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Service Specification

of Acute Oncology Services for the NHS in Wales

AOS

Gwasanaethau Oncoleg Aciwt Cymru

Acute Oncology Services Wales

Statement

This document has been developed to inform the commissioning and delivery of Acute Oncology Services (AOS) across the NHS in Wales.

In creating this document, the National Strategic Clinical Network for Cancer (Cancer Network) on behalf of the NHS in Wales has reviewed the available evidence and standards of care that are expected to deliver AOS.

Health Boards and Trusts require healthcare professionals to use their clinical judgement, knowledge and expertise when deciding the application of this Service Specification.

Authors

Dr Hilary Williams AOS Clinical Lead
National Strategic Clinical Network for Cancer, NHS Wales Executive

Kayleigh Chainey Cancer Treatment Programme Manager
National Strategic Clinical Network for Cancer, NHS Wales Executive

Dr Rosie Roberts AOS Lead Nurse
National Strategic Clinical Network for Cancer, NHS Wales Executive

Claire Birchall Cancer Network Manager
National Strategic Clinical Network for Cancer, NHS Wales Executive

Contents

Foreword

Cancer treatments are improving but sadly patients diagnosed with cancer in Wales spend an average of 25-30 days in acute care in the last year of life. Oncology services are largely outpatient based, however many patients at some point need emergency cancer support. This includes at diagnosis (approximately 30% of new diagnoses), first relapse or progression of cancer and complications of treatments. Oncology patients may be admitted to hospital multiple times and in Wales approximately 50% of patients with lung cancer die in an NHS bed.

Acute Oncology Services (AOS) have grown to bridge the gap between teams treating cancer and acute care. Patients tell us that continuity of care, compassionate care and team working across health systems are vital. Acute oncology teams have a role in ensuring complications of cancer are rapidly recognised. Immunotherapies, and in particular checkpoint inhibitors, have quickly changed the landscape of cancer care with the possibility of durable remissions. Immunotherapy has a different set of toxicities, and early recognition and pathways to manage toxicities are key to maintaining patients on treatments, improving outcomes, and reducing emergency admissions. For others, an acute oncology admission marks a change in prognosis, and patients need time and professional holistic expertise when they may feel at their most vulnerable. Lengths of stay can be long, there is a risk of being readmitted, and this can be linked to poor planning across clinical boundaries and lack of honest conversations with patients and their families about difficult choices ahead.

AOS teams across Wales are small, with frequently only one nurse per acute hospital. There are real opportunities to structure acute oncology care pathways for patients to deliver same day care where possible, streamline care pathways, and improve communications between sectors. This service specification has been developed following recommendations from the 2018 AOS Peer Review[1] and is based on experience of AOS across Wales, discussions with patients and carers and workshops with a wide range of staff across Wales. The workshops delivered in-depth and challenging discussion across professional boundaries, acute care, palliative care, oncology, primary care and there was a clear realisation of the potential to deliver real change.

A skilled, trained workforce is at the heart of good AOS. Currently teams are small, investment has varied across Wales, and there are significant gaps in the workforce with minimal 7 day working. Clear long term workforce plans, including training programmes, wider education and committed investment will lead to safer care and in many instances a reduction in acute care costs due to more efficient and effective care pathways.

[1] *Peer Review: Acute Oncology Service All Wales Report – July 2018.*
Available at: https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/7-4-appendix-b-all-wales-peer-review-final-pdf

"I have only been in 2 times since starting treatment…the 1st time I didn't see an oncology nurse but the 2nd time I did… but if I need to go there again I will ask for the doctors to refer me to the oncology team. It made the difference to me and my family - we need more of them so they can be in every hospital for us cancer patients." (Oncology patient)

With investment should come availability of Same Day Emergency Care (SDEC) capacity, streamlined pathways, and improved communications between primary care, palliative care, oncology and acute care. On discharge, careful consideration should be given to future care needs, risk of readmission, and communication. Accurate and timely data is lacking but will be key to understanding the demand and benefits of investment.

