

Clinical Advice to Cancer Alliances for the Commissioning of Acute Oncology Services

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Document Title

Clinical Advice to Cancer Alliances on Commissioning of Acute Oncology Services, including metastatic spinal cord compression

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Prepared by:

This guidance is prepared by the Acute Oncology Expert Advisory Group, Chaired by Dr Ernie Marshall, on behalf of the NHSE Chemotherapy Reference Group Chaired by Professor Peter Clark. The Acute Oncology Expert Advisory Group has a wide geographical and multi-disciplinary representation from the full range of professionals involved in delivering acute oncology services, as well as oversight from the fully constituted Chemotherapy Reference Group. The EAG's secretariat is provided by Macmillan.

Audience:

This document was written for local and specialist commissioners of cancer services and commissioners of urgent care and will have particular relevance for cancer alliances, acute care providers and specialist cancer Trusts.

Groups consulted:

This document was produced by the NHS E Chemotherapy Clinical reference Group and Acute Oncology Expert Advisory Group whose members represent a wide range of disciplines and geographical perspectives. The quality surveillance team were also consulted and involved in the development of the outcome measures.

Purpose:

The purpose of this document is to inform cancer and urgent care commissioners (specialist commissioning and local clinical commissioning Groups) and Providers of the requirements for establishing effective Acute Oncology services and outcome metrics and to recognise Acute Oncology as a vehicle to continuously improve the quality, safety and delivery of seamless urgent cancer care across primary, secondary and tertiary boundaries

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Executive Summary

Cancer emergency care places an enormous pressure on the NHS urgent care services and is frequently associated with poor patient experience and poor outcomes. One in five cancers are diagnosed following an emergency presentation, the number of older people living with cancer has grown by 23% over a 5 year period and 9.2million bed days are utilised for advanced cancer and end of life care. Emergency care represents a complex mix of late presentation of new cancers, complications of cancer therapy, complications of cancer and associated comorbidity in an aging population. Sustainable system change needs to be viewed in the context of the wider national urgent care strategy ensuring cancer patients receive the right care in the right place with the right expertise, delivered 24hours a day.

An effective acute oncology service (AOS) will enhance patient experience and clinical effectiveness and ensure that equitable, safe, high quality emergency care is consistently provided for non-elective/emergency adult patients with known or suspected cancer. Acute Oncology services are a vehicle to deliver continuous improvement in emergency and unplanned cancer care but services remain patchy across England despite national recommendations in 2009.

Every hospital with an emergency department (ED) or specialist oncology beds should ensure they have a fully functional and constituted acute oncology service responsible for emergency cancer care including metastatic spinal cord compression (MSCC)The overarching aim of the AOS is to:

- Ensure timely and equitable access to specialist oncology review and advice for all cancer patients who present with a cancer-related emergency
- Develop standard, evidence based management protocols and pathways to ensure safe, high quality and effective treatment for emergency cancer care
- Conform to national standards and guidance and ensure local audit is conducted to ensure these standards are met
- To deliver a standard training and education programme in emergency cancer care to staff involved in the care of acute oncology patients to ensure safe high quality care is available 24/7
- To ensure primary care teams and patients a range of options for emergency cancer care review (advice and triage, fast track clinics, ambulatory pathways, Multidisciplinary Diagnostic Centres, telehealth) reduce inappropriate ED presentation.
- To improve the safety and effectiveness of unplanned cancer inpatient care and reduce variation in hospital length of stay following emergency presentation
- To develop effective communication pathways and record keeping to ensure that all those involved in the patients care are informed regarding emergency presentations and actions taken

1.1 Key Priorities:

To establish a robust and fully functional AOS in every hospital with an emergency department and/or specialist oncology beds

To align acute Oncology services with the urgent care strategy

Awareness and reducing ED presentation

- Commissioned service that provides public and professional awareness of urgent cancer symptoms and a range of options for accessing emergency and unplanned care via expert advice 24hrs, 7 days a week

Reducing variation in practice

- Commissioned service that provides timely access to specialist care and information and optimises the safety and quality of care for those requiring unplanned emergency care
- Commissioned service that reduces variation in hospitalisation, patients outcomes and patient experience

