# Acute Oncology Service Recommendations

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| Name of responsible group | Acute Oncology Pathway Board |
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| Document Type | Operational Document |
| Audience | All appropriate teams |

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| **Service/Care Pathway** | Acute Oncology (AO) |
| **Commissioner Lead** | Ali Jones on behalf of Greater Manchester Commissioning |
| **Provider Lead** | All Greater Manchester, East & Mid Cheshire providers managing acute oncology patients |
| **Distributed** | October 2020 |
| **Date for Review** | March 2022 (this is a working document and given current change in the system needs to be reviewed every year) |

**Document History:**

| Version | Date | Amendment History |
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| 1.1-2.0 | 2017-2018 | This document has been built from historical service specification documentation, National AO guidance and AO Board group discussions. |
| 2.0 | Jul 2020 | LL updated from GAP analysis with Board agreement of changes to measures. |
| 2.1 | Jul 2020 | CM/LL added resource recommendations per Trust |
| 2.2 | Jul 2020 | CM/LL review added ACU and SACT section |
| 2.3 | Aug 2020 | CM/LL/BM review |
| 2.4 | Aug 2020 | CM/LL added purpose and vision statement |
| 2.5 | Sep 2020 | CdMM/TC/SS/TW/AL review |
| 2.6 | Sep 2020 | KS / LL Review – to include Mid Cheshire (MC) which was omitted in error |
| 2.7 | Oct 2020 | MM / LL – to include patient, carer considerations. |
| 2.8 | Mar 2021 | LL – final review of feedback to formalise for 10 March 2021 AO Board. |

**Reviewers:**

| Name | Title/Responsibility | Date | Version |
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| Acute Oncology Pathway Board | See Appendix for membership | October 2020 | V2.8 |

## Contents



This document has been prepared for the Greater Manchester, Eastern and Mid Cheshire (GM, EC, MC) Acute Oncology (AO) Board in conjunction with the AO Commissioning on behalf of GM Cancer. Please see appendices for group membership. The GM, EC & MC Cancer AO Pathway Board has been consulted throughout the development of the clinical standards and performance measures.

**Related documents:**

This document draws its evidence and rationale from a range of documents as listed below. These documents will provide additional information

| Document Title | Date |
|---|---|
| The NHS Long Term Plan | 2019 |
| Achieving world-class cancer outcomes: Taking charge in Greater Manchester | 2017-21 |
| Clinical Advice to Cancer Alliances for the Commissioning of AO Services | 2017 |

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| Implementing the Cancer Taskforce Recommendations: Commissioning Person Centred Care for People Affected by Cancer | 2016 |
| Achieving World-Class Cancer Outcomes: Taking the strategy forward | 2016 |
| Achieving World – class Cancer Outcomes: A strategy for England | 2015-20 |
| Taking Charge of our Health and Social Care in Greater Manchester | 2015 |
| Macmillan Sharing good practice acute oncology | 2014 |
| National Cancer Peer Review Report AO | 2012 -13 |
| National Confidential Enquiry into Patient Outcomes and Death | 2008 |
| National Chemotherapy Advisory Group | 2009 |

**Audience:**
This document has been written for local Acute Oncology Teams (AOT's) and local commissioners of cancer services and where applicable commissioners of urgent care. In addition it will provide advice to acute care provider Trusts and specialist cancer Trusts providing AO care.

## 1. Purpose and Vision

The purpose of this document is to inform AOT's, urgent care commissioners and providers of the requirements for establishing effective Acute Oncology Services (AOS's). It outlines the clinical standards and outcome measures against which the proposed delivery model (agreed by AO Pathway Board Jun 2020) can be developed and monitored.

In order to achieve our strategic objectives of:

1. Develop an Acute Oncology service model in collaboration with all key stakeholders that will reduce the variation in access, outcomes and experiences - providing patients with the right care at the right time and in the right place.

2. To identify sustainable funding for Acute Oncology Services across Greater Manchester (GM), East Cheshire (EC) and Mid Cheshire (MC) through effective system wide-engagement including commissioners and providers to ensure that AO services are future proofed with sufficient flexibility.

3. Collaboration where appropriate with emergency care, ambulatory and or enhanced supportive care will be required in order to provide and demonstrate equality, resilience and meet the recommended national and GM clinical standards.

This programme through mapping of GM, EC & MC AOS aims to recommend best practice based on NHS England measures (QST) and GM, EC & MC Cancer Clinical Standards (as agreed June 2020 GM, EC & MC Cancer AOG Board) to ensure equality for all patient's no matter their demographic. The programme will support Trusts to work towards Board agreed modelling

that fits with their local Trust objectives and that aligns all AOS's - "Providing the right care, at the right time, in the right place."

In order to achieve the standards, services should be a mixture of locally owned (AOT's working within the emergency and inpatient settings) and close collaborative links with all interdependencies. Key interdependencies would be AO Management Patient services, SPC services, Emergency Medicine, Systemic Anti-Cancer Treatment (SACT's), Haematology and Malignancy of Unknown Origin (MUO)/Cancer of the Unknown Primary (CUP) teams. Some of these interdependencies will potentially be centralised services (if appropriate for that Trust), that provide a service or resource across GM, EC & MC to ensure that patients receive equality of care and access to specialist care.

It is the vision of the AO programme to have a multi-faceted recommended model utilising GM, EC & MC and The Christie resources. It is anticipated that AOS's will make use of a mixed model of staffing to ensure efficient use of resource. There is also need to consider the future-proofing of AO service provision based on likely increases in demand, enabling flexibility on each site based on future potential changes to delivery.

