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## Cancer National Specialist Advisory Group

### National Standards for Acute Oncology Services

June 2016

## TABLE OF CONTENTS

1. PURPOSE .....	2
2. INTRODUCTION .....	2
3. STRATEGIC CONTEXT.....	4
4. SCOPE OF ACUTE ONCOLOGY STANDARDS .....	4
5. BENEFITS ASSOCIATED WITH ACUTE ONCOLOGY SERVICES.....	4
6. BRIEF METHODOLOGY .....	5
Standards .....	6
Standard 1 The Acute Oncology Team.....	6
Standard 2 Rapid Assessment for Acutely Presenting Patients.....	8
Standard 3 AOS Team Review of Patient Management .....	9
Standard 4 Information.....	10
Appendix One.....	11

## 1. PURPOSE

1.1 The standards have been developed to provide a foundation for the NHS in Wales to plan and deliver effective high quality services for people with cancer, either known, or yet to be diagnosed, who present acutely to the NHS. These standards for acute oncology build on the current chemotherapy standards integral to the National Cancer Standards for Wales<sup>1</sup>. They apply to the services received by all adults (aged 18 and over) with malignancies (oncological, haematological and those with unknown origin). Standards relating to the management of disease in people under the age of 18 are covered elsewhere<sup>2</sup>.

1.2 These standards are based on current best practice and are intended to support Health Boards in providing services that adhere to NICE and other evidence-based guidance as it develops. They do not replace NICE Guidelines but rather bring these together in one document for Wales.

1.3 The authors recognise that the differing configurations and challenges across Wales, e.g. multiple locations and rurality, may result in additional local requirements. This document describes the core requirements of acute oncology services (AOS). Achieving the care described in this document is not solely the responsibility of the acute oncology team and requires engagement and collaboration at all levels of Health Boards, with cross-directorate, cross-care sector and cross-boundary working.

## 2. INTRODUCTION

2.1 The concept of an AOS was first proposed in 2009<sup>3</sup> in response to significant concerns raised by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)<sup>4</sup>.

2.2 An AOS brings together multi-disciplinary clinical expertise to facilitate the rapid identification and appropriate prompt management of patients that present acutely with complications following

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<sup>1</sup> <http://www.wales.nhs.uk/sites3/page.cfm?orgid=322&pid=23968>

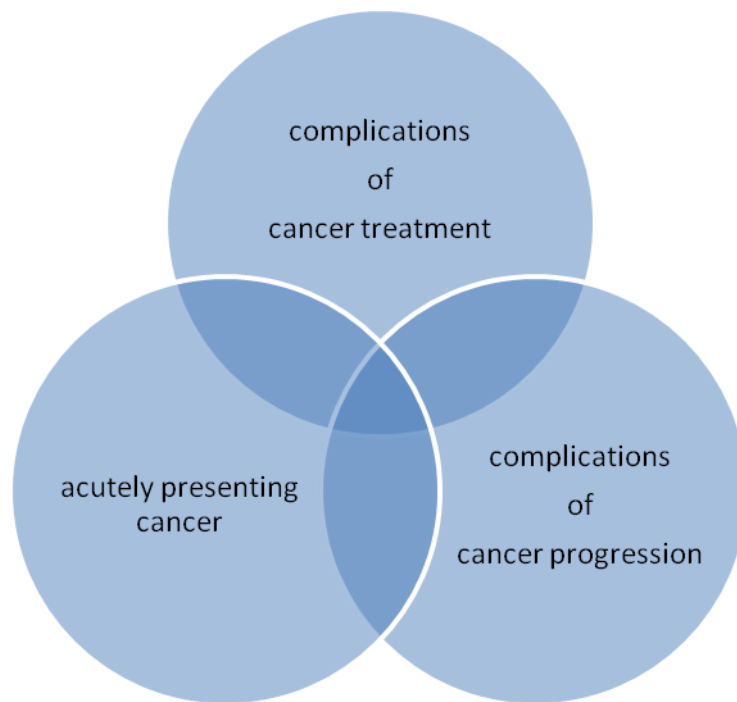
<sup>2</sup> National standards for children with cancer aged 0 to 15 years available from: <http://gov.wales/topics/health/publications/health/guidance/children/?lang=en> and NATIONAL STANDARDS FOR TEENAGERS AND YOUNG ADULTS WITH CANCER AGED 16 – 24 YEARS available from: [http://www.wales.nhs.uk/sites3/Documents/322/Teenagers\\_and\\_Young\\_Adults\\_Cancer\\_Standards\\_-\\_Final\\_-\\_English.pdf](http://www.wales.nhs.uk/sites3/Documents/322/Teenagers_and_Young_Adults_Cancer_Standards_-_Final_-_English.pdf)

