The South West London Metastatic Spinal Cord Compression (MSCC) Service

Standard Operating Procedure

July 2015 - Version 4

Incorporating:

South West London Hospitals: St George’s University Hospitals NHS Foundation Trust, Royal Marsden NHS Foundation Trust, Epsom and St Helier University Hospitals NHS Trust, Croydon University NHS Trust, Kingston NHS Foundation Trust

St Luke’s Cancer Alliance, Royal Surrey County NHS Foundation Trust, Ashford and St Peter’s NHS Trust, Frimley Park NHS Foundation Trust and Surrey and Sussex Healthcare NHS Trust.
Contents

1. Aims and Functions of the South West London MSCC Service
   1.1 Definition of MSCC
   1.2 Incidence
   1.3 Service Configuration
   1.4 Service Users
   1.5 Aims and function of the service

2. Overview of the South West London MSCC Service Team Members
   2.1 Senior Clinical Advisors – Surgery
   2.2 Senior Clinical Advisors – Neuro-Radiology
   2.3 Senior Clinical Advisors – Clinical Oncology
   2.4 Lead MSCC Co-ordinator

3. Clinical Triggers

4. Referral Pathways
   4.1 Pathway 1
   4.2 Pathway 2
   4.3 Pathway 3

5. Contact Details for Associated MSCC Co-ordinators

6. Referral Process
   6.1 Recommended Imaging
   6.2 Imaging Provision in the South West London MSCC Service
   6.3 South West London MSCC Referral Form
   6.4 Case Discussion

7. Definitive Treatment
   7.1 Preliminary Management
   7.2 Spinal Stability
   7.3 Surgical Intervention
   7.4 Oncological Management

8. Multi-disciplinary MDT Discussion

9. Nursing Management
   9.1 Autonomic Dysreflexia
   9.2 Pain Management
   9.3 Thromboprophylaxis
   9.4 Bladder Management
   9.5 Bowel Management
   9.6 Pressure Area Care

10. Rehabilitation

11. Supportive Care

12. Audit

13. Appendix 1 – London Cancer Alliance Alert Card and Leaflet


15. Appendix 3 Referral Flowchart for the South West London MSCC Service (Pathway 1)

16. Appendix 4 – Local MSCC Co-ordinator Contacts

17. Appendix 5 – South West London MSCC Service Referral Form

18. Appendix 6 – Rehabilitation Facilities within areas covered by

1. Aims and Functions of the South West London MSCC Service

1.1 Definition of MSCC

Metastatic spinal cord compression (MSCC) is defined in this guideline as spinal cord or cauda equina compression by direct pressure and/or induction of vertebral collapse or instability by metastatic spread or direct extension of malignancy that threatens or causes neurological disability (DoH, 2008).

1.2 Incidence

Evidence from an audit carried out in Scotland between 1997 and 1999\(^1\) and from a published study from Canada\(^2\), suggests that the incidence may be up to 80 cases per million people every year. This equates to approximately 4000 cases each year in England and Wales, or more than 100 cases per cancer Network each year. These figures are set to rise as treatments evolve and survival increases.

MSCC can occur in virtually all types of malignancy, but myeloma, lung, prostate and breast cancer are the commonest.\(^3\)

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>Proportion of Patients Who Develop MSCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>20 - 31%</td>
</tr>
<tr>
<td>Prostate</td>
<td>18 - 21%</td>
</tr>
<tr>
<td>Breast</td>
<td>13 - 17%</td>
</tr>
<tr>
<td>Haematology</td>
<td>8 – 10%</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>5 - 13%</td>
</tr>
<tr>
<td>Kidney</td>
<td>3 - 12%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 - 7%</td>
</tr>
<tr>
<td>Other</td>
<td>7 - 14%</td>
</tr>
</tbody>
</table>

The majority of MSCC cases occur in patients with a pre-existing cancer diagnosis, however in around 20% of patients it is their first cancer presentation.

Work was initially carried out within the Network Acute Oncology Group (NAOG) to produce documentation that can be given to patients at risk of MSCC. This work has been subsumed into the London Cancer Alliance (LCA) Acute Oncology Pathway Group for further development. The purpose of this documentation is to raise awareness of symptoms and to provide the patient with comprehensive instructions to facilitate effective management.

An example of the alert card and information leaflet can be found in Appendix 1 (please note that the information leaflet presently displays the SWLCN logo rather than the new LCA logo. We are in the process of re-branding and reprinting this leaflet for use once existing stocks have been exhausted. The content of this leaflet has been clinically reviewed as part of this review process).

1.3 Service configuration

The London Cancer Alliance (LCA) was established in 2011 as the integrated cancer system across West and South London. They work collaboratively with 17 NHS provider organisations, including two academic health science centres, and the voluntary sector, to deliver safe and effective care, improve cancer clinical outcomes and enhance patients' and carers' experience and quality of care.

The LCA Acute Oncology Pathway Group leads collaborative working for MSCC. MSCC services that sit within the LCA are

- The South West London MSCC Service
- Kings Healthcare Partners
- Imperial College Healthcare NHS Trust

Collaborative working for MSCC is driven by an MSCC subgroup of the LCA Acute Oncology Pathway Group which includes the clinical lead and MSCC coordinator from each service.

1.4 Service Users

Appendix 2 outlines the entire patient pathway and incorporates three access pathways.

The South West London MSCC Service is designed to facilitate urgent management for patients on Pathway One or for patients who progress from Pathway Two to Pathway One (Appendix 2).

The patient groups that should be managed by this service are as follows:

- Adults with metastatic spinal disease at risk of developing metastatic spinal cord compression.
- Adults with suspected and diagnosed spinal cord and nerve root compression due to metastatic malignant disease.
- Adults with primary malignant tumours (for example, lung cancer, mesothelioma or plasmacytoma) and direct infiltration that threatens spinal cord function.

N.B. Patients with an established diagnosis of multiple myeloma may require complex medical management. For this group of patients, the South West London MSCC service will facilitate an initial discussion between the Senior Clinical Advisors for surgery and oncology and the Consultant Haematologist responsible for the management of the patient. This discussion must take place prior to any clinical decision making.

The patient groups who should not be managed by this service are as follows:

- Adults with spinal cord compression due to primary tumours of the spinal cord and meninges.
- Adults with spinal cord compression due to non-malignant causes.
- Adults with nerve root tumours compressing the spinal cord.
- Children.

These patient groups should be managed as per the established treatment protocols within their specific clinical area.
1.5 Aims and Functions of the South West London MSCC Service

The aims and functions of the South West London MSCC Service reflect the recommendations made within the Acute Oncology Measures (DoH, 2011) to ensure that patients with MSCC receive timely and effective investigation and treatment. This is imperative, as untimely and ineffective management of this oncological emergency can lead to permanent disability and loss of function which in turn leads to a poor performance status and quality of life.

The overall aim of the service is to provide a specialist advisory service **24 hours a day, 7 days a week** for clinicians and MSCC Co-ordinators within secondary care.

The agreed MSCC Service for South West London Hospitals and St Luke’s Cancer Alliance is based at St George’s University Hospitals NHS Foundation Trust

All spinal surgery for patients with MSCC **must** be performed at St Georges University Hospitals NHS Foundation Trust as agreed by the LCA Acute Oncology Pathway Group.

The Trust’s that are served by the South West London MSCC service are:

**South West London Hospitals**
- The Royal Marsden NHS Foundation Trust (Cancer Centre)
- St George’s University Hospitals NHS Foundation Trust
- Epsom and St Helier University Hospital NHS Trust
- Croydon University Hospital
- Kingston NHS Foundation Trust

**St Luke’s Cancer Alliance**
- The Royal Surrey County NHS Foundation Trust (Cancer Centre)
- Surrey and Sussex Healthcare NHS Trust
- Frimley Park Hospital NHS Foundation Trust
- Ashford and St Peter’s NHS Trust

The function of the Network MSCC Service is to facilitate:

- Early detection
- Effective communication
- The production and distribution of accurate and useful information for patients and healthcare professionals
- Specialist interpretation of all related imaging
- Timely treatment
• Early identification of rehabilitation and/or palliative care patient needs

• Auditable results

• Ongoing education

2. Overview of the South West London MSCC Service Team Members

The Senior Clinical Advisors for the South West London MSCC Service have representation from three disciplines: surgery, neuro-radiology and oncology. These are outlined below. The Senior Clinical Advisors are supported by the Lead MSCC Coordinator.

2.1: Senior Clinical Advisors - Surgical

The South West London MSCC Service at St George’s Hospital comprises of a rota of the following senior clinical advisors who are spinal specialist within their field:

• Mr Matthew Crocker – Consultant Neurosurgeon, Clinical Lead for MSCC
• Mr Pawan Minhas – Consultant Neurosurgeon
• Mr Marios Papadopoulos – Consultant Neurosurgeon
• Mr Francis Johnston – Consultant Neurosurgeon
• Mr James Laban, Consultant Neurosurgeon
• Mr George Eralil, Locum Consultant Neurosurgeon
• Mr Jason Bernard – Consultant Orthopaedic Surgeon
• Mr Tim Bishop – Consultant Orthopaedic Surgeon
• Mr Jim Sale – Locum Consultant Orthopaedic Surgeon

These Consultants with the support of the three other consultant neurosurgeons will jointly provide an advisory on call rota 24 hours a day and 7 days a week to provide rapid surgical assessment and advice on interventional management. Please see Referral Flowchart (Appendix 3) for clear guidance.