Finally, in order to keep care close to home for patients as per Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-21, where possible, patients should receiving care and treatment at local sites including acute care if required. The future status of AOS's should reflect the needs of the patient and available specialist resources on site.

## 2. Historical reasoning for the development of Acute Oncology Services

This document is a revision from ongoing and historical work on AO. Following the NCAG (2009) recommendations, AOS's largely focused on improving inpatient care. Despite many challenges, peer review 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 national requirements.

It was agreed AOS's should provide a vehicle to deliver seamless emergency care and contribute to admission avoidance in line with Future Hospital: Caring for medical patients (2013), the Emergency Care strategy (2013) and NHS 5 year forward view (2014). AO represented one aspect of emergency or unplanned cancer care and AOS's 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, 7 days per week.

It also suggested AOS's should ensure that their expertise extends 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.

Historically and now there is still national evidence of significant variation as to how an AO patient is managed both 'in hours' and also 'out of hours'; the variation in care has a significant impact on outcomes as well as patient experience. In 2015 national modelling showed that 30% of emergency admissions related to cancer could be managed by other solutions and 25% could have a shorter stay.

Since AOS's were first established across Greater Manchester and Eastern Cheshire in 2011/12, there have been improvements in the care of this patient group, however evidence of variation across the geographical area is still reflected in clinical outcomes, service delivery and patient experience; for example:

- Door to needle times for the administration of antibiotics within one hour in patients with suspected neutropenic sepsis range from 22% to 75% between Trusts.
- Variation in AO patients being seen by a member of an AOT within 24hours with impact on adherence to clinical guidelines and patient experience
- Variation in the level of medical support (oncology) for AOT's.
- Currently the ability to provide a seven day service in acute Trusts is variable.
- Median length of stay for AO patients varies from two to seven days between Trusts; however there are numerous factors which potentially may impact on a patient's length of stay in hospital.
    - *This also reflects the challenging of emerging toxicities from ICIs etc. Immunotherapy group currently working on projects for SDEC of IR toxicities through The Christie. Local admission will increase LOS for these patients.*
- There is currently a lack of alternatives for an AO patient other than to attend or be admitted to hospital.
    - *Hospital at home services and telemedicine services are being developed. These may require greater centralisation.*
- Patients do not have equality of access to specialist 24 hour advice across GM, EC & MC.

## 3. What is Acute Oncology:

AO focuses on the management of patients with complications of their cancer diagnosis and treatment, as well as the management of patients with an acute episode following a new cancer diagnosis. Although patients are often treated in specialist oncology centres, they are more likely to present to their local hospital when acute problems develop.

This 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 or haematological cancers. AOS's across GM, EC & MC will cover the following groups of patients:

- Type I: Patients in whom a first diagnosis of cancer is made in the emergency setting, who require non-elective admission due to presenting with symptoms secondary to their malignancy.
- 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; e.g. neutropenic sepsis.
- Type IIIa: Patients who present acutely due to complications from their primary tumour or due to complications secondary to spread of their cancer (metastases), for example Metastatic Spinal Cord Compression (MSCC).
- Type IIIb: Patients with known cancer that are acutely ill because of comorbidity

The National Chemotherapy Advisory Group report (NCAG, 2009) 'Chemotherapy services in England: ensuring quality and safety'; highlighted inadequacies in the care of cancer patients admitted as an emergency with neutropenic sepsis following chemotherapy. The report was produced in response to significant concerns raised by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD, 2008), and highlighted the need to improve services for AO patients. An effective AOS's will improve the patients' experience, health outcomes and maximise efficiency. The advantages to commissioning and delivering a good AO service are:

- Quality improvement on patients' and families experience by providing expert advice, prompt communication and support.
- Reduction in urgent care demand and EM attendances.
- Reduction in average length of stay in hospital.
- Less delay to definitive treatment or progression to enhanced supportive or SPC care as appropriate.
- Reduction in avoidable deaths due to complications of treatment

## 4. Patient, Carer Considerations:

It is the responsibility of AOS's to identify and proactively seek to support the welfare of carers in addition to the acute patient. Most patients entering the terrains of AO are **looking after someone** or they are **being looked after and supported by someone** who, often, is invisible. Identifying and supporting carers' health and wellbeing in addition to the patient is committing to and justifying supporting self-care and admission avoidance thus improving outcomes through seamlessly delivered AO best practice pathways. Poor patient and carer experience, lack of support from CNS's but also the impact that COVID has already had on normal services which also support patients i.e. tumour specific CNS, Macmillan / SPCT services, primary care; means AOS's need to be in a position to mitigate this now.

## 5. Key Priorities:

To establish a robust and fully functional AO service in every hospital with an emergency department and/or specialist oncology beds. To align AOS's with the urgent care strategy

**Awareness and reducing presentation at an Emergency Department:**

- A resilient and sustainable 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 and outcomes**

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

**Best Practice**

- A 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

## 6. Key Service Outcomes:

To improve outcomes through seamlessly delivered AO best practice pathways with the aim of achieving the following objectives:

- Reduce variation in access, outcomes and experience of care through consistent application of AO best practice and universal application of NICE guidance, Quality Surveillance Team (QST) and QS measures with pathway-agreed quality standards.
- Ensure AO cancer patients experience high quality, supportive care that is appropriate for their individual circumstances wherever they access the healthcare system.
- Ensure a high standard of training and education to healthcare staff delivering AO care to patients with known or suspected cancer diagnoses.

Meeting the service outcomes listed above will provide a service that is fit for the future, has sufficient flexibility to provide emergency care, ambulatory care and/or ESC and SPC, withstand pressures, and which consistently meets all of the minimum clinical standards.