Thank you to all the patients, carers, NHS Wales clinical and non-clinical staff, professional bodies and charities who have supported and contributed to this service specification, which provides a clear blueprint for AOS in Wales.

Dr Hilary Williams
AOS Clinical Lead
National Strategic Clinical Network for Cancer

Executive Summary

This specification has been developed by the National Strategic Clinical Network for Cancer (Cancer Network) in response to the recommendations from the 2018 Acute Oncology Service (AOS) Peer Review[2]. The development has involved a range of stakeholders from across AOS, associated services and patients and it aims to set out national agreed standards of care for AOS that patients and carers can expect to receive from their local Health Board or NHS Trust. Acute Oncology extends right across the cancer journey from diagnosis to end of life care and includes oncological and hematological cancer. The key to excellent AOS care is collaboration and communication across traditional service boundaries.

This specification is set out in three parts:

- Introduction to Acute Oncology
- Principles of Acute Oncology (including the 'who' and 'what' that is required to deliver an equitable and effective AO service)
- Standards that local Health Boards and Trusts should strive to work towards.

This specification sets out standards to ensure a resilient workforce including the roles required in core, associate and tertiary teams. The specification has been aligned to Six Goals for Urgent Emergency Care (Welsh Government, 2022)[3] which provides an excellent framework against which to develop AOS and provision for cancer patients, both those on treatment and those where the focus is supportive care.

The eight principles identified in this document should be embedded within every AO Service across Wales as they will ensure teams are working towards the best possible care, placing patients at the heart of decision making, helping to reduce admissions and length of stay, and aligning with wider NHS Wales improvement strategies. The Standards in Section 3 are aligned to the principles, and detail how the services will be measured at Peer Review.

We are hugely grateful to colleagues and patients across Wales who helped develop this specification, to ensure it reflects the shared vision of how AOS should look in the future.

[2] *Peer Review: Acute Oncology Service All Wales Report – July 2018*.
Available at: https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/7-4-appendix-b-all-wales-peer-review-final-pdf

[3] Welsh Government. (2022). *Right care, right place, first time: Six Goals for Urgent and Emergency Care. A policy handbook 2021–2026*. OGL Crown Copyright.
Available at www.gov.wales/sites/default/files/publications/2022-09/six-goals-for-urgent-and-emergency-care_1.pdf

Who is this document for?

This service specification has been written for all NHS staff:

- in urgent and emergency care, including those delivering care for oncology and haematology patients in the acute sector
- based in the community
- developing services in any NHS Wales Health Board or Trust
- commissioning Acute Oncology Services

What is the purpose of a service specification?

The purpose of a service specification is to set service standards:

a. that patients and their carers can reasonably expect to receive.

b. for Acute Oncology Teams, the oncology community, primary care, acute care and palliative care to aspire to achieve. For the purposes of this service specification, acute care is defined as secondary emergency care including emergency medicine, Same Day Emergency Care (SDEC) and inpatient care.

c. for Health Boards and Trusts, who will own the specification and will be responsible for delivering the standards within it.

d. to address equity of access and align with NHS Wales health and care strategies and ambitions:

- Six Goals for Urgent Emergency Care (Welsh Government, 2022)[4]
- The Quality Statement for Cancer (Welsh Government, 2021)[5]
- National Clinical Framework (Welsh Government, 2021)[6]
- The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023 (Welsh Government, 2023) [7]
- Value Based Health Care[8]
- A Cancer Improvement Plan for NHS Wales 2023-2026[9]

e. to enable benchmarking and Peer Review.

Patient views and priorities

To inform the development of the Service Specification of Acute Oncology Services for the NHS in Wales, patients and carers across Wales were asked to respond to a brief survey (Appendix 1). The detail from the survey responses has been used to inform every aspect of this specification.