During office hours, a dedicated Spinal Consultant will review the patient’s scans in person, and utilise the clinical information supplied on the MSCC Referral Form to make an immediate clinical decision. This clinical decision will be communicated back to the referrer immediately via the Lead MSCC Co-ordinator.

Out of hours, the on-call Neurosurgical Registrar will initially review the scans and discuss them with the Neurosurgery Consultant on call, utilising the clinical information supplied on the MSCC Referral Form, to allow an immediate clinical decision to be made. This decision will be communicated back to the referrer by the on-call Neurosurgical Registrar.

Overnight an advisory service will be provided and a final clinical decision will be made and communicated back to the referrer after discussion of the case within the morning neurosurgical clinical meeting. Emergency surgery will be offered/perform overnight as clinically indicated by the on call neurosurgery service.
If the patient is to have surgical intervention, the Lead MSCC Co-ordinator /on-call Neurosurgical Registrar will provide the referrer with the information required to facilitate urgent transfer of the patient to St George’s Hospital (refer to Section 7.2).

If the patient is not for surgical intervention, it is then the referrer’s responsibility to liaise directly and immediately with the Cancer Centre to arrange urgent radiotherapy (refer to Section 7.3).

**N: B:** The referrer is expected to send the patients scans and e-mail the referral form to both the South West London MSCC Centre and the local Cancer Centre. They are also responsible for letting the centres know how this data transfer has taken place. This allows the patient to be pre-registered at the cancer centre to streamline radiotherapy planning if required.

The outcome of this process will be summarised and faxed/e-mailed to the Acute Oncology Service (AOS) Administrator in the respective Cancer Centre (RMH NHS FT and RSCH – St Luke’s Cancer centre) by the local MSCC Service Administrator. The AOS Administrator will be responsible for cascading that information back to the AOS Service from the referring Trust for audit purposes.

**2.2: Senior Clinical Advisors - Neuro-Radiology**

The Neuroscience Department at St George’s Hospital provides a 24 hour, 7 days a week on call Consultant Neuro-Radiologist rota to support the acute workload within the unit. Therefore, the South West London MSCC Service will have access to a Consultant Neuro-Radiologist at all times.

**2.3: Senior Clinical Advisors – Clinical Oncology**

This is provided by the respective cancer centres:

- For South West London Hospitals support is provided by the Royal Marsden NHS Foundation Trust
  - MSCC clinical lead: Dr Katharine Aitken, Consultant Clinical Oncologist
- For SLCA network support is provided by the Royal Surrey County NHS Foundation Trust
  - MSCC clinical lead: Dr May Teoh, Consultant Clinical Oncologist

A Clinical Oncology SpR will be available to discuss any new case 24 hours a day, 7 days a week and will be able to view IEP/PACS images. The SpR is supported by the relevant Consultant clinical oncology on call rota as required. Please see Referral Flowchart (Appendix 3) for clear guidance.

**2.4: Lead MSCC Co-ordinator**

The role of the Lead MSCC Co-ordinator is as follows:

- To co-ordinate care for patients who present with actual or potential MSCC and who require access to the specialist supra-regional spinal oncology service
- To provide detailed information to the referrers on referral criteria
- To triage referrals, liaising with referrer, SCA & patient/carers ensuring prompt and effective patient management
• To act as a co-coordinator of the pathway, facilitating multidisciplinary working across healthcare sectors, and organisational boundaries for the supra-regional service

• To demonstrate sound knowledge of the principles of spinal oncology care ensuring optimum standards for patients

• To be based within the specialist trust and liaise with acute and primary care trusts and other organisations across the region to ensure prompt and efficient referrals to the service

• To provide a resource for advice and support across the network

Office hours: The role of the Lead MSCC Co-ordinator will be fulfilled from a rota comprising of the following senior clinical staff:

• Pam Floyd – Spinal Clinical Nurse Specialist and MSCC Co-ordinator

• Moey Chen Lim – Trauma and Orthopaedic Nurse Practitioner (Spinal) (mutual cover)

They will carry the Lead MSCC Co-ordinator bleep (Bleep 6027)

Out of hours: The role of the Lead MSCC Co-ordinator will be fulfilled by the Neurosurgical Registrar on call. They will carry the on call neurosurgery bleep (Bleep 7242)

Please see Referral Flowchart (Appendix 3) for clear guidance.

2.4.1: Training for Lead MSCC Co-ordinator

The SWLCN Acute Oncology Group (NAOG) initially agreed that the Network MSCC Co-ordinator must having the following experience and training to achieve effective service delivery. This work is being taken forward by the LCA.

• Minimum of two years acute clinical experience within oncology, neurosurgery or spinal orthopaedics

• Senior healthcare professional (Band 6 or above)

• Educated to or working towards degree level

• Evidence of ongoing specific training within relevant speciality

Competency assessment was initially carried out at the launch of the service and assessments will be carried out annually as follows:

Pam Floyd - to be assessed for competency by Mr Matthew Crocker

Moey Chen Lim – to be assessed for competency by Mr Jason Bernard

Competencies may be amended and updated to reflect changes within the service or clinical management strategy.

3. Clinical Triggers
The South West London MSCC Service relates to patients with either a prior diagnosis of cancer or an unknown primary cancer with symptoms suggestive of spinal metastases/metastatic spinal cord compression who present with:

- 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
- Radicular pain
- Any limb weakness, difficulty in walking
- Sensory loss or bladder or bowel dysfunction
- Neurological signs of spinal cord or cauda equina compression

A patient with a cancer diagnosis and confirmed vertebral metastases is at high risk of developing MSCC. It is important that the patient is educated about the risks of developing MSCC, how to identify these symptoms, what to do and who to contact. (See Appendix 1 for alert card and patient information leaflet)

4. Referral Pathways (in correlation with the Patient Pathway)

There are three possible pathways within the entire patient pathway which are outlined in Appendix 2.

4.1 Pathway One

This pathway relates to patients who present with symptoms suggestive of spinal metastases with neurological symptoms or signs suggestive of MSCC.

A Referral Flowchart has been created to streamline referral. This can be found in Appendix 3.

Contact must be made with the Lead MSCC Co-ordinator within 24 hours or less.

4.2 Pathway Two

This pathway relates to patients who present with symptoms suggestive of spinal metastases without new neurological symptoms. These patients must undergo an MRI scan within 7 days.

Contact must be made with the Local MSCC Co-ordinator (who will be the lead for the Acute Oncology Service (AOS) for the Trust) within 24 hours of the scan. If neurological compression is identified they must be immediately placed on Pathway One.

4.3 Pathway Three

This pathway relates to patients who present with non specific spinal pain. These patients should be managed locally through standard back care protocols. This falls outside the remit of the AOS Measures and it is not appropriate for these patients to be managed through the South West London MSCC Service. However, the patient should be closely observed for signs of symptom progression, and if symptoms persist or progress then they should be referred to the South west London MSCC Service via either Pathway One or Pathway Two as appropriate.
5. **Contact details for associated MSCC Co-ordinators**

The contact numbers for all Local MSCC Co-ordinators (AOS Leads) within the South West London Hospitals and SLCA are outlined within Appendix 4. It is essential that good communication links are established to ensure prompt and effective patient management.

6. **Referral Process**

The local Acute Oncology Service must be contacted in the following cases (see Appendix 4 for contact details):

- All patients with symptoms suggestive of spinal metastases with neurological symptoms
- Signs suggestive of MSCC
- Primary imaging suggestive of MSCC

The referral process relates to patients being referred into the South West London MSCC Service via **Pathway One** (see Appendix 3 for Referral flowchart).

6.1 **Recommended Imaging:**

All Trusts using the South West London MSCC Service must have access to the Information Exchange Portal (IEP) or allow the Senior Clinical Advisors unlimited (including remote) access to the individual Trust’s PACS. Scans should be **simultaneously** sent via IEP to the South West London MSCC Service and to the Cancer Centre (The Royal Marsden Hospital for South West London Hospitals and the Royal Surrey County Hospital if the patient sits within SLCA). The purpose of this is to speed up the ongoing commencement of radiotherapy if surgery is not an option.

Patients presenting with a known malignancy and suspected spinal cord/cauda equina compression should undergo whole spine imaging. MRI is the **preferred** modality. Protocols may be varied according to local practice and patient tolerance but if at all possible should include a minimum of whole spine sagittal T1 and T2-weighted sequences with STIR sequences if time allows. Axial scans should be done through any levels of spinal cord/cauda equina compression. Contrast enhanced scans are not usually necessary unless unenhanced scans suggest metastases within the spinal cord itself or spinal infection is suspected.