## 7. Key Responsibilities:

<u>Commissioners:</u>
To commission fully constituted AOS's that deliver against the standards and outcome measures.

<u>Acute Oncology Team (AOT)</u>:

Delivery of a clinical service, with review of patients within 24hrs, delivery of an AO induction and education programme, collection of data in line with agreed Minimum Data Set (MDS).

Trust AO Steering Group:
All provider Trusts to comply with Quality Surveillance (QS) measures, implementation of pathways, protocols, production of outputs, competency sign off as per GM, EC & MC Cancer AO Clinical Standards.

GM, EC & MC Cancer AO Pathway Board:
Pathway Board members to produce and agree standardised protocols and clinical standards in line with national guidance; analysis and monitoring of GM, EC & MC AO data, based on submissions from provider Trust AOT's; development of GM, EC & MC wide education programmes for AO. Provision of MSCC coordination and education across GM, EC & MC.

Specialist / Tertiary Oncology Services:
Take leadership and responsibility for supporting robust AOS's and pathways across the GM, EC & MC footprint, thus ensuring seamless care and timely specialist oncology intervention across health care boundaries.

Urgent care commissioners and providers:
To have an awareness and consideration of the specific needs of cancer patients who present in the emergency setting and the key role of AOS's.

Improving cancer outcomes through seamless patient pathways from prevention to end of life care, remains an important vision for commissioning of cancer services. Where possible, tumour specific pathways and cross cutting services should be collaboratively commissioned to agreed quality standards and delivered by providers working in partnership in an integrated system.

The nature of cancer and its treatment means that there will many providers. A collaborative approach ensures that all parties, commissioners, service users and providers, recognise the whole patient pathway, the duty of partnership working and the need for seamless care across organisational boundaries.

## 8. Outcome measures:

To establish a robust and fully functional AO service in every hospital with an emergency department and/or specialist oncology beds. To align AOS's with the urgent care strategy.

1. Inpatient Care

An effective AO service will:

- Carry out AO review by specialist teams with defined competencies within 24hrs of admission, 7 days a week

- Improve safety and quality of emergency care with development and implementation of AO pathways, protocols and staff training as per clinical standards
- Improve patient experience
- Will be responsible for implementing the MSCC pathway in line with published NICE guidance
- Support the MUO/CUP patient pathways in line with national guidance
- Provide regular emergency cancer intelligence delivered by the agreed minimum dataset.

2. Admission Avoidance

An effective AO service will deliver services to promote admission avoidance and a reduction in emergency admissions by:

- Providing 24/7 advice lines for health professionals and cancer patients across GM, EC & MC
- Developing options for rapid access and ambulatory care
- Supporting MUO/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 AOS's to support primary care
- Supporting site specific teams to develop and deliver patient information, education and self-help concerning emergency contingency planning.

3. Data and information Management:

An AO service will maintain the agreed minimum dataset and have an explicit data and information strategy in place that covers: GDP/GDPR data protection, confidentiality, accessibility, transparency, analysis use, dissemination and risks.

**Scope:**

The principal role of the AO service in emergency cancer care is advisory and lies in:

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

## 9. Accessibility:

The AOS's should be accessible to all patients with cancer, regardless of sex, race, or gender. Facilities provided should offer appropriate disabled access for patients, family or carers. When required providers will use translators and printed information in multiple languages. The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, and religion and disability equality legislation (including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation).

## 10. Location of service delivery:

GM, EC & MC AOS's will be provided in every acute Trust with an emergency department and the specialist / tertiary cancer centre. The AOT's are supported by a 24 hour advice line based at the specialist cancer centre. The Christie Acute Oncology Management Service (AOMS) 24 hour advice line is as of 2020 still only accessible to The Christie only patient's; with some independent SLA's agreed between Trusts for other patient cohorts. There is the need for a 24 hour advice line accessible to all GM, EC & MC patients and health care professionals – this is within the objectives of this AO programme and demonstrated within the model.

## 11. Interdependencies with other services:

GM, EC & MC AOS's are multi- professional which integrate/collaborate with existing expertise in the following services:

- Enhanced Supportive Care (ESC)
- Specialist Palliative Care (SPC)
- Malignancy of the Unknown Origin (MUO)
- Ambulatory care
- SACTS
- Urgent care
- Acute medicine
- Primary care

## 12. GM, EC & MC Cancer Clinical Standards (as agreed June 2020 GM, EC & MC Cancer AOG Board):

**The following measures were agreed by the AO Board in June 2020 to define the standards that our services should aim to achieve. The attainment of these standards may be met solely by Trust AOT's or in conjunction with interdependent services or centralised network services.**