Best Practice

- Commissioned service that ensures care is delivered according to the best evidence-based guidelines and relevant NICE guidance including Carcinoma Unknown Primary, Neutropenic Sepsis and Metastatic Spinal Cord Compression.
- Commissioned services that ensure coordination and seamless care for patients requiring emergency and unplanned cancer care including onward referral to appropriate allied services

1.2 Key Outcome measures

- Admission avoidance
- Hospital Length of stay
- 30 day readmission rate
- Mortality within 30 days of systemic anticancer therapy (SACT)
- Neutropenic Sepsis mortality
- MSCC outcomes
- Patient experience
- Emergency admission/presentation of new cancers

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1.3 Key Responsibilities:

Commissioners: Commissioning a fully constituted, Acute Oncology team with appropriate competencies and staffing to provide 7day services

Acute Oncology Team: Clinical service delivery, review with 24hrs, delivery of AO induction education, collection of data

Acute Oncology Steering Group: Trust compliance with Quality Surveillance measures, implementation of pathways, protocols, production of outputs, competency sign off

Network Steering Group, population based –MSCC coordination, development and sign off of standardised protocols, Trust performance management based upon submitted outputs, education of AOTs

Specialist Oncology Services: Take leadership and responsibility for supporting robust Acute Oncology Services and pathways across a network footprint, thus ensuring seamless care and timely specialist oncology intervention across health care boundaries

Urgent care commissioners and providers: awareness and consideration of the specific needs of cancer patients who present in the emergency setting and the key role of Acute Oncology services.

2. Population Needs

2.1 National/local context and evidence base

Emergency admissions place an enormous burden on patients and the NHS. Over the last decade, emergency admissions have increased by 31% and attendances at Emergency departments have increased by more than 2 million to 16 million per annum¹ Emergency presentation linked to cancer has doubled with 300,000 unplanned admissions per year² and often associated with poor patient experience, poor coordination of care, poor communication and fragmented patient pathways^{3,4}. Following admission, there is wide variation in hospital length of stay for these patients with an average of 9.6 days¹. It is estimated that the NHS could save in the region of 566,000 bed days, equating to £113million, if this variation was reduced to meet the best performing quartile.

A publication from a single Cancer network on over 3000 AO admissions reported that approximately, 50% of admissions are a consequence of cancer progression or associated comorbidity, 30% a consequence of cancer treatment and 20% represent an emergency presentation of a new cancer diagnosis⁵. In England, 24 per cent of all new cancers, around 58,400 cases a year, are diagnosed through an emergency presentation associated with reduced 1 and 5 year survival⁶. Finally, emergency presentation following chemotherapy is increasing as a consequence of advances in new systemic anticancer therapy (SACT) and the greater use of multiple lines of palliative SACT.

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2.2 Acute Oncology

Acute Oncology service provision was identified in 2009 as a key recommendation of the National Chemotherapy Advisory Group (NCAG) for improving quality and safety of emergency care for those patients with previously undiagnosed cancer and complications of cancer or treatment⁷. The report addressed concerns raised by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)³, national peer review appraisals and the National Patient Safety Agency⁸. The role of AOS has since been consolidated with the publication of NICE guidance concerning CUP, Neutropenic Sepsis and MSCC⁹. A baseline impact assessment by the Department of Health concluded that the establishment of Acute Oncology would be cost neutral as a consequence of improved efficiency in bed utilisation⁷. Despite some progress in recent years, national peer review¹⁰ (2013/14), the 4th annual report of the Cancer Strategy¹¹ and Achieving World-Class Cancer Outcomes¹² have all highlighted particular concern in relation to the implementation of AO and CUP services with many areas of non-functioning and non-compliant services due to lack of staffing, lack of training and lack of robust emergency cancer pathways including MSCC.