If MRI is unavailable on site or contraindicated, CT should be used to diagnose or rule out compression of the spinal cord or cauda equina (Crocker et al. Clinical Radiology 2011). Reformatted images in axial, sagittal and coronal planes presented on soft tissue and bone window settings from a routine protocol cancer staging body CT scan are sufficient.

If MSCC is demonstrated on the MRI or CT scan the South West London MSCC Service should be contacted immediately (<24hours).

If CT is done rather than MRI and MSCC is not seen, the patient should be assessed locally and an MRI scan performed within 7 days. The Local MSCC Co-ordinator (AOS Lead) should be contacted (< 24 hours) following the scan. During this time their neurological function should be **closely** monitored and further deterioration **should** prompt immediate discussion with the South West London MSCC Service for reconsideration of transfer.
6.2 Imaging provision with the South West London MSCC Service:

As a minimum requirement, all Trusts within the South West London MSCC Service are able to provide an MRI within 24 hours during the hours of 9am to 5pm Monday to Friday for patients with suspected MSCC and demonstrating clinical signs. This in essence, provides cover for patients presenting between 10am Sunday to 5pm Friday. Between the hours of 8am and 5pm Monday – Friday, the point of contact for imaging at local level will be the radiology consultant covering MRI. The ongoing discussions at the LCA AOS Pathway MSCC Sub-Group indicate that the referral will come via the local MSCC Co-ordinator within the referring unit or via the GP if the patient is being cared for within the primary care setting.

Only one department in the South West London MSCC Service currently offers an on call MRI service, although many departments offer booked out patient lists on at least one day of the weekend. We aim to minimise unnecessary movement of patients between Trusts, particularly when the patients are clinically unstable or in pain. As a result the minimum standard agreed by the LCA AOS Pathway Group includes the provision of a CT scan, contrast enhanced if necessary, within 24 hours.

If an MRI scan is possible during the weekend period, this is optimal. We encourage the development of this service where possible, in compliance with the imaging aspects of the Acute Oncology Measures (DoH, 2011).

6.3 South West London MSCC Service Referral Form

Referring clinicians/local MSCC Co-ordinators will be signposted by the Lead MSCC Co-ordinator/On-call Neurosurgical Registrar to access the South West London MSCC Service Referral Form.

This form can be found at

http://www.stgeorges.nhs.uk/docs/hcp/neuro_mscc.doc

This form must be completed electronically and returned to the South West London MSCC Service. The fully completed form should then be e-mailed to:

Stgh-tr.mscc@nhs.net.

A copy of the form can be found in Appendix 5.

A copy of the form should also be sent to the Cancer Centre at the same time to provide patient details to allow the Clinical Oncologist to initiate emergency radiotherapy if/once surgery has been excluded.

Royal Marsden Hospital - rmh-tr.MSCC@nhs.net

Royal Surrey County Hospital - rsc-tr.MSCC@nhs.net

Please contact the Lead MSCC coordinator and the Clinical Oncologist (or AOS administrator at the local Trust) to confirm how the form has been sent (i.e. email)

These email addresses/faxes are only accessed only Monday to Friday between 0900hr – 1700hrs. Out of hours direct contact should be made with the
neurosurgical SpR on call (via St George’s switchboard bleep 7242 and the on-call clinical oncology SpR via switchboard at SLCA or RMH.

6.4 Case Discussion

Every referral must be discussed with the Lead MSCC Co-ordinator/Neurosurgical Registrar on call at St George’s Hospital on 0208 672 1255, bleep 6027 and the on call Clinical Oncologist at the relevant cancer centre via switchboard. This provides an alert that the patient may require urgent radiotherapy if surgery is not appropriate and allow the patient to be registered to facilitate timely planning.

The Lead MSCC Co-ordinator will facilitate the review of imaging and appropriate case discussion. Definitive treatment decisions are made according to the patients overall disease burden (including prognosis), neurological state and rate of neurological deterioration.

If surgery is not indicated then an immediate follow-up discussion should take place between the referrer and the Clinical Oncologist on call at the Cancer Centre to arrange urgent radiotherapy. In cases where the overall disease burden is high and the prognosis is poor the immediate discussion will be co-ordinated with the Clinical Oncology Senior Clinical Advisor.

In complex cases a three way discussion with all Senior Clinical Advisors may need to occur before a definitive treatment decision is made.

Patients with an established diagnosis of multiple myeloma may require complex medical management. For this group of patients, the South West London MSCC Service will facilitate an initial discussion between the Senior Clinical Advisors for surgery and oncology and the Consultant Haematologist responsible for the management of the patient. This discussion must take place prior to any clinical decision making.

7. Definitive Treatment

Definitive treatment will be agreed when the South West London MSCC Service has received the scans and the referral form for the patient.

N.B. It is essential that the referrer assesses and records an accurate and up to date neurology for the patient on the MSCC Referral Form to facilitate appropriate decision making

7.1 Preliminary Management

In order to preserve optimum neurological function and facilitate best practice, patients should be managed as follows:

- The patient should be commenced on oral (PO) or intravenous (IV) dexamethasone, with a stat dose of 16 milligrams (mg) with the exception of patients with multiple myeloma. In these cases the steroid dose should be agreed with the haematono oncologist responsible for the patient.

- The patient should continue on 16 mg dexamethasone PO or IV a day, in two doses (8mg BD)

- The patient should be started on gastric protection whilst on steroids (Lansoprazole 30mg once a day)
• The patient should be assessed spinally and neurologically according to local policy. The frequency of these observations should increase if there is a deterioration in neurological function.

• Patients should be nursed using spinal precautions for an unstable spine (as per Trust policy) until the stability of the spine is confirmed by the Lead MSCC Co-ordinator following review of the scan by the Surgical Clinical Advisor on call. (see section 7.2)

• The patient should be kept nil by mouth with IV fluid support if there is an indication that the patient may require immediate surgery.

• The patient should be considered for a urinary catheter if they are developing or showing signs of urinary retention or have an unstable spine which does not allow them to use a bedpan safely.

• Comprehensive bowel management is essential including immediate prescribing of oral aperients where appropriate.

The patient should have their level of pain assessed using a recognised pain assessment tool on presentation and at regular intervals to facilitate assessment of their pain control needs. The patient needs to given effective, regular and appropriate analgesia. Consider early referral to the acute pain service and/or palliative care team for specialist pain management.

7.2 Spinal Stability

Patients should be nursed using spinal precautions for an unstable spine (as per Trust policy) until the stability of the spine is confirmed by the Lead MSCC Co-ordinator following review of the scan by the Surgical Clinical Advisor on call.

The LCA guidelines for spinal instability are as follows:

Initial Precautions

Patients with severe pain suggestive of spinal instability, or any neurological symptoms or signs suggestive of MSCC, should be nursed flat with neutral spine alignment (including 'log rolling' and use of a slipper bed-pan) until bony and neurological stability are ensured.

• Assume the spine unstable until clearly documented in the medical notes
• Full neurological assessment including PR examination
• Respiratory assessment and treat as appropriate
• Nurse patient with spine in neutral alignment
• For cervical lesions, ensure immobilisation with hard collar (refer to local policy for fitting procedures)

Spine stability after definitive treatment

• Please refer to NICE guidance on the management of MSCC
• Ensure referral to physiotherapist within 24 of admission
• Consider spinal brace
• Gentle mobilisation under instruction when pain well controlled
• Encourage gradual sitting from supine to 45 degrees, once tolerated progress to 60-90 degrees as able. Monitor neurology and pain during this process.
7.3 Surgical Intervention

If emergency surgical intervention has been agreed then immediate transfer will be arranged. The Lead MSCC Co-ordinator will liaise with the Neuroscience Bed Manager/corresponding unit (within normal working hours) or the On-call Neurosurgical Registrar will liaise with directly with the senior nurse on Neurosurgical Unit/corresponding unit (out of normal working hours). The aim is for patients to be transferred from the referring unit and admitted to a bed within St George’s Hospital within 24 hours dependant on capacity.

Patients with rapidly progressive cord lesions may undergo emergency surgery out of normal working hours, however, wherever possible surgery will be performed within normal working hours according to standard practice.

7.4 Oncological Management

If surgery is not indicated for the patient with MSCC then the Lead MSCC Co-ordinator will feed this decision back to the referrer immediately. An immediate follow-up discussion should take place between the referrer and the Clinical Oncologist on call at the Cancer Centre to arrange urgent radiotherapy. They will already know about the patient following initial referral discussion and having received the referral form and scans.

If the patient is being referred to the Royal Marsden Hospital the referrer must go through switchboard and ask to speak to the Clinical Oncology SpR on call.

If the patient is being referred to the Royal Surrey County Hospital then the referrer must contact their switchboard and ask for the Clinical Oncology SpR on call or the ‘Oncology Hot Bleep’.

The patient will remain in their referring unit and will be transferred to the Cancer Centre as an inpatient or attend as an outpatient for urgent radiotherapy. The Lead MSCC Co-ordinator will ensure the referrer is aware of the process and confident of ongoing communication channels to ensure the patient receives their definitive treatment quickly and efficiently.