| Quality Standards | ID | Secondary Care AO Services: Clinical services (AO) |
|---|---|---|
| AO-18-001<br>AO-18-002 | 1 | All hospitals with an ED or admitting acute medical patients should have an AO team providing a 7 day AO service. |
| AO-18-006 | 2 | All hospitals should have clear guidelines on referral methods, clinical guidance and signposting readily available to clinical teams within their trust. |
| AO-18-006 | 3 | Referral methods should include electronic alerts, electronic referrals, in-reach and direct clinical referral. |
| AO-18-001<br>AO-18-002 | 4 | AO core teams will consist of dedicated AO Consultant physicians who have dedicated AO sessions within their job plan (these may be medical oncologist, clinical oncologist, haemo oncologist palliative care or acute physicians with AO training), competent AO Nurse Specialists and a Co-ordinator/administrator. |
| AO-18-001<br>AO-18-002 | 5 | The AO team should have direct access to support from medical oncologists, clinical oncologist, palliative care and haem - oncologists if these specialities are not core members of the AO team. |
| AO-18-001 | 6 | There should be dedicated minimum on-site AO Consultant time of 1 DCC daily Monday to Friday OR named cover provided by the AO nursing provision with access to AO Consultant advice. |
| AO-18-006 | 7 | All AO patients admitted to a Trust should be seen by a member of the AO team within 24hrs including weekends. |
| AO-18-003 | 8 | Parental teams (i.e. treating oncologist) should be informed of a patient's attendance within 1 working day) excluding weekends, where they should be informed on the Monday following attendance and subsequent discharge. |
| AO-18-003<br>AO-18-006 | 9 | All AO patients admitted to a Trust should be reviewed/discussed by an AO consultant or fully competent AOT member within 24hrs of admission. |
| AO-18-006 | 10 | AO patients presenting with suspected neutropenic sepsis should receive IV antibiotics within 1 hour of presentation in ED or as in-patient within 1 hour of clinical suspicion. |
| AO-18-005 | 11 | All hospitals should establish a system to identify patients attending ED who have had SACT within the last 6 weeks to allow urgent triage and clinical review. |
| AO-18-007 | 12 | All hospitals should comply with local microbiology advice in relation to antibiotic therapy of choice for neutropenic sepsis. |

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| AO-18-201 | 13 | Audit of patient experience in AO should be undertaken by teams on an annual basis either as part of a network wide survey or Trust survey with the aim of achieving an overall rating of 9/10 in the National Survey * (To be developed). |
| | | **Secondary Care AO Services: Ambulatory Care Service** |
| | 30 | All patients should have access to ambulatory care services Monday – Friday for AO patients who potentially can be safely managed in the ambulatory setting. These should provide ambulatory care for AO presentations including access for day procedures i.e. paracentesis and day treatments, blood transfusions, enhanced supportive care and MUO pathway. |
| | 31 | AO Ambulatory Care services should offer a review of patients within 24hrs of referral (Monday – Friday) including GP referrals. |
| | 32 | Hospitals should ensure appropriate radiological and diagnostic support for AO ambulatory care services to ensure timely investigation (i.e. meeting SCR/2WW pathway targets) for patients in the ambulatory care setting in order to avoid admissions. |
| | 33 | Referrals to the AO ambulatory care services should be easily accessible within secondary care, from the tertiary cancer centre (via the advice line) and directly by GP's. |
| | 34 | Following interventions via the AO ambulatory care pathway a discharge notification should be sent to the patients GP within 24hours |
| | | **Secondary and Tertiary Care AOS's: Education and Training:** |
| | 20 | All ED consultants, ED trainees, Medical Consultants and juniors on the acute take rota should receive role essential AO training and be stipulated on their training needs analysis. |
| AO-18-004 | 21 | All AOT's should provide basic AO training as part of induction training for all ED clinical staff and other teams where appropriate i.e. awareness of the service and referral guidelines. |
| | 22/23 /27 | All AONS should advance their training and education in accordance with the Cancer and Education Framework for Cancer Nursing; at a level suitable for their seniority with a view to progressing both personal and professional development. This should include attendance to AO annual conferences or study days with consideration in MSC – with CPD being assessed and monitored as part of ongoing appraisal and PDR. Study leave for this should be provided by Trusts. |
| | 24 | Provision of quarterly AONS nurse forum training with an expected annual attendance of 50% for AONS for CPD. |
| | 26 | Provision of e-learning AO training for use with local Trusts to ensure compliance with AO training standards. |
| | | **MSCC Service (Secondary Care)** |
| AO-18-007 | 14 | All patients with spinal pain suggestive of spinal metastases, but with no neurological symptoms or signs, have an MRI of the whole spine and any necessary treatment plan agreed within 1 week of the suspected diagnosis. |

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| AO-18-007 | 15 | All patients with suspected MSCC who present with neurological symptoms or signs have an MRI of the whole spine and any necessary treatment plan agreed within 24 hours of the suspected diagnosis. Patients should be admitted. |
| AO-18-007 | 16 | All patients with confirmed MSCC should be referred to the MSCC Co-ordinator service based within the tertiary cancer centre. |
| AO-18-007 | 17 | All patients admitted with suspicion of MSCC should have 7 day access to cervical collars where cervical instability is suspected on confirmed. |
| AO-18-007 | 18 | All patients with confirmed MSCC should be referred to rehabilitation services (physiotherapy within 24 hours, occupational therapy within 48 hours and orthotics should a brace be required). |
| | | **Tertiary Care AO Service: MSCC Co-ordinator Service** |
| AO-18-006 | 51 | Health professionals where appropriate including the disease specific clinical team, AOT's, AHP's should ensure all patients at high risk of developing MSCC and their families or carers (as appropriate) are given information that describes the symptoms of MSCC, and what to do if they develop symptoms. |
| AO-18-007 | 52 | Access to the MSCC Co-ordinator service based at the tertiary cancer centre should be available 24hrs a day, 7 days a week for referring health care professionals – this will include referrals from local Trusts, primary care, community health care providers and allied health care professionals. |
| AO-18-007 | 53 | All patients with suspected MSCC who present with neurological signs or symptoms should have urgent diagnostic investigations including MRI of the spine and urgent CT staging scan where indicated, in secondary care. |
| AO-18-007 | 54 | For patients with confirmed cord compression, urgent discussion with the MSCC Co-ordinator should take place and a treatment plan agreed within 24 hours of the suspected diagnosis, and definitive treatment (where appropriate) is commenced within 24 hours of confirmed diagnosis. |
| AO-18-007 | 55 | All patients with MSCC have a management plan as per the GM, EC & MC MSCC Pathway that includes assessment of ongoing care and rehabilitation needs. Any appropriate referrals for treatment or symptom control and rehabilitation in the community to be done by the local AO or medical team. |
| AO-18-007 | 56 | The MSCC service will advise when transfer to the specialist treating site is necessary. If surgical assessment/intervention have been agreed following triage. Transfer between the local hospitals will be co-ordinated between local Trusts and specialist treating sites i.e. SRFT (spinal surgical team) and Christie NHS Trust (radiotherapy). |
| | | **Secondary Care AOS's: MUO/CUP Service:** |
| | 35 | All patients should have access to MUO/CUP service which is delivered by the AO team for patients presenting with metastatic disease of unknown origin (based on imaging results). The membership of this team is as detailed above for AO, but in addition should include a named lead for radiology and a named lead for |