2.3 Opportunities, 5 year view and Cancer Strategy/Urgent care

Following the NCAG recommendations, AOS have largely focused on improving inpatient care. Despite many challenges, peer review has identified many areas of good practice highlighting improved quality of care and reduced Length of stay. Moving forward, AO represents a vehicle to deliver seamless emergency cancer care and admission avoidance in line with the Future Hospital commission¹²³ and Emergency Care strategy¹ and NHS 5 year view¹³⁴. Acute Oncology represents one aspect of emergency or unplanned cancer care and Acute Oncology Services should connect to the whole urgent and emergency care system with the aims of supporting self-care, supporting admission avoidance and ensuring emergency cancer patients receive the right care in the right place with the necessary facilities and expertise, available 24 hours per day. Acute Oncology services should ensure that their expertise should extend to community services to facilitate the dialogue between primary and secondary care staff and to promote education, service redesign and the timely flow of patient information. In this context, Acute Oncology services are uniquely placed to support multidisciplinary diagnostics centres (MDC) and novel pathways for vague symptoms¹²

3. Process and outcome measures

3.1 Inpatient Care

An effective AOS will:

- Ensure AO review by specialist teams with defined competencies within 24hrs of admission, 7 days a week
- reduce Hospital length of stay (LOS)
- reduce 30 day readmission
- Improve safety and quality of emergency care with development and

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implementation of AO pathways, protocols and staff training

- Responsible for improving outcomes and reducing mortality for Neutropenic Sepsis in line with published NICE guidance.
- Improve patient experience
- Responsible for implementing the Metastatic spinal cord compression (MSCC) pathway in line with published NICE guidance
- Support the MUO/CUP patient pathway in line with national guidance
- Provide regular emergency cancer intelligence delivered by an agreed minimum dataset

3.2 Admission Avoidance

An effective AOS will:

Deliver services to promote admission avoidance & reduction in emergency admissions by:

- Supporting 24/7 advice lines for health professionals and cancer patients
- Developing options for rapid access and ambulatory care
- Supporting Carcinoma of unknown primary (CUP) services in line with published NICE guidance and including options for fast track review in cases of suspected cancer/vague symptoms that require urgent oncology review.
- Developing community/outreach AO services to support primary care
- Support site specific teams to develop and deliver patient information, education and self-help concerning emergency contingency planning

3.3 Data and Information Management:

An AOS will maintain the agreed minimum dataset and have an explicit data and information strategy in place that covers: types and quality, data protection, confidentiality, accessibility, transparency, analysis use, dissemination and, risks.

- Number of emergency admissions for cancer-related problems by acute oncology category and tumour type;
- **Type I:** First diagnosis of cancer is made in the emergency setting
- **Type II:** Complications of non- surgical therapies
- **Type III** Patients with known cancer
- Time of referral and time of review by member of the Acute Oncology Service
- Number of patients reviewed by the AOS
- Length of Inpatient stay for all medical emergency cancer patients
- Readmission rates within 30 days of acute oncology review
- Mortality in neutropenic sepsis according to risk stratification group

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(MASCC)

- Time to first antibiotic in suspected neutropenic sepsis
- Compliance with Trust antibiotic protocol in neutropenic sepsis
- Compliance with MSCC measures;
- Audit of MSCC management and outcomes including surgical interventions, functional outcome and survival
- Deaths within 30 days of receiving chemotherapy
- Annual acute oncology patient experience survey

- **Triage and assessment outcomes:**
- Numbers of patients/professionals contacting 24 hour advice line services
- Numbers of patients managed with advice and/or referral to primary care services
- Numbers of patients managed with telephone follow up or planned outpatient review
- Number of patients asked to attend an ambulatory or assessment unit.
- Numbers of patients asked to attend ED/Acute Medical Unit for assessment
- Numbers of patients admitted for on-going care.
-
- Patient advice line experience including complements and complaints

4. Scope

4.1 Acute Oncology and Haemato-oncology

This Acute Oncology (AO) commissioning guidance covers Haemato-oncology as well as solid tumour oncology. All Haemato-oncology services and patients are considered to be subject to this guidance. In many services, established Haemato –Oncology pathways already fulfill the core principles set out within the guidance for AO. The differing work patterns of haematologists and oncologists are recognised and local differences in the delivery of AO by haematologists and oncologists are acceptable as long as the principles set down in this document are adhered to. It is expected that haematologists and oncologists will work together as closely as possible to ensure efficient use of AO resources and for this reason, the membership local AO teams must include both haematology and oncology representatives.