8. Specialist Multi-Disciplinary Team (SMDT) Discussion

The Neurosciences SMDT meeting takes place on a Friday am at 08.00 hours in the radiology Seminar Room, 2nd Floor, Atkinson Morley’s Wing, St George’s Hospital. The MDT Co-ordinator can be reached on 020 8725 4191 via e-mail on

stgh-tr.Neuro-OncologyMDT@nhs.net

Patients referred into the South West London MSCC Service via Pathway One and have a confirmed diagnosis of MSCC will have a retrospective discussion. Following surgery they will be added to the next Neurosciences specialist MDT by the Lead MSCC Co-ordinator. The Lead MSCC Co-ordinator will fax a copy of the patient’s discharge summary and histology within 24 hours of histological confirmation to both the patient’s Oncologist and their GP.
Patients referred to the South West London MSCC Service via Pathway One or Pathway Two and have bony metastases with pending rather than actual MSCC will have a prospective discussion. Referrers will be asked to liaise with the MDT Co-ordinator to ensure that the patient’s scans are present and correct, that the referral form is completed and returned and that there are agreed pathways for feeding back the decision and ongoing management. The Lead MSCC Co-ordinator will ensure feed back of the outcome of the Neuroscience SMDT within 24 hours of the discussion taking place.

9. Nursing Management

9.1 Autonomic Dysreflexia

• Alterations of sympathetic vascular tone, relative parasympathetic over-activity and respiratory muscle paralysis may cause complex and sometimes life-threatening vascular, cardio-respiratory and autonomic changes in people with MSCC.

• Autonomic dysreflexia is a potential complication with any patient who has complete paralysis above T6. This medical emergency is caused by excessive activity of the sympathetic nervous system elicited by noxious stimuli below the level of the lesion. Unresolved, it can cause fatal cerebral haemorrhage.

• Common presenting symptoms of autonomic dysreflexia:
  • Severe hypertension (abrupt rise) – Systolic BP can exceed 200mm/Hg
  • Bradycardia
  • ‘Pounding’ headache
  • Flushed or blotchy appearance of skin above the level of lesion
  • Profuse sweating above the level of the lesion
  • Pallor below the level of lesion
  • Nasal congestion
  • Non-drainage of urine

• Management of acute autonomic dysreflexia is the removal of any causes of noxious stimulation, eg blocked catheter, constipation, undue pressure upon extremities/other body areas, and or administration of a beta-blockade in a critical care environment. If present it is both indicative of a complete spinal cord lesion and a near absolute contraindication to surgery.

9.2 Pain Management

• Pain assessment should be carried out on admission and re-assessed daily or more frequently depending on the severity of pain or level of distress.

• A formalized pain assessment tool should be used in partnership with the patient to obtain a comprehensive assessment of each individual site of pain identified.

• Following pain assessment, prompt pain management should be initiated to maximize pain relief.

• It is recommended that the principles of the WHO Analgesic ladder (Figure 2) are used for pharmacological management of pain in combination with other non-pharmacological modalities (e.g. relaxation and gentle massage).

• Patients should be referred to the specialist palliative care team for assessment and advice regarding pain management.
• A multidisciplinary approach to pain management is recommended.

Figure 2. WHO Analgesic ladder

9.3 Thromboprophylaxis

• Patients with MSCC are at increased risk of developing venous thromboembolic events. This is due to a combination of a ‘hypercoaguable state’ as a complication of malignancy and reduced mobility as a result of MSCC

• Other risk factors for thrombo-embolic disease should be considered, including recent chemotherapy, surgery, previous history of thromboembolic disease, the use of oestrogenic drugs such as Tamoxifen and Stilboestrol, and patients with indwelling venous catheters.

• Patients should be assessed for thromboprophylaxis on admission, according to local Trust protocols.

• Consider anti-embolic stockings (TEDS) if unlikely to be mobile for >3 days.

• If patient likely to be immobile for >24 hours and no contra-indications, start low molecular weight heparin (LMWH) at a prophylactic dose (e.g. Dalteparin 5000iu SC daily)

9.4 Bladder Management

• MSCC can cause progressive nerve compression that can result in urinary retention, incontinence or large post-voiding residual volumes.

• The type of and degree of bladder dysfunction depends on the site and extent of damage to sensory and motor tracts of the spinal cord.

  • If the MSCC is above T12, the patient will have an upper motor neurone (spastic) bladder – incontinence, no voluntary control of bladder emptying
  • If the MSCC is below T12, the patient will have a lower motor neurone (flaccid) bladder – urinary retention, dribbling incontinence when bladder is overfilled, large post-voiding residual volumes
• Some patients may have a ‘mixed’ bladder when there is only partial compression of the spinal nerves

• Assessment of bladder function on initial presentation is vital for effective bladder care management.

• Patients with no symptoms should be monitored daily for any changes.

• Patients who have urinary incontinence, urinary retention or are unable to use a bedpan safely due to an unstable lumbar spine should be catheterized.

• If long term catheterization is required, intermittent catheterization or suprapubic catheters should be considered.

9.5 Bowel Management

• Altered bowel function is a common problem in patients with MSCC or cauda equine syndrome.

• The patient may become severely constipated due to decreased mobility, loss of rectal sensation, poor anal and colonic tone, use of opioids and other analgesics, and anorexia.

• Constipation can lead to overflow diarrhoea, abdominal distension, nausea and vomiting.

• If the MSCC is T12 or above, the patient will have an upper motor neurone (spastic) bowel – anal sphincter tone maintained, bowel will contract and empty when stimulated

• If the MSCC is L1 or below, the patient will have a lower motor neurone (flaccid) bowel – anal sphincter will be flaccid, faecal retention and overflow of faecal fluid may occur

• Assessment of bowel function on initial presentation is vital for effective bowel care management.

• Patients with no symptoms should be monitored daily for any changes.

• Patients should be managed according to a neurological bowel management programme. The aim of bowel care in patients with MSCC is to attain a ‘controlled continence’.

• Establish a regular bowel routine:
  • Review diet and fluid intake (aim for a high fibre diet and high fluid intake).
  • Regular oral laxatives with PR intervention every 1-3 days may be required

Example of oral laxative regime:
Softener – Sodium docusate 200mg BD
Stimulant – Senna 2 tabs at night, or Movicol 1-2 sachets daily

Example of regular PR intervention regime:
Suppositories – Bisacodyl and glycerine (on alternate nights)
If not effective, may require microlax enema or gentle manual evacuation
• If faecal loading:
  • 1st line – glycerine or bisacodyl suppositories or microlax enema
  • 2nd line – arachis oil enema overnight
  • 3rd line – phosphate enema
  • 4th line – gentle manual evacuation (generally required if flaccid bowel)
9.6 Pressure Area Care

- Patients with MSCC are at high risk of developing pressure sores, due to impaired mobility and sensation, and compromised bladder and bowel function.

- If on bed rest, patients should be log-rolled every 2-3 hours.

- Patients with reduced sensation and restricted mobility should be offered pressure relieving cushions and/or mattresses with high pressure relieving properties (refer to local Trust policy on pressure ulcer risk assessment and prevention)

- Skin inspection should be carried out systematically at least once a day (frequency determined by the patient’s individual condition)

- The following signs may indicate incipient pressure ulcer development: persistent erythema, non-blanching hyperaemia, blisters, discolouration, localized heat, localized oedema and localized induration, In those with darkly pigmented skin: purplish/bluish localized areas of skin, localized head which if tissue becomes damaged, is replaced by coolness, localized oedema and localized induration.

- Skin changes should be documented/recorded immediately to classify ulcer stage and extent of tissue damage.

10. Rehabilitation


Rehabilitation and supportive care services for patients with MSCC may include:

- Physiotherapy
- Occupational Therapy
- Speech & Language Therapy
- Dietetics
- Lymphoedema services
- Complementary therapy services (NCAT 2010)

A comprehensive overview of the rehabilitation provision within the area covered by South west London Hospitals and SWSHCN is provided in Appendix 6.

Ongoing re-assessment at key stages of the patient pathway is recommended with any changes in the patient’s clinical presentation (DH,MCS & NHSI 2010). This is necessary during acute community (including out-patient services) and voluntary (third) sector services. Where appropriate, access to intensive rehabilitation units should be provided. The potential benefits of specialist in-patient neurological and functional rehabilitation have to be weighed against the time required to achieve
these (often small) gains for patients with MSCC. Additionally the general health and ability and wish to return home of patients with a life-limiting diagnosis and decreasing functional ability needs to be considered (NICE 2008).

The rehabilitation of patients with MSCC should focus on their goals and desired outcomes, which could include promoting functional independence, participation in normal activities of daily life and aspects related to their quality of life (NICE 2008).

To ensure a holistic approach, it is essential that local service provision provides specialist rehabilitation including: vocational/leisure interests, equipment provision, environmental adaptation, and psycho-social support (NICE 2008, Macmillan 2009).