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| | | pathology. |
| | 36 | The MUO/CUP service should be supported by the solid tumour oncologist (medical /clinical oncologist) within the AO team – a proportion of their AO sessions should involve MUO/CUP service development and provision. |
| | 37 | All inpatients should be seen within 24hrs of referral by a member of the AO team (providing the MUO/CUP service). Clear referral guidelines should be provided within the AO guidance. For outpatients presenting as a MUO/CUP, adherence to standard NHS guidelines should be followed and consideration should be given to upgrade patients to appropriate cancer pathways. |
| | 38 | All hospitals should provide access to outpatient care pathways for patients presenting with metastatic disease of unknown origin (based on imaging results) that do not require admission (as detailed above). |
| | 39 | All MUO/CUP patients should be designated a key worker at their first assessment. |
| | 40 | Patient's investigation and management should occur as within the agreed GM, EC & MC MUO/CUP guidelines. |
| | 41 | A diagnosis notification should be sent to the GP after a patient's first review and after each intervention with the patient an updated notification should be made. |
| | 42 | Patients on the MUO/CUP pathway should be upgraded on the cancer pathway. Provision for reporting of radiological and histopathology results for these patients should be prioritised within HSC pathways. |
| | 43 | Radiological alerts to identify patients with MUO should be established to allow early referral to the MUO/CUP service. |
| | 44 | All hospitals should collect data on all patient referrals for MUO/CUP as specified within the GM, EC & MC AO minimum dataset. |
| | 45 | All hospitals should have an identified MUO/CUP MDT which their patients are discussed within – this may be held within the Trust or at a linked organisation. The MDT should have the capacity to hold meetings on a weekly basis to ensure delays in discussion/reviews do not occur. |
| | | **Secondary and Tertiary Care AO Service: MUO/CUP Service** |
| | 57 | Daily access to specialist clinical advice of patients with a provisional diagnosis of CUP and complex MUO cases Monday to Friday. |
| | 58 | Weekly access to CUP MDT review for patients with a provisional diagnosis of CUP and complex MUO cases, with scheduled weekly meetings providing oncological, radiological, pathology and supportive care input. |
| | 59 | Co-ordination of data collection in accordance of agreed GM, EC & MC AO minimum dataset for MUO and CUP to ensure that annual audits are completed within the network for MUO/CUP. |
| | 60 | Provision of guidelines and management pathways for patients presenting with MUO/CUP to ensure the timely and appropriate management of these patients. |