<sup>3</sup> 'Chemotherapy Services in England – Ensuring Quality and Safety' published by the Department of Health 2009 [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_104500](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104500)

<sup>4</sup> [For better, for worse? National Confidential Enquiry into Patient Outcome and Death, November 2008.](#)

their cancer treatment, complications as a consequence of their cancer, or who present acutely with previously undiagnosed cancer (figure 1)<sup>5</sup>.

Figure 1 Clinical domains of an acute oncology service



2.3 Specifically, an AOS will provide urgent assessment, rapid initial management and appropriate specialist input (ensuring access to appropriate disease site specific advice) for any patient presenting acutely with problems relating to cancer or its treatment. The essence of an AOS is to accelerate, coordinate and signpost patients on to the correct assessment and treatment pathway and ensure consistent access to oncology expertise, wherever the patient presents<sup>6</sup>.

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<sup>5</sup> This definition was agreed by the AOS Standards Project Team

<sup>6</sup> The patient remains under the care of the site-specific or admitting team, and any treatment plan should be developed collaboratively.

### 3. STRATEGIC CONTEXT

3.1 The Welsh cancer plan “Together for Health, Cancer delivery plan up to 2016”<sup>7</sup> stipulates that all Local Health Boards will need to consider how acute oncology services can be developed to support patients presenting as emergencies.

3.2 The following standards define the core aspects of the service that must be provided for cancer patients across Wales. As with the current National Cancer Standards, the quality of the service will be monitored as part of the cancer peer review process.

### 4. SCOPE OF ACUTE ONCOLOGY STANDARDS

4.1 The AOS standards will focus principally on non-surgical treatment as systems are already in place for patients with complications directly related to surgery to be managed by a specific surgical team. AOS will support patients with acute complications of systemic anti cancer therapy or radiotherapy. The AOS will also cover acute complications of cancer in general, including where the primary cancer may be unknown. This will include arrangements for dealing with metastatic spinal cord compression (MSCC), which may need initial treatment with either surgery or radiotherapy.

### 5. BENEFITS ASSOCIATED WITH ACUTE ONCOLOGY SERVICES

5.1 Good working partnerships and arrangements between emergency departments, medical and surgical admission type units, and acute oncology services have led to significant improvement inpatient care including<sup>8</sup>:

- Increased patient experience outcomes through admission avoidance and reduced length of stay.
- Identified and improved pathways for cancers of unknown primary (CUP).
- Early diagnosis of cancers that present acutely.
- Reduced unnecessary investigations.
- Treatment for patients in the most appropriate setting.
- Improved patient outcomes and experience.
- Improving services through data analysis, measuring outcomes and patient satisfaction.

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<sup>7</sup> Together for Health, Cancer Delivery Plan for the NHS to 2016, pub.2012, available at: <http://gov.wales/topics/health/nhswales/plans/cancer/?lang=en>

<sup>8</sup> Acute oncology: a developing sub-specialty. Pugh, Alison; Rogerson, Helen; Cosh, Helen; Hart, Jane; Williams, Hilary; Jenkins, Christopher. British Journal of Nursing - 2015 Oncology Supplement, Vol. 24, pS18-S25. 6p.

## 6. BRIEF METHODOLOGY

6.1 The standards have been developed following a literature review by the South Wales Cancer Network Macmillan Systemic Anti Cancer Therapy/Chemotherapy and AOS project. Drafting was undertaken in collaboration with clinicians from existing and emergent AO services, Health Boards and Velindre NHS Trust. A wide formal consultation on an advanced draft undertaken by the Cancer NSAG led to an editorial group review. The post-consultation editorial group is detailed in appendix one.