References

Department of Health (DH), Macmillan Cancer Support (MCS), NHS Improvement (NHSI). National Cancer Survivorship Initiative 2010. (Available at: http://www.ncsi.org.uk)


11. Supportive Care

Symptom control and palliative care provision is central to the care provided for patients with metastatic disease, and in particular MSCC. It is crucial to ensure that patients are referred to palliative care at the right time in the pathway. For some patients this will be at the time of diagnosis. The LCA referral criteria for specialist palliative care stipulate the following referral criteria:

- Pain and symptom management
- Meeting the psycho-social needs of the patient & their family, and/or significant others
- Terminal care/dying

The referral can be made by any health care professional, but has to be agreed by the medical team. The reasons for referral should always be explained by the medical/surgical team with the patient and family/ carers. If the referral is for terminal care this should have been discussed specifically with the patient/family/carer by the medical/surgical team.
The Lead MSCC Co-ordinator should work in close collaboration with the specialist palliative care team. If the patient is being managed in the referring unit and not being transferred then the Lead MSCC Co-ordinator will ensure that the referring team refer the patient to the specialist palliative care team at the corresponding unit.

If the patient is an inpatient at St George’s Hospital, the referral can be made at the Neuroscience SMDT or at any other time in the week. If the patient is at another hospital or in the community, the Neuro-oncology CNS should inform the referring team about the SMDT decision to refer to specialist palliative care.

For patients who are due to be transferred back to the referring hospital and who do not require urgent specialist palliative care, the Lead MSCC Co-ordinator will refer to the specialist palliative care team in the referring hospital. If a patient requires urgent palliative care and immediate intervention on transfer, the specialist palliative care team will liaise with their specialist palliative care team colleagues within the referring hospital.

To ensure that this seamless transition and collaboration occurs, a member of the palliative care team attends the Neuroscience SMDT.

For patients at home, the service is provided by community palliative care teams. The initial discussion and referral to the community team predominantly takes place during the treatment planning stage at SGH, RMH or RSCH, unless the patient requires urgent referral for symptom control or psychological support. In this situation, the specialist palliative care team will review the patient and liaise directly with their colleagues in the community palliative care team to ensure an urgent referral for symptom control or psychological support. This would be initiated by the hospital palliative care team and then referred to the community team on discharge.

12. Audit

The South West London MSCC Service will be required to complete audit data agreed by the LCA AOS Pathway Group/MSCC subgroup to monitor the following:

- The timeliness of referral (from patient presentation to Network MSCC Service contact)
- The appropriateness of referral (based on scan findings/neurological assessment)
- Time to scan
- Speed of image transfer
- Effective completion and timely completion of referral form
- Speed of decision to treat and communication of definitive treatment
- The date of SMDT discussion
- The timeliness of transfer for surgery
- The timeliness of commencement of radiotherapy
- The timeliness of ongoing communication to patient’s Oncologist and GP
• Outcome data at 1 month, 3 months, 6 months and at a year. The outcomes measured are mobility, sphincter function and pain.

The results on this ongoing audit will be presented on a **yearly** basis to the following groups for dissemination:

• The local AOS Group

• The local Clinical Cancer Directorate (if applicable)

• The LCA AOS Pathway Group

• The LCA Brain and CNS Pathway Group

**Appendix 1 – MSCC Alert Card and Information Leaflet**
METASTATIC SPINAL CORD COMPRESSION

Metastatic spinal cord compression (MSCC) and damage can develop if cancer has spread to the spinal cord (spinal metastases). If you develop any of the following 3 symptoms of MSCC telephone the contact numbers below URGENTLY:

- A narrow band of severe pain down your arm or leg or around your body
- Numbness, weakness or difficulty using your arms or legs
- Bladder or bowel control problems

Mon-Friday contact:

All other times contact:

SPINAL METASTASES

If you develop any of the following symptoms of spinal metastases, please contact your doctor, GP or palliative care team within the next 48 hours:

- Funny feelings, odd sensations or a sense of heaviness in your legs
- Unsteadiness when walking, especially on stairs
- Back pain that is new or different, which may become worse when lying flat and keeps you from sleeping
- Back pain that doesn’t get better with painkillers
- Agonising back pain, which is extremely difficult to bear
There is an ‘alert’ card available from your clinical team with the symptoms to look out for and actions to take.

**Diagnosis**
Diagnosing spinal cord compression quickly can help to prevent spinal cord damage and disability. Depending on the symptoms, you may be advised to go to hospital for a scan and possible treatment. Usually you will have an MRI scan although you may be offered a different scan. This will help your clinical team to make decisions about the best treatment for you.

**How is spinal cord compression treated?**
Treatment for spinal cord compression should start as quickly as possible (ideally within 24 hours of being admitted to hospital).
Your clinical team will discuss your treatment options with you and you should be involved in all decisions about your treatment and care. You may be offered one or several of the following treatment options:
- **Painkillers (analgesics)**: they may be mild or strong.
- **Corticosteroids**: medicines that help to reduce swelling and relieve the pressure on the spinal cord.
- **Radiotherapy**: radiation treatment directed at your spine to destroy cancer cells and relieve the pressure on your spinal cord.

**Surgery**: an operation to help relieve the pressure on your spinal cord and strengthen your spine.
- **Kyphoplasty and vertebroplasty**: injections of a special bone cement into the spine to help ease pain and strengthen your spine.
- **Chemotherapy** may occasionally be used for tumours that are sensitive to chemotherapy drugs.
- **Bisphosphonates**: medicines that help to relieve pain and protect the bones in your spine.

**Care in hospital**
Your symptoms may mean you need to stay in bed. This is to reduce the movement of your spine to protect your spinal cord from further damage. You may be asked to lie flat and your clinical team will monitor you where you first start to all up. Health professionals such as physiotherapists and occupational therapists may also offer you advice on what support you need to move around safely.

**Blood clots**: you are at risk of developing a blood clot if you are unable to move around. Your clinical team will advise you on how you can reduce this risk.

**Pressure sores or ulcers**: including how much you move around, can also increase your risk of developing pressure sores or ulcers. You will be helped to change position regularly if you are unable to do this yourself. A special mattress may help prevent sores developing.

**Bowel or bladder control problems**: you may need help with bladder and/or bowel care. If you are unable to pass urine, you may need a catheter to help empty your bladder. If bowel function is a problem you may need medicines which may help improve it. Your clinical team will monitor your bladder and bowel function regularly, even if you don’t have problems.

**Going home after treatment**
Most people will be able to go home after hospital treatment. However, some people may be offered specialist rehabilitation from physiotherapists and occupational therapists. You may need additional support and equipment at home from your local community services to help you regain some independence.

Your family and carer should also be offered support and training so that they feel confident in caring for you at home. You should also be offered information on how to access psychological and spiritual support if you feel it would be helpful.

The information in this leaflet has been taken from the National Institute for Health and Clinical Excellence (NICE) guidance document, which is available from their website www.nice.org.uk.

- CG75 Metastatic spinal cord compression: understanding NICE guidance (2008)

Please ask if you would like the information in this leaflet in a different language.
Appendix 3 – Referral Flowchart for the South West London MSCC Service

Treatment Algorithm for Metastatic Spinal Cord Compression (MSCC)

1. Symptoms suggestive of spinal metastases (with neurological symptoms) or signs suggestive of MSCC (Refer to MSCC Standard Operating Procedure)

2. Comprehensive assessment of current neurology and detailed medical history (including whether the patient has already had radiotherapy to the affected area)

3. Contact your local AOS Team AND Urgent MRI (or CT scan if not possible) <24 hours (sooner if rapid deterioration)

4. Confirmed metastatic spinal disease

5. Known solid malignancy

6. Start Dexamethasone 15mg (2 x 8mg doses IV/O daily) with PPI cover as soon as possible after assessment unless contraindicated

7. Nurse the patient using spinal precautions for an unstable spine (as per Trust policy) until the stability of the spine is confirmed by the MSCC Co-ordinator

8. Unknown primary malignancy

9. Contact local Haematologist; start steroids only after this consultation

10. Known or suspected Lymphoma/Myeloma

11. Transfer MRI/CT images to MSCC Centre & the Cancer centre via IEP urgently via blue light on system

Contact MSCC Co-ordinator at St. George’s by:
Completing the MSCC referral form at https://www.stgeorges.nhs.uk/service/neuro/neurosurgery/metastatic-spinal-cord-compression/
AND
0900-1700 Mon-Fri Bleep 6027 via SGH switchboard
All other times Bleep 7242 for urgent clinical advice only

Contact the Clinical Oncology Registrar on call at the Cancer Centre via the switchboard at either the Royal Marsden (020 3642 6011 on cordless 1487) or the Royal Surrey County (01483 571122 on Hot Bleep 9.5 Mon-Fri) and warn them that the patient may require urgent radiotherapy if surgery is not appropriate