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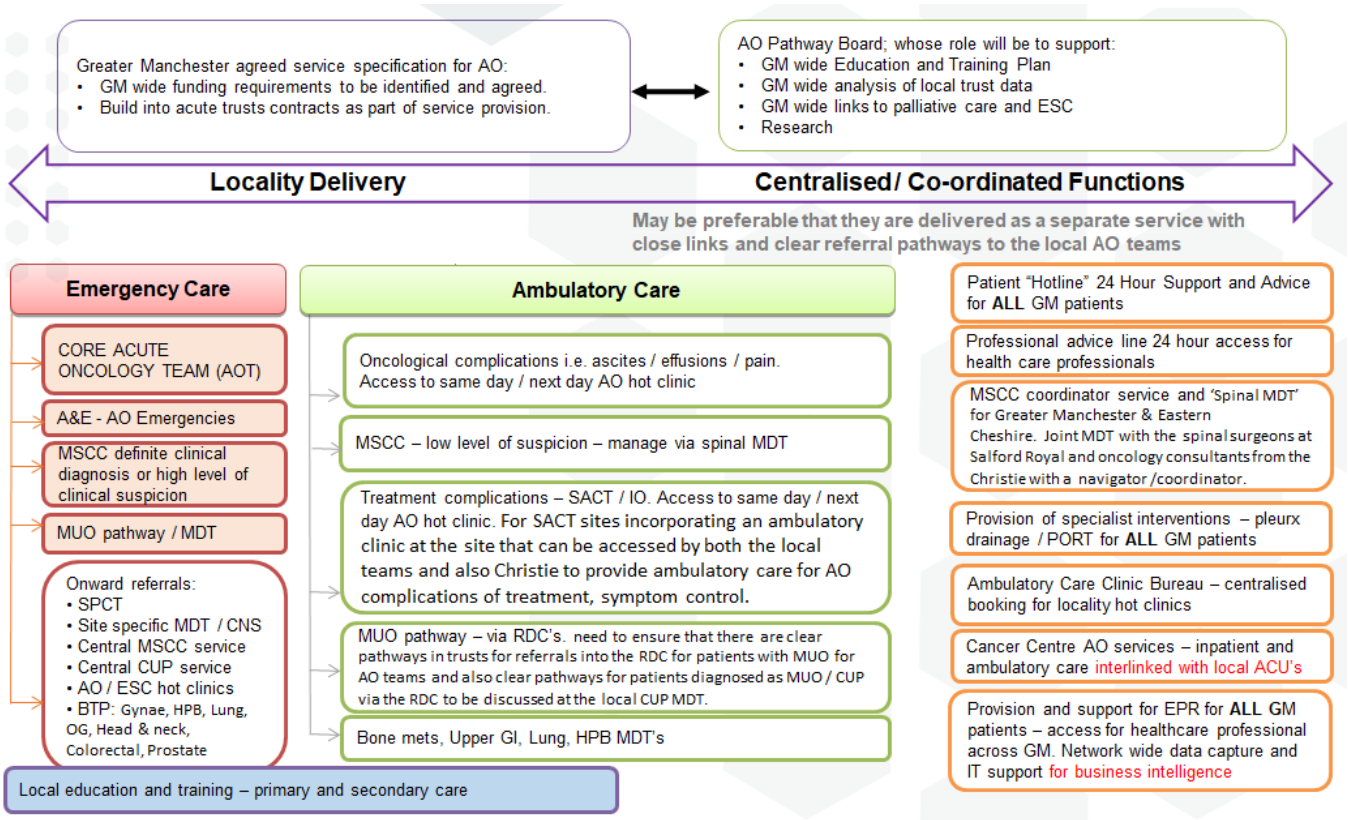
| | 61 | All patients seen within the hospital at high risk of developing metastatic spinal cord compression (MSCC), and their families or carers (as appropriate), are given information that describes the symptoms of MSCC and what to do if they develop symptoms. |
| | | **Tertiary Care AO Service: Centralised Clinical Advice Service/24 Hour Advice Line** |
| AO-18-003 | 46 | **All** GM, EC & MC cancer patients should have access to 24 hour advice line. |
| AO-18-003 | 47 | **All** hospital medical staff should have access to 24 hour telephone support from the oncology team based at the tertiary cancer centre. |
| AO-18-003 | 48 | **All** primary care physicians should have access to 24 hour telephone support from the oncology team based at the tertiary cancer centre. |
| AO-18-003 | 49 | All telephone enquiries should be dealt with urgently and assessed to determine appropriate management – outcomes may include admission either locally or to the tertiary cancer centre, referral to local AO ambulatory care services, primary care or community service review or telephone follow up. |
| | 50 | The service should also provide a link to regional clinical services i.e. NWAS/AHP/CMN to assist in the development of pathways in the acute management of AO patients. |
| | | **Secondary Care AOS's: IT and Data Collection** |
| AO-18-005 | 28 | All ED medical staff and medical personnel on the acute take rota should have access to a patient's electronic patient information in order to obtain information on diagnosis/ treatment and prognosis. |
| AO-18-101<br>AO-18-102 | 29 | All hospitals should undertake collection and audit of the agreed AO MDS as specified by GM, EC & MC AO Pathway Board (in line with national requirement), |
| | | **Tertiary Care AO Service: IT and Data Collection** |
| | 62 | Centralised data collection for AO and MUO/CUP to provide annual reports on outcomes and key performance indices for individual Trusts and GM, EC & MC wide service. |
| AO-18-101<br>AO-18-102 | 63 | Provision of an AO dashboard to highlight variance in clinical services and outcomes. |
| AO-18-005 | 64 | Provision of access to a patient's electronic patient information in order to obtain information on diagnosis/ treatment and prognosis for ED medical staff and medical staff on the acute medical rota plus community services i.e. primary care/community Macmillan/SPC. |
| | | **Tertiary Care AO Service: Research** |
| | 65 | Provide the infrastructure and support to facilitate participate in any appropriate AO clinical trials and contribute to the development of an evidence base for practice. |

## 13. Key Performance Measures with Minimum Data Set:

- KPI's are currently under review and to be formally agreed through the AO data sub group and then Board.
- Consideration will need to be given as to where the responsibility lies for certain measures where the treatment/care is provided centrally rather than locally.

## 14. AO Service Model Recommendation

In order to meet the agreed clinical standards the service model below has been defined. The model describes how services can sit across the network and the components required to achieve the service measures and clinical standards.




When further developing this model locally we still need to consider the following -

**Where** – ACUs are under tremendous capacity strain following COVID-19. Many units are small and having to reduce capacity due to social distancing. This is putting huge strain on local units who will need to be compliant with SDEC requirements/targets.

**Who** – Which clinicians will see these patients? Many AO nurses are not nurse prescribers or qualified in advanced practice. In those centres without availability of these colleagues who would be asked to see these extra patients?

## 15. Recommended Resource Requirements (as of June 2020) –

The aim of this document is to enable each AOS to effectively work towards the following recommendations:

### 15.1. Core Trust AO Services:

The following proposed requirements are based on calculations relating to the number of acute general beds within a trust (NHS England: SDCS data collection - KH03) plus service activity. The numbers given are a suggested minimum requirement for the local AO service to provide a 5 day service.

Ideally as per the agreed standards Trusts should be delivering a 7 day AO service. To enable a 7 day AO service to be delivered a minimum of 3 x AO Nurse's (AONS) would be required to provide sufficient cover and resilience to the service although 7 day service needs could be met by collaborative working with associated specialties i.e. ESC &/or SPC depending on the Trusts requirements.