6.2 Key national reports have reflected the need for improved quality and safety in Wales and the rest of the UK;

1. Patients with cancer who have new or acute needs frequently present to professionals who have limited cancer experience<sup>9</sup>.
2. Increased risks were identified following a review of the care of patients who died within 30 days of receiving Systemic Anti Cancer Treatment<sup>10</sup>.

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<sup>9</sup>The Royal College of Physicians and Royal College of Radiologists. Cancer patients in crisis: responding to urgent needs. Report of a working party. London: RCP, 2012

<sup>10</sup> 'For better, for worse?' – a report of the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) <http://www.ncepod.org.uk/2008sact.htm>

## Standards

### Standard 1 The Acute Oncology Team

**Rationale:** The AO team bring together disciplines, combining skills from acute medicine, surgery, oncology, haemato-oncology and palliative care as appropriate to support local acute teams to provide a cohesive service for people presenting with oncological emergencies. AO teams work in partnership with Healthcare Professionals from across care sectors (primary, secondary, tertiary and third sector) to ensure a comprehensive route and access as appropriate for all acutely presenting cancer patients across their pathway.

Standard statement	Indicative monitoring criteria
1.1 Each Health Board (HB) will establish a core AO team. The team must provide a physical presence (AO nurse) in each site with an acute medical intake	1.1 Cancer Management Team annual report to the Health Board <sup>11</sup> on compliance with the AOS standards.
1.2 The core designated HB AOS team will include: <ul style="list-style-type: none"> <li>a. a designated medical physician or surgeon</li> <li>b. a Specialist Acute Oncology Nurse<sup>12</sup></li> <li>c. a lead manager of the AOS team</li> <li>d. a Co-ordinator/Data clerk/administrator.</li> </ul> And have access to: <ul style="list-style-type: none"> <li>a. a designated consultant haematologist</li> <li>b. a designated consultant oncologist<sup>13</sup></li> <li>c. a designated consultant in palliative care</li> <li>d. any other specialities as deemed necessary.</li> </ul>	1.2 Documentation detailing: <ul style="list-style-type: none"> <li>a. AOS team members</li> <li>b. job plans</li> <li>c. cancer treatment triage advice service</li> <li>d. cover arrangements</li> <li>e. evidence of team meetings and management plans</li> <li>f. the designated medical physician/surgeon to affirm that access is sufficient.</li> </ul>
1.3 The AO team will have the appropriate knowledge and skills to advise and co-ordinate the management of patients with acute oncology needs.	1.3 Evidence of training for the AO team <sup>14</sup> .
1.4 The AO team will take the lead on dissemination of knowledge around management of AO across the organisation through education provision.	1.4 Evidence of the education given by the AOS Team e.g. teaching materials, schedules, lesson plans and evaluations etc.
1.5 The AO team will ensure that clinical pathways are in place for the assessment and management of all patients with complications from their cancer or cancer treatment.	1.5 Evidence from local audit that all patients with complications access appropriate clinical pathways <sup>15</sup> .

<sup>11</sup> National Cancer Standards (Standard 2.6)

<sup>12</sup> This incorporates Advanced Nurse Practitioners

<sup>13</sup> Medical or clinical oncologist

<sup>14</sup> Examples of training may include; Macmillan e-learning <http://learnzone.org.uk/courses/course.php?id=110>; advanced clinical assessment skills training, oncology/ haematology Credit Qualification for Wales level 6/7 academic module, an acute oncology masters module, BMJ MSCC module, UKONS

<sup>15</sup> Examples of current guidelines at the time of going to press include NICE guidance on Febrile neutropenia and MSCC.