The principal role of the Acute Oncology Service in emergency cancer care is advisory and lies in:

- Defining the most clinically appropriate care pathway
- Improving patient experience,

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- Communication with and signposting to appropriate specialist advice and services.
- Training and education

The overarching aim of the AO service is to:

- Ensure timely and equitable access to specialist oncology review and advice for all cancer patients who present with a cancer-related emergency
- Develop standard, evidence based management protocols and pathways to ensure safe, high quality and effective treatment for emergency cancer care
- Conform to national standards and guidance and ensure local audit is conducted to ensure these standards are met
- To support a standard training and education programme in emergency cancer care to staff involved in the care of acute oncology patients to ensure safe high quality care is available 24/7
- To develop alternative pathways to hospital admission and reduce variation in hospital length of stay following emergency presentation
- To develop effective communication pathways and record keeping to ensure that all those involved in the patients care are informed regarding emergency presentations and actions taken

4.2 Population covered

This service specification relates to the treatment of adults requiring emergency medical care as part of their treatment for cancer, whether curative or palliative and including treatment for solid tumours and haematological cancers. The service outlined in this specification is for patients ordinarily resident in England*; or otherwise within the commissioning responsibility of the NHS in England (as defined in Who Pays?; Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purpose of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

An Acute Oncology Service should cover at least the following patient groups:

Type I: Patients in whom a first diagnosis of cancer is suspected in the emergency setting

Acute Oncology Teams (AOT) have a key role in Malignancy of unknown Origin (MUO) and Carcinoma Unknown Primary (CUP) services but also generic skills and competencies for all new emergency cancer presentations when defining aims and objectives for inpatient care (early access to site specific teams, specialist palliative care, appropriate investigation, treatment options and discharge planning)

Type II: Patients with known cancer who present as an emergency with acute complications of non-surgical treatment – including Systemic Anti-Cancer Therapy (SACT) or radiotherapy.

Type III a. Patients with known cancer that are acutely ill because of the disease itself: This group represent the largest proportion of emergency patients and often present with

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complex issues including comorbidity, progressive cancer and end of life care (EOL) needs. AOS has a leading role in the assessment of specific complications as outlined in national peer review. For many patients, the AOT should outline the care pathway and discharge to appropriate services (eg Specialist palliative care, cancer site-specific teams, primary care) to ensure optimal efficiency and effectiveness of the service.

Type III b. Patients with known cancer that are acutely ill because of comorbidity. This group of patients will be managed by admitting physicians but may require AOS input where a cancer diagnosis might impact on the medical management and to support care planning, prognosis and ceiling of care.

4.3 Acceptance Criteria

Referrals to the AOS should sent electronically and be triaged daily to ensure timely review by the most appropriate team member. To ensure that all appropriate type II and type III patients are able to access AO services, Trusts should implement electronic recognition and alert systems that would automatically inform the AOS at the point of a patient's unplanned attendance. Patients who attend hospital, as an emergency/unplanned event when receiving SACT or radiotherapy should trigger an electronic alert in the admitting area that will inform the acute care team of their special circumstances.

4.4 Exclusion Criteria

Management of cancer in children and young adults treated within the children's services (see separate service specification B15/S/B).

Elective admission of known cancer patients

Emergency admission requiring primarily surgical input

Type III cancer patients managed by site specific teams or specialist palliative care:

4.5 Service description/care pathway (QS measure AOS-16-007)

4.5.1 The Acute Oncology Patient Pathway The acute oncology pathway requires a whole system approach towards prevention and contingency planning. There should be regular assessment of risks and systematic adoption of emergency contingency planning for individual patients with cancer. AOS should hold cancer site-specific teams to account according to the quality of patient information and contingency planning.

The acute oncology patient episode begins at the same point for all patient groups at the first contact with a health professional during this acute episode and ends at the point that responsibility for care is transferred to site specific, Specialist palliative or primary care team

4.5.2 Community presentation & cancer patient triage (QS Measure AOS-16-006)

For known cancer patients, with urgent care needs,, access for both patients and health care professionals to urgent telephone advice is essential and may direct patients to appropriate emergency care such as direct admission or ED/AMU attendance or offer

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admission avoidance strategies including patient self-management, advice or community review by one of the following: General Practitioner, specialist palliative care team, district nursing services, ambulance service , access to ambulatory care or day-case facility, or urgent OPD review

- 24 hour advice lines should be available for healthcare professionals and should have links with the on call oncology team.
- All cancer patients should be provided with clear information on emergency contact numbers, recognising that these may change during a patient cancer journey.
- 24 hour dedicated specialist advice lines should be available to all Patients with known cancer who are receiving SACT or radiotherapy.