[4] Welsh Government. (2022). *Right care, right place, first time: Six Goals for Urgent and Emergency Care. A policy handbook 2021–2026*. OGL Crown Copyright. Available at www.gov.wales/sites/default/files/publications/2022-09/six-goals-for-urgent-and-emergency-care_1.pdf

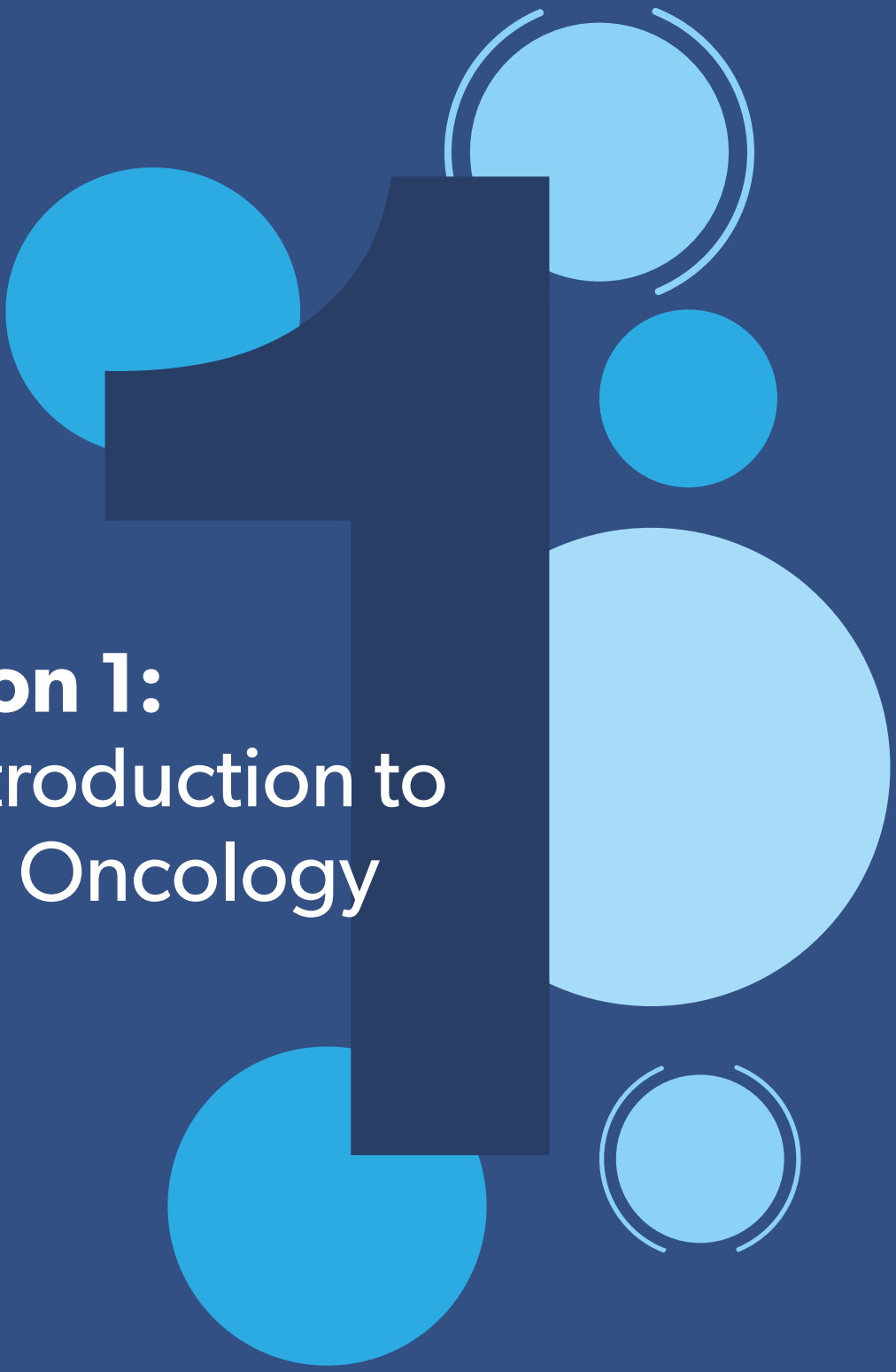
[5] Welsh Government. (2021). The quality statement for cancer. Available at www.gov.wales/quality-statement-cancer

[6] