblastoma by an appropriately trained consultant paediatric oncologist.

A register of SACT trained staff is held by the BWCH Lead Chemotherapy Trainer.

Medical staff are not routinely required to administer intravenous SACT (with the exception noted above), but may do so having received the same training and competency assessment as nursing staff, or be covered by the exemptions. This may be covered by the "Low Risk" Chemotherapy Training for one specific drug group e.g. the administration of intravenous bolus vinca-alkaloids.

Only medical staff assessed as competent to do so, and whose names appear in the current register of competent staff, may administer intrathecal chemotherapy (Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy).

A register of chemotherapy trained staff is maintained by the Oncology Education Team. Staff must undertake annual re-accreditation to maintain their practice.

8. References

National Cancer Peer Review Programme (2013) Manual for cancer services: children's cancer measures Version 3.0

Children's cancer services: Principal Treatment Centre's Service Specifications (2021) Standards for Children's Nursing

Policy for the Prescribing, Dispensing, Issuing, Delivery, Checking and Administration of Intrathecal Chemotherapy (2020)

BWC Policy for minimising the risk and management of extravasation and phlebitis (2022)BWC Policy for the Care and Management of Central Venous Lines (2020)

Central Venous Lines Information Leaflet for Parents, Carers, Children, Young People and Relatives (2017) Haematology/Oncology Information Leafet for Children/Young People (2021)

CCLG Systemic Anti-Cancer Treatment Passport (2022) Available online at: https://www.cclg.org.uk/professionals/cyp-sact-passport (Accessed 16th May 2024).

Appendix I - Policy for the development and management of policy documents

Policy Review Group Checklist for the Review and Approval of a policy

To be completed by the Policy author prior to submission for approval/ratification

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**State Title:**		
	Is the title clear and unambiguous?	Y	
2.	Has all of the information on the front page been completed?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
3.	**Rationale**		
	Are reasons for development of the document stated?	Y	
4.	**Development Process**		
	Is the method described in brief?	Y	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of appropriate consultation with stakeholders and users?	Y	
5.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the language used in the document clear, jargon free and spelt correctly?	Y	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are supporting documents referenced?	Y	
7.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?		
8.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
9.	**Document Control**		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	Y	
10.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
11.	**Review Date**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
	Equality Impact Assessment		
	Has an EIA been carried out?	Y	
12.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y	

Policy Review Group Ratification			
If you are happy to ratify this document, please sign and date.			
Committee /Other Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			

Appendix II of the Policy for the development and management of policy documents

Consideration of Equality Impact analysis

1. **Name of document being analysed**	Policy for the administration of systemic anti-cancer therapy (SACT) for malignant disease for malignant disease
2. **Person completing analysis**	Julia Bottle
3. Contact information	j.bottle@nhs.net
4. **Date of analysis**	20TH April 2021
5. Is it a policy, strategy, service or function that is being assessed?	Policy
6. Name of the policy/ strategy/ service / function	Policy for the administration of systemic anti-cancer therapy (SACT) for malignant disease for malignant disease
7. Provide a brief description of the aims of the policy/ strategy/ service/ function (include details of key objectives and who your intended customers are)	Aims: To ensure all BCH Trust clinical staff has a clear understanding of who can administer SACT and guidance on where administration can take place at BCH. Objectives: To ensure safe administration of Systemic anti-cancer drugs Customers: Patients undergoing treatment with systemic anti-cancer drugs
8. Is responsibility for this policy/ strategy/service/function shared with another agency? Yes □ No □	No
9. Is this policy/service/function/strategy carried out (partially or completely) by contractors? Yes □ No □	No
10. Does the policy/ strategy / service/ function affect stakeholders? Stakeholders include customers, service users, staff, the wider community or other organisations. This includes commissioned services and services that rely on the input or resources of the Trust.	Yes

Yes □ No □	
11. If you have reached a conclusion that the policy, service or function is not relevant to equalities and you have clearly evidenced why then exit here and submit this form to:	

Relevant □ (Complete the details below and go on to complete Section B Full Equality Analysis)
Not relevant □ (Complete the details below and submit the form electronically to the above: retaining a copy for your records).