The consultant in AO delivering the PA's in AO should have the PA's allocated in their job plan and they should be specifically for the delivery of direct clinical care in AO (sessions to be dedicated to a specific site as agreed in SLA with Trust). For each trust a minimum of at least 2 PA's of the consultant in AO should be delivered by a consultant oncologist (either medical or clinical oncology); the other PA's could be delivered by an associated specialty i.e. acute medicine, haemato-oncology, SPC. As per NHS England measure (QST)

| | | # Acute General Beds | # Occupancy % | Acute Oncology Specialist Nurse - AONS (WTE) | | | Consultant in Acute Oncology (PA's) | | | Acute Oncology Co-ordinator (WTE) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Current | Proposed | Additional | Current | Proposed | Additional | Current | Proposed | Additional |
| RWJ | **Stepping Hill, Stockport** | 621 | 88.5 | 1 | 3 | 2 | 0 | 5 | 5 | 0 | 1 | 1 |
| RBT | **Mid-Cheshire (Leighton)** | 514 | 94.7 | 3 | 3 | 0 | 2 | 5 | 3 | 0.95 | 1 | 0.05 |
| RJN | **East Cheshire (Macclesfield)** | 329 | 90.1 | 1.6 | 3 | 1.4 | 0 | 5 | 5 | 0 | 1 | 1 |
| RMC | **Royal Bolton Hospital** | 586 | 85.2 | 4.34 | 3 | 0 | 2.5 | 5 | 2.5 | 1 | 1 | 0 |
| | **MFT - MRI (ORC)** | 1112 | 87.7 | 4 | 4 | 0 | 3 | 5 | 2 | 1 | 2 | 1 |
| | **MFT - Wythenshawe** | 775 | 87.7 | 4.4 | 4 | 0 | 5 | 5 | 0 | 0.52 | 1 | 0.48 |
| RMP | **Tameside & Glossop** | 427 | 88.6 | 1 | 3 | 2 | 3 | 5 | 2 | 0.64 | 1 | 0.36 |
| RW6 | **NCA - Pennine Acute** | 1134 | 93.3 | 6 | 6 | 0 | 4 | 5 | 1 | 2.6 | 2.5 | 0 |
| RM3 | **NCA - Salford Royal** | 806 | 92.8 | 1.6 | 4 | 2.4 | 2 | 5 | 3 | 0.5 | 1 | 0.5 |
| RRF | **Wrightington, Wigan & Leigh** | 451 | 85.7 | 3 | 3 | 0 | 5 | 5 | 0 | 0.6 | 1 | 0.4 |
| | | | | | | 7.8 | | | 23.5 | | | 4.79 |

**GOLD STANDARD RECOMMENDATION**

* Each component: AONS, Consultant and Co-ordinator must be seen in their own right adhering to the National Standards
* Each Trust should be working towards a **7 day service** - the above recommendation presents the 5 day minimum resource required.
* This is a snapshot of committed resource dated **July 2020** and may not represent a true reflection of actual working resource.

# Source of data: NHS England SDCS data collection Jan-March 2020

Local AOT's will be responsible for delivering the clinical standard linked to secondary care and the emergency care plus aspects of ambulatory care described in the service model. Teams should work and link closely with services based within the cancer centre and other interdependent services.

7 day service modelling may look something like this:

| | | # Acute General Beds | # Occupancy % | Acute Oncology Specialist Nurse - AONS (WTE) | | | Consultant in Acute Oncology (PA's) | | | Acute Oncology Co-ordinator (WTE) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Current | Proposed | Additional | Current | Proposed | Additional | Current | Proposed | Additional |
| RWJ | **Stepping Hill, Stockport** | 621 | 88.5 | 1 | 5 | 4 | 0 | 7 | 7 | 0 | 1.5 | 1.5 |
| RBT | **Mid-Cheshire (Leighton)** | 514 | 94.7 | 3 | 5 | 2 | 2 | 7 | 5 | 0.95 | 1.5 | 0.55 |
| RJN | **East Cheshire (Macclesfield)** | 329 | 90.1 | 1.6 | 5 | 3.4 | 0 | 7 | 7 | 0 | 1.5 | 1.5 |
| RMC | **Royal Bolton Hospital** | 586 | 85.2 | 4.34 | 5 | 0 | 2.5 | 7 | 4.5 | 1 | 1.5 | 0.5 |
| | **MFT - MRI (ORC)** | 1112 | 87.7 | 4 | 6 | 2 | 3 | 7 | 4 | 1 | 2.5 | 1.5 |
| | **MFT - Wythenshawe** | 775 | 87.7 | 4.4 | 6 | 0 | 5 | 7 | 2 | 0.52 | 1.5 | 0.98 |
| RMP | **Tameside & Glossop** | 427 | 88.6 | 1 | 5 | 4 | 3 | 7 | 4 | 0.64 | 1.5 | 0.86 |
| RW6 | **NCA - Pennine Acute** | 1134 | 93.3 | 6 | 8 | 2 | 4 | 7 | 3 | 2.6 | 3 | 0 |
| RM3 | **NCA - Salford Royal** | 806 | 92.8 | 1.6 | 6 | 4.4 | 2 | 7 | 5 | 0.5 | 1.5 | 1 |
| RRF | **Wrightington, Wigan & Leigh** | 451 | 85.7 | 3 | 5 | 2 | 5 | 7 | 2 | 0.6 | 1.5 | 0.9 |
| | | | | | | 23.8 | | | 43.5 | | | 9.29 |

## 15.2. AO Ambulatory Care Provision: Alignment with SACT's Delivery

Systemic Anti-Cancer Treatment (SACT'S). Through GAP analysis refreshed Jan-Mar 2020 it demonstrated variability and non-equality of services across the GM, EC & MC demographic. At present the teams provide, in the majority a 5 day Monday to Friday service focusing mainly on the provision of in-patient AO care. For out of hours support health professionals within the Trust can contact the Christie on-call service; patients are able contact the Christie Hotline for advice/support. There are no specific AO ambulatory services or ESC services to speak of for AOT's across the network.