Healthcare professionals manning advice lines should be trained to: -

- Assess and triage patients contacting advice lines
- Provide advice and guidance that is underpinned by national algorithms (e.g. UK Oncology Nursing Society triage tool) and provide timely access to senior clinician advice when required.
- Direct and link patients to associated services, such as specialist palliative care, general practitioners, and district nursing services or ambulance teams.
- Ensure that the patient episode is recorded and communicated to the oncology team responsible for the patients’ management.
- Provide timely specialist emergency care advice for cancer related problems for healthcare professionals

Advice line providers should have clear protocols for: -

- The provision of patient and professional information regarding the advice line contact numbers and what to lookout for and when to contact the advice lines
- Admission and assessment pathways
- Continued monitoring and review process for patients who have contacted the advice line
- Pathway for rapid review as an outpatient

4.5.3 Patient Information: (QS Measure AOS 16-005)

Health care professionals should have access to key patient information and treatment details 24/7. This information should be made available through hospital-wide electronic medical record systems, which should link, to cancer-specific systems (e.g. Somerset) and community electronic records.

4.5.4 Emergency Department (ED): (Measures AOS-16-005, AOS-16-008 AOS-16-010)

ED attendance is for acutely unwell patients where there is no established diagnosis or

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pathway and that require emergency review and management (within 24hours). ED staff should have training and 24-hour access to agreed emergency cancer treatment protocols, appropriate intra venous antibiotics, emergency cancer management pathway algorithms and advice from an AOS service. ED should develop pathways to ensure patients with suspected cancers are referred urgently to the appropriate cancer site-specific multidisciplinary team (MDT) according to existing flows, guidance (eg The National Optimal Lung Cancer Pathway- NOLCP) and nationally agreed 2 week rule pathways. AOS services should facilitate responsive urgent referral pathways for patients with suspected new cancers that do not fit existing 2 week referral criteria. The AOS should be informed of all known cancer-related emergency presentations within 24 hours of presentation.

4.5.5 Acute Medical Units (AMU):

The AOS should develop collaborative working with AMU to provide seamless care for all cancer patients admitted to AMU with the aim of delivering expert care and options for early hospital discharge. This integration should include daily access to AOS team, pathways and protocols. Integration may be facilitated and enhanced by joint posts, link nursing roles, training and AMU core membership of the weekly AO meeting and Trust AO steering group. The AOS should be informed of all known cancer-related emergency presentations within 24 hours of presentation

4.6.6 Inpatient Care: (QS Measure AOS-16-009)

The AOS should be made aware within 24hrs of admission for Type II/III patients or within 24 hours of a suspected diagnosis for Type I patients.

The AOS should provide advice and/or review within 24hours of referral and should ensure transfer of responsibility to site-specific team at the earliest time point.

4.5.7 Discharge planning

The AOS should provide advice and guidance to clinicians and patients on treatment aims, prognosis and care planning. Working with the specialist palliative care team, AOS should support timely discharge planning and communication with primary care and community services.

Patients must be given appropriate after treatment care and follow-up including information on contingency planning for subsequent emergency events, and advice on self-management.

4.5.8 Clinical Trials

As is the standard for all areas of health care the importance of evidence based care must be emphasized. Providers should endeavor to participate in any appropriate AO clinical trials and contribute to the development of an evidence base for practice.

4.5.9 AO and Carcinoma of Unknown Primary

All patients presenting with malignancy of undefined primary origin (MUO) should be assessed and managed according to NICE Carcinoma of unknown primary Guidance

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(CUP). In some instances, CUP assessment arrangements may be offered as part of AOS if appropriate, or to be a separate entity. In either case, there should be a single service for each Hospital Trust and details governing this pathway should be agreed locally and should be made explicit to all referring disciplines.

4.5.10 AO and Metastatic Spinal Cord Compression (MSCC) (QS Measures AOS-16-011-13)

MSCC assessment and management requires multi professional and multi-agency collaboration and often spanning several organisations. Service provision and individual patient management should be delivered in line with NICE guidance and national cancer peer review. Against this background, the AOS is responsible for delivering peer review measures and has an important role to play in raising awareness, promoting education, supporting seamless care, audit and service development. The metastatic spinal cord coordinator function should link seamlessly with 24/7 emergency cancer triage services.