Email typed MSCC Referral For to the MSCC Centre to zg-h-tr.MSCC@nhs.net
ALSO Email or fax a copy of the form to the patient’s Cancer Centre
(Royal Marsden Hospital) rmh-tr.MSCC@nhs.net (Fax: 020 7811 8436) or
(Royal Surrey County Hospital) rsc-tr.MSCC@nhs.net (Fax: 01483 464876)

If the decision is that the patient should have surgery then the patient will be transferred to St George’s as a priority admission - this will be organised by the MSCC Co-ordinator

If the decision is that the patient should not have surgery then it is the referrer’s responsibility to contact the Clinical Oncology Registrar on call again at the Cancer Centre (with advice from the MSCC Co-ordinator) to initiate urgent radiotherapy and transfer

All cases referred through this pathway will be discussed retrospectively within the neuro/Spinal Oncology MDT Meeting at St George’s Hospital on Friday morning at 08.30hrs. The outcome of this meeting will be emailed to the original referrer, they AOS Service from the referring Trust (via the Cancer Centre) and the patient’s GP.
### Appendix 4 – Local MSCC Co-ordinator Contacts

#### South West London Hospitals – Acute Oncology Service Contacts

<table>
<thead>
<tr>
<th>Trust</th>
<th>Name</th>
<th>Role</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epsom and St Helier NHS Trust – Epsom Hospital</td>
<td>Dr David Watkins</td>
<td>AOS Consultant</td>
<td>07917 553735</td>
</tr>
<tr>
<td>Epsom Hospital</td>
<td>Dawn Brewer</td>
<td>AOS CNS</td>
<td>07826 859516</td>
</tr>
<tr>
<td>Epsom and St Helier NHS Trust – St Helier Hospital</td>
<td>Dr Jaishree Bhosle</td>
<td>AOS Consultant</td>
<td>07584508099</td>
</tr>
<tr>
<td>St Helier Hospital</td>
<td>Julia Lowes</td>
<td>AOS CNS</td>
<td>07826859570</td>
</tr>
<tr>
<td>Kingston NHS Trust</td>
<td>Thora Thorhallsdottir or Lesley Chamberlain or Lorraine Hyde</td>
<td>AOS CNS</td>
<td>Bleep 086 via switchboard</td>
</tr>
<tr>
<td></td>
<td>Katharine Aitkin Dr Marina Parton</td>
<td>AOS Consultant</td>
<td>07946 548990 07703 727185</td>
</tr>
<tr>
<td>Croydon University Trust</td>
<td>Nicola Beech</td>
<td>Nurse Consultant and AOS Lead Advanced Nurse Practitioner</td>
<td>Ext 5726, Bleep 946 via switchboard or 020 8401 3000</td>
</tr>
</tbody>
</table>

#### SLCA – Acute Oncology Service Contacts

<table>
<thead>
<tr>
<th>Trust</th>
<th>Name</th>
<th>Role</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Surrey County NHS Foundation Trust</td>
<td>Sam Russell or Aga Kehinde</td>
<td>AOS CNS</td>
<td>01483571122 Bleep 71-0727 01483571122 Bleep 71-4490 <a href="mailto:m.teoh@nhs.net">m.teoh@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>Dr Simon Page</td>
<td>AOS Specialty Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr May Teoh</td>
<td>AOS Consultant</td>
<td></td>
</tr>
<tr>
<td>Frimley Park NHS Foundation Trust</td>
<td>Shobana Srinivasan or Joseph Peralta</td>
<td>AOS CNS</td>
<td>01276526342 Bleep 670/710 01276 526904 <a href="mailto:nita.patel12@nhs.net">nita.patel12@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>Mary Hayes</td>
<td>Lead Nurse for Cancer &amp; Palliative Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Nita Patel</td>
<td>AOS Consultant</td>
<td></td>
</tr>
<tr>
<td>Ashford and St Peter’s Hospitals NHS Trust</td>
<td>Faithe Cockroft or Sian Wing</td>
<td>AOS CNS</td>
<td>01932722684 or 0193287000 Bleep 8441 01932722851 or 01932872000 Bleep 8176 <a href="mailto:m.teoh@nhs.net">m.teoh@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>Sarah Burton</td>
<td>Lead Nurse for Cancer &amp; Palliative Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr May Teoh</td>
<td>AOS Consultant</td>
<td></td>
</tr>
<tr>
<td>Surrey and Sussex Healthcare NHS Trust – East Surrey Hospital</td>
<td>Lisa Jacques or Tina De La Cruz</td>
<td>AOS CNS</td>
<td>01737768511 ext 6984/ Bleep 956</td>
</tr>
<tr>
<td>Dr Eirini Thanopoulou</td>
<td>AOS consultant</td>
<td><a href="mailto:eirini.thanopoulou@nhs.net">eirini.thanopoulou@nhs.net</a></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5 – South West London MSCC Service Referral Form

London Cancer Alliance (LCA) and Surrey West Sussex and Hampshire Cancer Network (SWSHCN) Metastatic Spinal Cord Compression (MSCC) Referral

Every referral must have this form completed and emailed to stgh-tr.MSCC@nhs.net

AND

0900-1700 Mon-Fri Bleep 6027 via SGH switchboard
All other times Bleep 7242 for urgent clinical advice only
All fields are mandatory.

<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Hospital Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>Referring Hospital</td>
</tr>
<tr>
<td>Forename</td>
<td>Your Name</td>
</tr>
<tr>
<td>Date Of Birth</td>
<td>Your Designation</td>
</tr>
<tr>
<td>(dd/mm/yyyy)</td>
<td>Choose a Designation</td>
</tr>
<tr>
<td>NHS Number</td>
<td>Your Email</td>
</tr>
<tr>
<td>Address</td>
<td>Bleep/Mobile</td>
</tr>
<tr>
<td>Postcode</td>
<td>Consultant</td>
</tr>
<tr>
<td>Telephone</td>
<td>Consultant Email</td>
</tr>
<tr>
<td>GP Name</td>
<td>Where is the patient currently? Choose</td>
</tr>
<tr>
<td>GP Address</td>
<td>Hospital and Ward.</td>
</tr>
<tr>
<td></td>
<td>Contact Number:</td>
</tr>
<tr>
<td></td>
<td>Date of admission</td>
</tr>
<tr>
<td></td>
<td>(dd/mm/yyyy)</td>
</tr>
</tbody>
</table>

Brief and Relevant Clinical Details

Clinical History (MUST include presenting condition; motor & sensory status)

Previous medical history:

Exact date of first onset of symptoms: (dd/mm/yyyy)

Motor Score:
- Upper Limb Left
- Upper Limb Right
- Lower Limb Left
- Lower Limb Right

Pain: Choose
- Specific Location:
- Severity (0 no pain to 4 severe pain):

Primary: Choose
- If known primary specify site:
- If primary is unknown have you discussed the patient with the Acute Oncology team? Choose
- If primary is known have you spoken to their current oncologist? Choose

Incontinence:
- Urinary: Choose
- Date onset: (dd/mm/yyyy)
- Date Catheter inserted: (dd/mm/yyyy)
- Faecal: Choose
- Date Onset: (dd/mm/yyyy)

Mobility: Choose
- Date last walked: (dd/mm/yyyy)
- Sensory: Choose
- Specify:

Haematological:
- Do you suspect Lymphoma/Myeloma? Choose
- Have you spoken to the Haematologist/AS? Choose

Previous oncological treatment: Choose
- Intent of treatment: Choose
- Date last given: (dd/mm/yyyy)
- If Radiotherapy, to which area:

Prognosis: Choose
- TNM Status:

Oncologist (if known):
- Steroid Administration (Give 16mg bolus of Dexamethasone followed by 8mg BD with PPI cover): Choose a relevant option
- Anticoagulant/Antiplatelet Use: Choose a relevant option
- Specify:
- Performance Status: Prior to presentation: Choose relevant option
- Current Presentation: Choose relevant option
Staging Information

MRI whole spine: Choose Date: [dd/mm/yyyy] Time: [hh:mm]
Other Scans: Choose if appropriate
Outcome of Staging:

Patient’s status

Has the patient been told their diagnosis? Choose
Do they wish to consider surgery? Choose

Additional information that may be useful to us

Please send the completed form immediately via e-mail to stgh-tr.MSCC@nhs.net

If you need to discuss an emergency Neuro-Surgical referral out of office hours, please contact the Neuro-Surgical registrar on call (Bleep 7242) at St George’s Hospital.

Name of Neuro-Surgical registrar contacted:
Date: [dd/mm/yyyy]
Time: [hh:mm]

Please call the MSCC Coordinator to inform them of this referral.

Have you spoken to the Clinical Oncologist on call at the Cancer Centre and pre-warned them of a potential emergency referral for radiotherapy if surgery is inappropriate?