The Christie NHS Trust provides AOS's which support the local AO teams across the network. The AOMS based at the Christie provides the "hotline" advisory service for patients, health professional advice via the Trusts on-call service and MSCC Co-ordinator service.

The Christie also provides an AO/ESC ambulatory care service which currently resides at the Christie site. This service supports a multidisciplinary approach running with an advanced nurse practitioner (ANP Band 8a) and support from Consultants in Acute Medicine and members of the Specialist Palliative Care team.

Alignment of AOS's with SACT potentially enables more efficient use of resource and infrastructure whilst providing specialist oncology support and advice locally.

The aims of The Christie SACT strategy for AOS's in relation to ambulatory care and SACT are:

- More patients are able to access treatment and associated specialist care closer to home.
- Enabling patients to access an increased range of treatment options including complex care, that are currently not undertaken outside of The Christie or available on a limited basis (e.g. chemo-radiotherapy, immunotherapies, research, enhanced supportive care).
- Ensuring patients can access trials and research at networked sites on a sustainable basis, with sites able to deliver care, treatment and administration for research trials effectively and consistently.
- Future-proofing of provision based on likely increases in demand, enabling flexibility on each site based on future potential changes to delivery (e.g. proportion of orals/IV etc.) Where possible aligning surgical and non-surgical pathways using the network model to ensure improved cancer waiting time performance and patient experience.
- Aligned provision of SACT, Haematology and AO provision on site so that best use can be made of resources and best care provided to patients.

AO provision **could** be co-located with interdependencies, with a nurse-led AO/ESC clinic sat within potential SACT/Haem units on site (as well as available virtual clinics) which enables patients who are attending for treatment, but also requiring attendance for medical review (e.g. for toxicity issues) or other treatment-related aspects and disease-related complications to be seen rapidly.

In all SACT related patient complications or acute instances referrals would be expected to be made as required via The Christie Hotline or via the local AO teams and / or their acute services (e.g. Emergency Department, if patient has presented without previous contact) co-ordinating via the Christie Hotline which would act as a central Co-ordinator for the service. The AO/ESC clinic service operating hours will be based on available capacity and predicted demand, with iterative extensions to operating hours as required for service based on utilisation and other factors.

It is anticipated that such a service will make use of a mixed model of staffing to reduce the dependency on consultant cover. ANPs could provide day-to-day AO care on the unit; over time, utilisation could be made of Physicians Associates in support roles where required and appropriate; as with other clinically-facing aspects of service provision on-site, staffing for AO clinic could sit with the Christie using a hub/spoke model linking to the ambulatory services at Christie for wider staffing and support, with additional medical support provided by a mixture of the available on-site consultant and Christie medical support where required.

We need to consider current ways of working. These services will require close links with local AO team to ensure that pathways between local services i.e. ED/AMU are interlinked

into the ambulatory clinic provision. Best care will be provided by ensuring that relevant staff have clinical exam skills training and ability to prescribe. Include local Acute Medicine Consultants and ED physicians into the discussions and development of this ensuring how the extra work is job planned.

In order to keep care close to home for patients – (Achieving world-class cancer outcomes: Taking charge in Greater Manchester 2017-21) where possible patients receiving care and treatment at local sites will also receive required acute care on-site. However, the future state for the AO service should also reflect the needs of the patient and available resources on site. As such, it is anticipated that where a patient requires more substantive oncological acute care requiring specialist oncological management, they could be directed via the site AO clinics (via Christie Hotline) through to the pathways currently in development for AO and enhanced supportive care in the AAU based at the Christie, however this is currently in consultation through The Christie SACT Strategy planning stage.

### 15.3. AO Ambulatory Care Provision: MUO/CUP Pathway

Patients presenting with MUO potentially may follow several diagnostic pathways prior to them being placed on a disease specific pathway which potentially leads to delays in diagnosis and treatment. A higher proportion of these patients will be managed in inpatient settings rather than via 2WW pathways or ambulatory care pathways. These patients often present as an emergency.

Alignment of MUO pathways with RDC (Rapid Diagnostic centres) sites/principles will allow for the streamlining of pathways for these patients. These would enable urgent referral for diagnostics for patients presenting with metastatic disease at presentation from primary and secondary care facilities.

Where RDC's are established AOT's should ensure collaborative working with the centres to support signposting, facilitate the local CUP MDT and provide support for patients who remain a MUO requiring referral to SPC services and MUO patients who have a more complex and prolonged diagnostic pathway prior to referral to specialist centres.

As RDC's are developed in the network the AOS's aligned with them will need to adapt to their local service needs. Local AOS's are responsible for ensuring that the MUO/CUP clinical standards are met.

### 15.4. Centralised/Co-ordinated services

Several aspects of AOS's are centrally based and provide service for the entire network. These services are based with the appropriate providers. These services include:

- Ambulatory care AO provision aligned to SACT's as per above.
- MSCC Co-ordinator service (interlinking with spinal services)

- Patient advice line – “hotline”
- Healthcare Professional advice
- AO ambulatory care service/Enhanced supportive care services
- Data collection and IT facilitation

In order to achieve the agreed clinical standards certain aspects of these services may require further expansion and resource. The requirements to meet these needs will be assessed on an individual service basis and where possible look to co-ordinate services to ensure efficient use of available and existing resources.