5 Service model

5.1 SACT and radiotherapy treatment centres (Tertiary Cancer Referral Centres)

AOS within specialist cancer centres should have a role in the clinical assessment and immediate management of emergency presentations as well as ongoing advice and support of acutely unwell inpatients. In such centres, Oncologists and/or Haematologists will retain chief responsibility for the patient. Tertiary Cancer Referral centres should develop clear management protocols for inpatient care and a single point of access for cancer-related emergency presentation ensuring appropriate levels of expertise, timely review by consultant staff in line with national guidance, competencies and treat and transfer policies. Service development should be supported by acute medicine expertise to ensure networked emergency care pathways and joint working.

5.2 Acute Hospitals without dedicated specialist oncology beds

Acute medicine and/or, according to local agreement, haematology, supported by site-specific cancer teams, designated key workers and specialist palliative care should retain chief responsibility for the patient.

AOS have a key role providing advice and coordinating care for specific cancer presentations, clearly described in the Manual for cancer standards measures for acute oncology and MSCC. In these circumstances, the AOS would not have direct responsibility for care or defined inpatient bed resource.

5.3 Acute Hospitals with dedicated specialist oncology beds

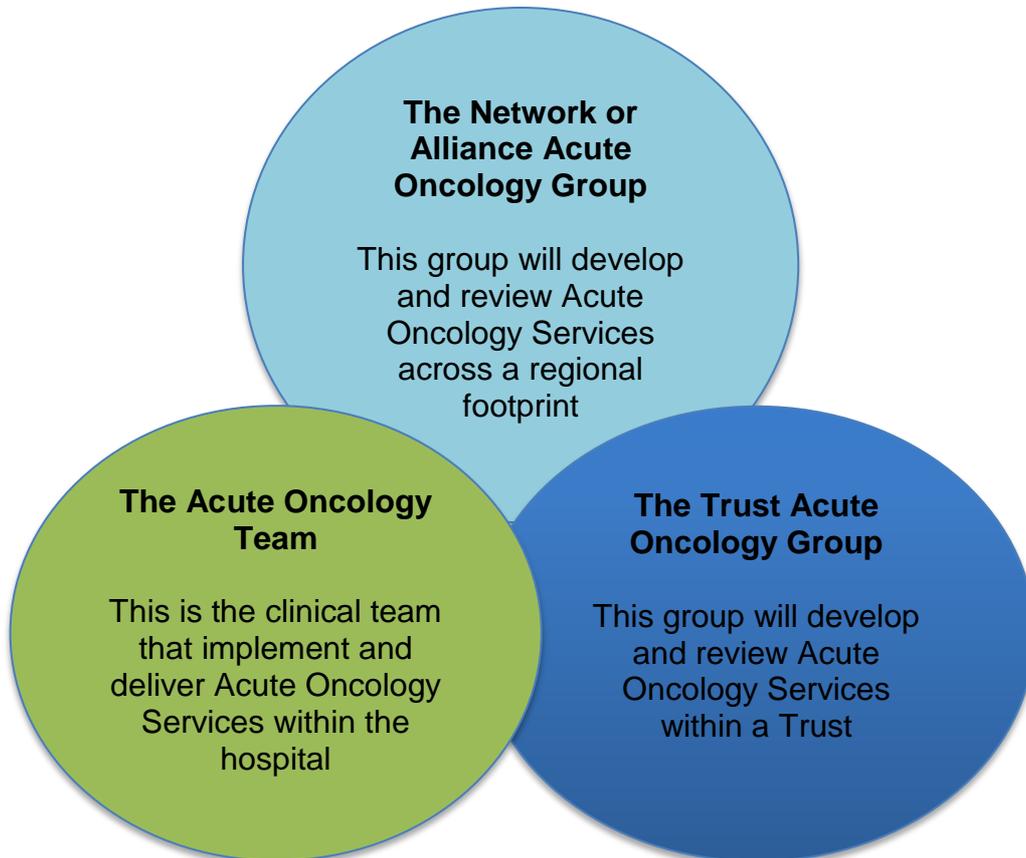
In Acute Hospital Trusts where resident oncology is available, oncology may retain chief responsibility if there are designated oncology beds and an explicit protocol defining the patient group. In this instance, policies should clearly define responsibilities and operational arrangements required to ensure seamless care at all times to ensure optimal patient safety, clinical effectiveness, and patient experience.