<p>1.6 Operational policies and management protocols for the management of acute oncology patients will be in place and accessible electronically across disciplines and organisational boundaries<sup>16</sup>.</p>	<p>1.6 Local audit of compliance to operational policies and protocols<sup>17</sup>.</p>
<p>1.7 All operational policies will include detail of what information needs to be communicated to whom<sup>18</sup> along the clinical pathway and in what timescale.</p>	<p>1.7 Evidence from local operational related policies, and from surveys of patients, carers, key workers, and AOS team members.</p>

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<sup>16</sup> To include Neutropenic Sepsis, Cancer of Unknown Primary and Spinal Cord Compression, monitoring will expand to include newer guidance as appropriate.

<sup>17</sup> Examples of current guidance to include confirmation of date of review following new evidence.

<sup>18</sup> The patient, carer, key worker, AO team, cancer MDT, primary care, to include the supervising consultant and team at each acute presentation.



## Standard 2 Rapid Assessment for Acutely Presenting Patients

**Rationale:** AO patients are often treated in specialist oncology centres, although they are more likely to present to their local hospital when acute problems occur. Where local facilities do not exist, such as out-of-hours magnetic resonance imaging or surgical consultation, a protocol/pathway needs to be in place to ensure patients access the most appropriate investigative and treatment pathways in a timely manner in accordance with national guidance.

AOS patient management requires prompt or urgent action. Systems need to be in place to support this as well as ensuring review of management by the AOS team.

Standard statement	Indicative monitoring criteria
2.1 Hospitals providing 24/7 telephone support or accepting admissions will have rapid electronic access to information regarding the past medical history and treatment received by the patient and dedicated 24/7 number to call.	2.1 Review of access to information processes.
2.2 Electronic systems will be in place to automatically alert acute services, AOS, the key worker and oncologist/haematologist when a patient with a known malignancy, or undergoing active cancer treatment, presents acutely ill to secondary care via any route.	2.2 Detail the system in place.
2.3 Acute hospitals assessing or admitting patients with any acute oncological episode should ensure that a recognised national early warning scoring (NEWS) system is used and acted on in conjunction with national guidance <sup>19</sup> .	2.3 Provide evidence of the national early warning scoring system in use.
2.4 The AO team, working with local acute teams, will ensure all acutely ill cancer patients are assessed and triaged <sup>20</sup> . The AO team <sup>21</sup> will assess within 24 hours and update the appropriate cancer site MDT <sup>22</sup> in a timely manner.	2.4 Documentation detailing: <ul style="list-style-type: none"> <li>a. Dates and times when AO patients <ul style="list-style-type: none"> <li>i) presented</li> <li>ii) were seen by the AO team</li> </ul> </li> <li>b. Audit and reporting programme.</li> </ul> Detail from cancer site MDTs regarding appropriateness and timeliness of communication from AOS.

<sup>19</sup> For example, the National Early Warning Score

<http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Good%20NEWS%20for%20Wales%20%28web%29.pdf>

<sup>20</sup> Guidelines exist that require that patients with neutropenic sepsis have a quicker pathway which should be acted on as part of 2.4.

<sup>21</sup> Haemato-oncologist, oncologist, palliative care, AO nurse.

<sup>22</sup> AO teams should work with their respective cancer site and Specialist Palliative care MDTs to determine who the most appropriate first contact for each team is and how this information will be forwarded to the responsible clinician and CNS etc.

### Standard 3 AOS Team Review of Patient Management

**Rationale:** Ongoing service quality, safety and improvement are essential to support best outcomes for patients and their families and carers. Fundamental to this, and a requirement for all cancer MDTs, is review of patient management. This is particularly relevant in the acute clinical setting as is often the case in acute oncology.

Standard statement	Indicative monitoring criteria
3.1 People admitted to hospital because of an AO issue will have an individualised management plan and subsequent treatment summary which is developed in collaboration with the patient/carer.	3.1 Evidence of individualised management plan and treatment summary.
3.2 The HB AO team will review compliance with NICE guidelines, and other national approved AO guidance and associated clinical pathways.	3.2 Local audit of AOS patients to provide evidence of: a. AOS referral and review processes with associated times included. b. Individual management plans, in line with NICE <sup>23</sup> or other guidance, for inpatients. c. That all AO patients admitted with treatment related toxicity and death within 30 days are discussed at the Morbidity and Mortality meetings.