Name and Contact details:

If not, please contact the on call Clinical Oncology SpR at either RMH or the RSCH (both via their switchboards)

Please also send a copy to the Cancer Centre:

Royal Marsden Hospital rmb-tr.MSCC@nhs.net
Fax (020) 7811 8436
Royal Surrey County Hospital rscc-tr.MSCC@nhs.net
Fax (01483) 454813

PLEASE NOTE

It is the responsibility of the referring team to ensure that ALL relevant imaging studies are made available on the SGH PACS via the IEP and that all the fields in this form are filled correctly. The two biggest sources of delay in opinions are: no scans being transferred and incomplete forms.
### Appendix 6 - Rehabilitation Facilities within Areas covered by the South West London Hospitals and SWSHCN

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
<th>Level</th>
<th>Description</th>
<th>Brief outline of service</th>
<th>Contact Details</th>
<th>Directory (page no.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandsworth</td>
<td>St. George’s Hospital</td>
<td></td>
<td>Major trauma centre</td>
<td>Acute Trust</td>
<td>0208 672 1255</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Queen Mary's Hospital</td>
<td>2</td>
<td>Local rehabilitation unit</td>
<td>&gt;16 years; Inpatient neuro (14 beds) &amp; elderly; outpatient &amp; community services</td>
<td>0208 487 6000</td>
<td>Blp 151</td>
</tr>
<tr>
<td></td>
<td>Wolfson Rehabilitation Centre at St George’s Hospital (Thomas Young Ward)</td>
<td>1</td>
<td>Regional neurorehab unit</td>
<td>&gt;18 years; neurorehab incl. head injury; 32 inpatient beds - up to 12 weeks LOS</td>
<td>0208 8725 6544</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dawes House</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>&gt;16 years; residential home with x16 ICT beds (up to 6 weeks rehab); transfer with assistance 1-2</td>
<td>0207 326 8860</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICT Community Team</td>
<td>3b</td>
<td>ICT home</td>
<td>ICT home</td>
<td>0208 812 5000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>St. John's Therapy Centre</td>
<td>3a/3b</td>
<td>Community &amp; Day Hospital</td>
<td>Community &amp; outpatient services</td>
<td>0208 812 4070</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brysson Whyte Centre</td>
<td></td>
<td>Day Hospital</td>
<td>&gt;65 years; Elderly &amp; falls</td>
<td>020 8487 6170</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wandsworth Community Wards</td>
<td>3b</td>
<td>Community</td>
<td>Community &amp; outpatient services</td>
<td>Tel: 020 8812 5678</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wheelchair Service</td>
<td></td>
<td>Regional wheelchair service</td>
<td></td>
<td>0208 487 6084</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trinity Hospice</td>
<td></td>
<td>Palliative hospice care</td>
<td>Inpatient, outpatient and day services</td>
<td>2077871065</td>
<td></td>
</tr>
<tr>
<td>Merton &amp; Sutton</td>
<td>St. Helier's Hospital</td>
<td></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>0208 971 8021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parkside Hospital</td>
<td></td>
<td>Private Hospital</td>
<td></td>
<td>0208 971 8021</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Woodlands (Merton)</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>&gt;65 years; residential home with x12 ICT beds (up to 6 weeks rehab); full WB; transfer with assistance x1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crossways (Sutton)</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>&gt;65 years; residential home with x6 ICT beds (up to 6 weeks rehab); full WB; transfer with assistance x1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Saints Centre (Wimbledon)</td>
<td>3a</td>
<td>Community Centre</td>
<td>16-65 years; physical disability - many neuro; independent in wheelchair</td>
<td>0208 542 9587</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carshalton War Memorial Hospital</td>
<td>3b</td>
<td>Community Hospital</td>
<td></td>
<td>0208 770 8000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nelson Hospital</td>
<td>3b</td>
<td>Community &amp; Day Hospital</td>
<td></td>
<td>0208 296 2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sutton Hospital</td>
<td>3a/3b</td>
<td>Community Hospital</td>
<td></td>
<td>0208 296 4130</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wilson Community Hospital</td>
<td>3b</td>
<td>Community Hospital</td>
<td></td>
<td>0208 687 4833</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MILES</td>
<td>3b</td>
<td>Reablement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td>Local wheelchair service</td>
<td></td>
<td></td>
<td>0208 545 4361</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Raphaels Hospice (Sutton)</td>
<td>Palliative hospice care</td>
<td>Day service, community palliative team, inpatient</td>
<td></td>
<td>0208 335 4575</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Marsden (Sutton and Fulham)</td>
<td>Specialist Oncology hospital</td>
<td>Outpatient and inpatient Physio and SALT, inpatient OT</td>
<td>Sutton 0208 642 6011 Fulham 0207 3528127</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td>King's College Hospital</td>
<td>Major trauma centre</td>
<td>Acute Trust</td>
<td>0203 299 9000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Thomas' Hospital</td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frank Cooksey</td>
<td>1</td>
<td>Regional neurorehab unit</td>
<td>&gt;16 years; 15 beds; Neurorehab incl. head injury</td>
<td>0207 346 5325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulross Centre</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>1 ward; 16-65 years; Lambeth resident (SW2, SW4, SW8, SW9, SW16, SE24, SE11)</td>
<td>0207 411 6605</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth Community Care Centre</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>1 ward; GP referral</td>
<td>0207 587 5513</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whittington Centre</td>
<td>3b</td>
<td>Community &amp; Day Hospital</td>
<td>Community &amp; outpatient services</td>
<td>0203 049 4004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TACT</td>
<td>3b</td>
<td>ICT home</td>
<td>ICT home/supported discharge - only therapy input (no care provided)</td>
<td>0203 049 4004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIET</td>
<td>3b</td>
<td>Reablement</td>
<td></td>
<td>0207 926 5854</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SWIFT</td>
<td>3b</td>
<td>Social Services</td>
<td></td>
<td>0207 926 5854</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southwark ICT</td>
<td>3b</td>
<td>Intermediate care</td>
<td></td>
<td>0207 525 3962</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td>Local wheelchair service</td>
<td></td>
<td></td>
<td>0203 049 7729</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Christophers Hospice</td>
<td>Palliative hospice care</td>
<td>Inpatient, home care services, clinic based appointments</td>
<td></td>
<td>0208 768 4500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croydon</td>
<td>Croydon University Hospital</td>
<td>Trauma unit</td>
<td>Acute Trust (amputee service with prosthetist)</td>
<td>0208 401 3000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croydon ICT (CICS)</td>
<td>3b</td>
<td>Intermediate care</td>
<td>ICT bed or home (up to 6 weeks rehab)</td>
<td>0208 274 6444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broad Green Centre</td>
<td>3a/3b</td>
<td>Community</td>
<td>Community &amp; outpatient services; neuro rehab</td>
<td>0208 274 6880</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thornton Heath</td>
<td>Community</td>
<td>Community &amp; outpatient services</td>
<td>0208 274 6830</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beechwood Care Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hayes Court Care Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hill House Care Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td>Local wheelchair service</td>
<td></td>
<td></td>
<td>0208 665 9313</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Service Provider</td>
<td>Type</td>
<td>Description</td>
<td>Contact Info</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------</td>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kingston</strong></td>
<td><strong>Kingston Hospital</strong></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>0208 546 7711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hobkirk Rehabilitation/Rehabilitation/Step up Unit</td>
<td>Community</td>
<td>residential home with 24-hour care + rehab</td>
<td>0208 274 7088</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moseley Rehabilitation Hospital</td>
<td>Community Hospital</td>
<td></td>
<td>0208 941 4481</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surbiton Hospital</td>
<td>Community Hospital</td>
<td></td>
<td>0208 399 7111</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teddington Hospital</td>
<td>Community Hospital</td>
<td></td>
<td>0208 408 8210</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cedars Community &amp; Inpatient Service (Tolworth Hospital)</td>
<td>Intermediate care/Community</td>
<td>ICT bed or home (up to 6 weeks rehab); domiciliary physio</td>
<td>0208 274 7088</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kingston single point of access</td>
<td>Community Hospital</td>
<td>Community &amp; outpatient services</td>
<td>0208 274 7088</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Richmond &amp; Twickenham</strong></td>
<td><strong>West Middlesex Hospital</strong></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>0208 714 4060</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richmond Rehabilitation Unit</td>
<td></td>
<td></td>
<td>0208 630 3943</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richmond ICT</td>
<td></td>
<td></td>
<td>0208 630 3943</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Rehabilitation Team</td>
<td></td>
<td></td>
<td>0208 630 3943</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surrey</strong></td>
<td><strong>East Surrey Hospital</strong></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>01737 768511</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caterham Dene Rehabilitation Unit</td>
<td>Community Hospital</td>
<td>Inpatient elderly</td>
<td>01883 837517</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promoting Independence Programme</td>
<td>Community Hospital</td>
<td>Inpatient &amp; community eldery</td>
<td>01737 768511</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surrey Community Health: Domiciliary Physiotherapy</td>
<td>Community</td>
<td>&gt;18 years; East Surrey GP</td>
<td>01737 768511 x6265</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Neuro Physiotherapy Team</td>