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5.4 Core Minimum Requirements for the AOS

5.4.1 The AOS and Staffing:

The diagram below describes the basic structure, links and responsibilities that will need to be developed and demonstrated by those providing Acute Oncology Services.



5.4.2 The Acute Oncology Team (AOT): (measures AOS-16-002/3)

The AOT is the core clinical team that is responsible for delivering AOS within the Trust on a daily basis.

Membership: the core membership of the acute oncology team is as a minimum;

- Consultant Oncologist/deputy
- Consultant Haematologist/deputy
- Palliative Care Consultant/deputy
- Acute Oncology, Specialist Palliative Care and Haematology nursing team
- Administrative support

The core team should include an identified individual (s) with appropriate competencies (Clinical Oncologist or Therapy Radiographer) who is available for advice on radiotherapy and is able to coordinate urgent assessment for palliative radiotherapy treatment.

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An AOS requires strong leadership and engagement with non-surgical oncology services to ensure optimal service development and communication with tertiary, secondary and primary care. Providers must ensure adequate time for this leadership. The overall lead of the AOS should be a team member who is directly responsible for the development, management and ultimate clinical accountability and responsibility of the service

Acute Oncology teams will ensure that:

- Health care professionals are fully informed of 24 hour access to senior decision making by Consultant Oncology, Haematology and Specialist Palliative Care Physicians.
- 7 day availability for treat and transfer policy
- A fully competent acute oncology team member will assess all patients with a known cancer diagnosis who are admitted as an emergency/unplanned within 24 hours of admission 7 days per week
- A fully competent acute oncology team member should review all patients who are admitted as an emergency/unplanned and have a new diagnosis or high suspicion of cancer within 24 hours of referral.

Competency must be assessed and agreed by the trust Acute Oncology Lead Clinician.

Staffing levels of nurses with AO competencies should support 7 day working and ensure availability to provide direct clinical care within 24hours of referral, timely communication, clinical information capture and their key role in education and service development. Furthermore, team effectiveness, coordination of care, communication and data capture are dependent on appropriate levels of administrative support.

5.4.3 Weekly review meeting

The acute oncology team should meet weekly at an agreed time to ensure a high level of team working, multiprofessional review of care, good communication, coordinated patient follow up and collection of a minimum dataset The weekly meeting should not delay daily decision making but rather provides multi professional oversight, supporting decision making. All emergency haemato-oncology admissions should be discussed in a weekly meeting either as part of the AOT meeting (with Haematology representation) or as a separate haematology MDT. The weekly meeting should develop links to facilitate communication with community services.

The AO review meeting may act as the CUP MDT in some instances. If this is the case then the group membership should fully comply with peer review measures.

5.4.4.The Trust Acute Oncology Group: (QS measures AOS-16-001, AOS-16-015, AOS-16-016, AOS-16-019)

- Responsibilities: this is an overarching multidisciplinary strategic group responsible for governance, service development and monitoring of the AOS across a hospital trust in line with national guidelines and recommendations. .
- Membership: This group should have representation from the AOT, cancer services

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management and all disciplines/departments involved with the emergency care pathway for cancer patients.

5.4.5. The Network or Alliance Acute Oncology Group:

- **Responsibilities:** this expert advisory group will develop and review acute Oncology services across a defined clinical network and will support, cross boundary working and equitable service delivery according to national guidelines and recommendations. This group will offer expert opinion and guidance and will lead on AO performance monitoring on behalf of commissioning groups. The group will lead on education and training for AOTs.
- **Membership:** this group will be formed and led by representatives from each trust/organisation that provides an acute oncology service in total or a component of acute oncology services within a clinical network. For example an organisation may provide advice line services or deliver a component of MSCC management as part of an acute oncology service and as such should provide representation of their service to this group. This network AO group should ensure appropriate representation from all AOSs and including Oncology, Haematology, Specialist palliative care, primary care, acute medicine and commissioning. The group should have appropriate levels of administrative and data management support to fulfil its role.