<sup>23</sup> Current examples of relevant NICE guidance include those covering MSCC, Cancer of unknown Primary (CUP) and Sepsis/febrile neutropenia.

## Standard 4 Information

**Rationale:** An effective AOS service depends on patients, their carers and primary care being aware of symptoms that require medical or clinical advice and taking appropriate timely action. It also requires all involved along the care pathway in secondary care to have readily available access to up to date clinical information in relation to the patient and their treatment history.

Standard statement	Indicative monitoring criteria
4.1 Patients with cancer receiving SACT or radiotherapy will receive information in a variety of appropriate forms <sup>24</sup> about potential toxicities of treatment and complications of the cancer and who to contact with problems 24/7. This information, co-ordinated by the patient's key worker, will be in a format appropriate for the patient and will be shared with primary care.	4.1 Documentation providing evidence of <ol style="list-style-type: none"> <li>a. Local surveys of information given to patients.</li> <li>b. Evidence of named key worker<sup>25</sup>.</li> </ol>
4.2 The AO management plan/episode of care annotation should be available via a patient administration system for all relevant clinicians to view. The admitting/assessing hospital team will provide primary care with the treatment summary plan following an episode of AO care.	4.2 Audit/review evidence that information sent to primary care and see questions re standard.
4.3 Toxicities of chemotherapy /SACT/ Radiotherapy must be recorded <sup>26</sup> with systems in place to ensure this information is available to staff later prescribing or administering treatment. AOS interventions must be communicated back to the patient's responsible clinician.	4.3 Evidence of: <ol style="list-style-type: none"> <li>a. Completion of toxicity assessment data within the prescribing system<sup>27</sup>.</li> <li>b. Communication back to responsible clinician.</li> <li>c. Evidence of toxicity assessment within Patient Administration Systems (PAS)<sup>28</sup>.</li> </ol>
4.4 Radiology systems will have a process whereby unexpected findings of a cancer, and any associated complications, are reported to the AO team and to the appropriate specialist MDT.	4.4 Detail process to alert AOS and appropriate MDT.
4.5 Each acute hospital and specialist cancer centre will capture an all Wales agreed core AOS dataset so that each AOS team can benchmark their outcomes annually.	4.5 Detail data completeness against the core dataset and participation on national audit once this is established.

<sup>24</sup> To include verbal and written as a minimum

<sup>25</sup> Canisc or other system

<sup>26</sup> Examples of tools to record toxicities include UKONS available at: <http://www.ukons.org/downloads> and NCI common toxicity criteria for adverse events (NCI CTCAE) available at: [http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE\\_4.03\\_2010-06-14\\_QuickReference\\_5x7.pdf](http://evs.nci.nih.gov/ftp1/CTCAE/CTCAE_4.03_2010-06-14_QuickReference_5x7.pdf)

<sup>27</sup> Prior to the roll-out of e-prescribing systems this should be evidenced by audit of whatever system is in place, including information within clinical case notes.

<sup>28</sup> Canisc and Myrddin are examples of PAS systems.

## Appendix One

Members of the post consultation editorial team:

Jane Hanson: Head of Cancer National Specialist Advisory Group (Cancer NSAG) and Chair

Craig Barrington: Acute Oncology Registrar, Abertawe Bro Morgannwg UHB

Claire Garman: Macmillan Acute Oncology Clinical Nurse Specialist, Cwm Taf UHB

Chris Jenkins: Consultant Haematologist, Aneurin Bevan UHB

Yvonne Lush: Senior Development Manager, Macmillan

Delia Pudney: Consultant Oncologist, Abertawe Bro Morgannwg UHB

Sharon Richards: Clinical Nurse Specialist, Betsi Cadwaladr UHB

Hilary Williams: Consultant Oncologist, Velindre NHS Trust

Jane Whittingham: Macmillan Acute Oncology Nurse, Cardiff and Vale UHB

Gillian Knight: Macmillan Lead Cancer Nurse, South Wales Cancer Network

Ata Maaz: Consultant Physician in Child Health, Cardiff and Vale UHB

Louise Carrington: Programme Coordinator, Cancer NSAG, Public Health Wales