<td>Community Hospital</td>
<td>&gt;16 years: acute neuro</td>
<td>01883 733890</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Learning Disabilities Team</td>
<td>Community Hospital</td>
<td>&gt;18 years; East Surrey GP</td>
<td>01737 281071</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crawley Hospital</td>
<td>Community Hospital</td>
<td>Inpatient elderly, ortho &amp; stroke</td>
<td>01293 600300 Blp 159</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crawley Intermediate Care (CHAPS)</td>
<td>ICT Home</td>
<td>&gt;18 years; Crawley GP; up to 6 weeks rehab</td>
<td>0845 092 0414</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid Response Team</td>
<td>Reablement</td>
<td>&gt;18 years; Surrey resident; MDT</td>
<td>01737 768511 x6269</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Horsham Hospital</td>
<td>Community Hospital</td>
<td>Inpatient elderly; Horsham residents</td>
<td>01403 227000 x7246 / Blp 404</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Horsham Intermediate Care Team (CHAPS)</td>
<td>ICT Home</td>
<td>&gt;18 years; Horsham GP; up to 6 weeks rehab</td>
<td>0845 092 0414</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dorking Hospital</td>
<td>Community Hospital/ICT bed-based</td>
<td>&gt;18 years; inpatient - neuro &amp; elderly; Mid Surrey GP</td>
<td>01306 646258/9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dorking Integrated Rehabilitation Service</td>
<td>ICT Home</td>
<td>&gt;18 years; Dorking GP; up to 6 weeks rehab</td>
<td>01306 646283</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leatherhead Hospital</td>
<td>Community Hospital/ICT bed-based</td>
<td>Inpatient rehab; &gt;18 years; Mid Surrey GP</td>
<td>01372 384384</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Rehabilitation Service (IRIS)</td>
<td>3b</td>
<td>ICT Home</td>
<td></td>
<td>07968 388553/01372 384310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----</td>
<td>----------</td>
<td>-----------------</td>
<td>------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moseley Rehabilitation Hospital</td>
<td>3b</td>
<td>Community Hospital</td>
<td>Inpatient rehab; &gt;18 years; Mid Surrey GP</td>
<td>0208 941 4481</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrowlands Neuro Rehab Centre</td>
<td>3a</td>
<td>Local neuro rehab</td>
<td></td>
<td>01306 657900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epsom Hospital</td>
<td></td>
<td>DGH</td>
<td>Acute Trust</td>
<td>01372 735735</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashford Hospital</td>
<td></td>
<td>Private Hospital</td>
<td></td>
<td></td>
<td>01372 276161</td>
<td></td>
</tr>
<tr>
<td>East Elmbridge &amp; Mid Surrey Community Teams</td>
<td>3a/3b</td>
<td>Community</td>
<td>Domiciliary physio; Neurorehab; Mid Surrey GP</td>
<td>01372 201700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Epsom &amp; Ewell Community Hospital (NEECH)</td>
<td>3b</td>
<td>Community Hospital</td>
<td>Inpatient rehab; &gt;18 years; Mid Surrey PCT</td>
<td>01372 734834</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sussex Rehabilitation Unit (Brighton Gen. Hospital)</td>
<td>1</td>
<td>Regional Amputee Service</td>
<td>Inpatient &amp; outpatient amputee rehab + limb fitting centre</td>
<td>01273 242160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NW Surrey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frimley Park Hospital</td>
<td></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>01276 604604</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surrey Social Services OT</td>
<td>3a</td>
<td>Social services</td>
<td>OT assessment for major adaptations &amp; long term needs</td>
<td>01276 800205</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Surrey Hospital</td>
<td></td>
<td>Trauma unit</td>
<td>Acute Trust</td>
<td>01483 571122</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bradley Unit</td>
<td>1</td>
<td>Regional neurorehab unit</td>
<td>12 bedded unit; TBI &amp; complex neurorehab</td>
<td>01483 846344</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Godwin Unit (Haslemere)</td>
<td>3a</td>
<td>Intermediate care</td>
<td>Slower stream rehab incl. Stroke rehab beds</td>
<td>01483 782323</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farnham Community Hospital</td>
<td>3b</td>
<td>Community Hospital &amp; Day Hospital</td>
<td>Inpatient beds - Elderly, Stroke; Falls service</td>
<td>01483 782000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazelmere &amp; District Community Hospital</td>
<td></td>
<td>Community Hospital</td>
<td></td>
<td>01483 782000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holy Cross</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mole Valley ICT</td>
<td>3b</td>
<td></td>
<td></td>
<td></td>
<td>07968 833553</td>
<td></td>
</tr>
<tr>
<td>Pinehurst (Camberley)</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>ICT bed (up to 6 weeks rehab)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redwood (Guildford)</td>
<td>3b</td>
<td>ICT bed-based</td>
<td>ICT bed (assessment for complex cases re. long term mx)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woking Community Hospital</td>
<td>3a/3b</td>
<td>Community Hospital</td>
<td>48 beds (2 wards); stroke, #NOF, elderly, illness or disability</td>
<td>01483 715911</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARS (Community Assessment &amp; Rehabilitation) - Milford Hospital</td>
<td>3b</td>
<td>Intermediate care &amp; Community</td>
<td>ICT home (up to 6 weeks rehab &amp; up to 3 daily visits); Community PT/OT</td>
<td>01483 782644</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSCH - CARS team</td>
<td>3b</td>
<td>ICT Home</td>
<td></td>
<td>01483 782534 (ICT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Rehabilitation Teams</td>
<td>3a/3b</td>
<td>Community</td>
<td>MDT; neuro, complex physical disabilities +/- learning disability,</td>
<td>01483 846361</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Sector</td>
<td>Team/Unit</td>
<td>Contact Details</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>------------------------------------</td>
<td>-----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARC (Assisted Rehabilitation in the Community)</td>
<td>3b</td>
<td>Reablement</td>
<td>up to 6 weeks ADL reablement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Red Cross Home from Hospital Service</td>
<td>3b</td>
<td>Reablement</td>
<td>assistance with domestic tasks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>START (short term assessment &amp; reablement)</td>
<td>3b</td>
<td>Social services</td>
<td>6 week assessment for long term needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAT (short term assessment team)</td>
<td>3b</td>
<td>Social services</td>
<td>2 week assessment for long term needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frimley CTPLD</td>
<td>3a</td>
<td>Community</td>
<td>Learning disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Peter’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashford Hospital</td>
<td></td>
<td>DGH</td>
<td>Acute Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walton Community Hospital - Rapid Access Centre</td>
<td>3b</td>
<td>Community</td>
<td>elderly; MDT assessment - prevent admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walton Community Hospital</td>
<td>3a/3b</td>
<td>Community</td>
<td>64 beds (3 wards); stroke, #NOF, elderly, illness or disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Service</td>
<td>3b</td>
<td>ICT Home</td>
<td>&gt;18 years; NW Surrey GP; transfer independently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Team Falls Service</td>
<td>3a</td>
<td>Community</td>
<td>MDT falls assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Peter’s - CARS team</td>
<td>3b</td>
<td>ICT Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bournemouth Community &amp; Mental Health NHS Trust</td>
<td>3a/3b</td>
<td>Community</td>
<td>Community &amp; outpatient services; NW Surrey GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair Service</td>
<td>3a</td>
<td>Regional wheelchair service</td>
<td>Mild to mod. emotional, psychological distress incl. PTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woking Counselling Service</td>
<td>3a</td>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Cord Injury Units</td>
<td></td>
<td>SCIU Single point of access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital, Stanmore</td>
<td>1</td>
<td>Regional SCIU</td>
<td>Accept patients with +/- surgical fixation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoke Mandeville</td>
<td>1</td>
<td>Regional SCIU</td>
<td>Accept patients with +/- surgical fixation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salisbury</td>
<td>1</td>
<td>Regional SCIU</td>
<td>Accept patients post surgical fixation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury Units</td>
<td></td>
<td>Royal Hospital for Neuro-Disability (Putney)</td>
<td>Inpatient &amp; outpatient services; supported living units; locked facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blackheath Rehabilitation Centre</td>
<td>1</td>
<td>Regional brain injury unit</td>
<td>Severe behavioural brain injuries - locked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Category</td>
<td>Description</td>
<td>Phone Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------</td>
<td>------------------------------------------------</td>
<td>--------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Banstead Place (Queen Elizabeth’s Foundation)</td>
<td>National brain injury unit</td>
<td>&gt;16 years; rehab centre for traumatic brain injury</td>
<td>01737 356222</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Springfield Hospital</td>
<td>Mental health unit</td>
<td>inpatient &amp; outpatient services</td>
<td>0208 682 5873</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joan Bicknell Centre</td>
<td></td>
<td></td>
<td>0208 682 6158</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Merton Home Treatment Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutton CMHT</td>
<td></td>
<td></td>
<td>0208 254 8060</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ridgewood Centre</td>
<td></td>
<td></td>
<td>01276 605316</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cedar House</td>
<td></td>
<td></td>
<td>01276 605397</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Being Centre</td>
<td></td>
<td></td>
<td>01276 670911</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sycamore House</td>
<td></td>
<td></td>
<td>01276 671102</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headway</td>
<td>Charities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Injuries Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>