5.4.6 Acute Oncology Training and Education (QS measure AOS-16-004)

Acute Oncology Induction training in referral criteria, contact details, 24/7 triage and 24/7 consultant oncology availability should be made available to Consultants and NCCG medical staff in ED and on the acute medical take and contracted nurses of band 6 and above in the ED and on the acute medical unit.

Dissemination and monitoring of Acute Oncology Induction training is the responsibility of provider Learning and Development departments.

The Network AO group should be responsible for developing the induction training package and for training and education of AOTs, ensuring appropriate competencies. All nursing members of the AOT should have completed specific training and competencies in AO presentations and should participate in regular updates, at least on an annual basis.

5.4.7 AO and Specialist Palliative Care

Specialist palliative care has a key role in the delivery of an effective acute oncology service and should provide representation within the AOT. In many instances, Specialist palliative care services may lead the AOS on many aspects of care with specific expertise in symptom control, patient and family support, advance care planning, care in the last days of life and service development. A close working relationship between the acute oncology service and specialist palliative care team is necessary to ensure that patients and families receive appropriate specialist input as part of a cohesive and timely care pathway.

5.4.8 AO and Pharmacy

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Providers should ensure full engagement of pharmacy staff with the AOS to support the AOT with 24/7 access to specialist pharmacist advice for chemotherapy regimens prescribed and/or recently administered for a presenting patient, supportive medication needed, advice on and access to palliative care medicines,..

Confirmation of a thorough medication history for newly admitted patients, particularly focussing on identifying oral chemotherapy, chemotherapy adjunctive treatments and chemotherapy supportive medications.

Education and training of general medical and nursing staff to raise awareness of oral chemotherapy drugs and supportive medications to understand fully when to refer patients to specialist services.

6 Interdependencies with other services/providers

AOS is a multi-professional service that integrates existing expertise in acute medicine, specialist palliative care, haematology and oncology and community services. The AOS provides outlet for community management, admission avoidance as well as inpatient care across all cancer care providers

6.1 Co Located services

The service should be part of a clinical managed network and there should be significant representation from the local service on the network AO group.

This service should work closely with its local, regional and national colleagues to ensure continuous service improvement

6.2 Inter dependent services

The AOS will be required to set up and maintain formal links across the Tertiary Referral cancer centre, local district general hospitals and community services and to include governance, training and development and networked solutions for patient information and triage purposes. Cross cover arrangements for core AO members should be organised by the AOT and agreed by the AO lead

6.3 Additional key relationships include:

- Pathology Services (including histopathology, haematology, and microbiology)
- Ambulatory and day care facilities
- Inpatient Facilities
- Radiology
- Pharmacy
- Biomedical and clinical research
- Clinical Psychology
- Counselling service and PALS
- Specialist Nursing teams including community nurses
- Macmillan nurses,
- Social workers
- Community services
- Hospice services
- Ambulance service

7 Applicable Service Standards

7.1 Applicable national standards e.g. NICE

- NICE Improving Outcomes Guidance (IOG) – (<http://guidance.nice.org.uk/CSG>)
- NICE Guidance CG104: Metastatic malignant disease of unknown primary origin
- NICE Guidance: CG75: Metastatic Spinal Cord Compression
- NICE Guidance CG151: Prevention and management of neutropenic sepsis in cancer
- National Cancer Peer Review “The Manual for Cancer Services” Measures relating to chemotherapy services, acute oncology services and CUP services
- Chemotherapy Reference Group :Chemotherapy Service Specification
- Department of Health (2011) Improving Outcomes: A strategy for Cancer 2011
- National Chemotherapy Advisory Group (2009) Chemotherapy Services in England: Ensuring Safety and Quality
- NCEPOD (2008) “For Better, for worse? A review of the care of patients who died within 30 days of receiving systematic anti-cancer therapy”

Department of Health (2011) Innovation Health and Wealth, Accelerating Adoption and Diffusion in NHS [weblink](#)

All NICE Technology appraisal recommendations should be incorporated automatically into relevant local NHS formularies in a planned way that supports safe and clinically appropriate practice.

7.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- *Cancer Patients in Crisis: responding to urgent needs. A joint report by Royal College of Physicians & Royal College of Radiologists*

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