Signature (*person completing this screening tool lens*) _____ **Date** ___

Head of Service/Dept._____ **Date** _____

Appendix III of the Policy for the development and management of policy documents

Full Equality Analysis

Equality Action Plan – What are the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitative) used. If the work is targeted towards a particular group(s) – provide justification e.g. women

Even if you have found no evidence of potential negative impact, you should consider how to improve any positive impacts or how your policy could be adapted to promote equality.

A=Age / S=Sex / D=Disability/ R=Race / SO=Sexual Orientation / MCP= Marriage/civil partnership / PM= Pregnancy and Maternity / GR= Gender Reassignment / RB=Religion and Belief

Potential positive or negative impact	Potential impact on (please tick)									Action identified to resolve	Who will action	When by
	A	S	D	R	SO	MCP	PM	GR	RB			

Consultation – How does this proposal affect the rights of patients, staff and other stakeholders?

What have patients/staff or other stakeholders already told you about the policy and any negative impacts? State who has been consulted and the methods used for the engagement, consultation etc.	Systemic Anti-Cancer Therapy Review Group as detailed as detailed on page 4 Draft version of the policy circuited by email for comments.
Do you need to carry out further consultation if so who will you be consulting with and by what methods?	N/A

Monitoring Arrangements – What are the existing and new monitoring arrangements?

Is the service/policy accessible to all groups?	**Yes**
If there is a lack of information, what research will be carried out and for which group?	**No**

Including people who need to know - Consider the way in which the proposal will be explained to a wider audience.

Decision Making – Identify what your next step will be for the proposal.

Decision steps available	Rationale for your decision
1. Continue unchanged	This is a clinical policy relating to the administration of SACT and has no equality impact on users. This policy reflects current national guidance.
2. Adjust the proposal	NO
3. Fundamental review of/stop the proposal	NO

Sign Off and publication

Senior Responsible Officer*	
Date signed	
Presented to .....(insert)..... **Committee**	
Publication date	

as the Senior Responsible Officer you need to be assured that you have sufficient information about the likely effects of the policy in order to ensure proper consideration is given to the statutory equality duties.

Equality Analysis Sign Off:

This section is designed to be copied and pasted into a blank word document or into the required paperwork e.g. PID or policy etc. please note: The Equality Analysis Approval Committee have the key leads from the following key areas:

Directorate/Project details		**Service/Workstream:**
Policy for the Administration of Systemic Anti-Cancer Treatment		Haematology/Oncology
Executive Sponsor:	**Project Lead:**	**Project Manager:**
		Julia Bottle
Title: Policy for the Administration of Systemic Anti-Cancer Treatment for malignant disease		
EA details		

Version:	**Date:**	**Equality team Lead Assessors detail:**
3.0		
Is this a: <Tick as appropriate> **Relevance Screening** □ **Full Analysis** □(		
Are the Equality Analysis sub-group assured by the EA?		
If 'No' please send this document (electronic format only) back to the originator for more details		

If 'YES' please sign	*<please sign here>*

Appendix IV of the Policy for the development and management of policy documents

Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the Policy Review Group for consideration and approval.

Title of document:	Policy for the administration of systemic anti-cancer treatment for malignant disease		
Date finalised:	April 2021	**Dissemination lead: Print name and contact details**	Julia Bottle
Previous document already being used?	Yes		
If yes, in what format and where?	Trust intranet		
Proposed action to retrieve out-of-date copies of the document:	Request removal of previous document and upload replacement		

To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**
All Clinical Staff involved with the administration of SACT for malignant disease	Through communication – intranet under clinical polices	Electronic	

Dissemination Record – to be used once document is approved.

Date put on register / library of procedural documents		**Date due to be reviewed**	

Disseminated to: (either directly or via meetings, etc)	Format (i.e. paper or electronic)	Date Disseminated	No. of Copies Sent	Contact Details / Comments
BSC Speciality Meting	Electronic			

Appendix V of the Policy for the development and management of policy documents

Summary of Significant Changes to previous version of Policy

Policy Title	Policy for the administration of systemic anti-cancer therapy (SACT) for malignant disease for malignant disease		
Version	**Date**	**Author**	**Comment (Identify any significant changes to the procedural document)**
			▪ ▪ ▪ ▪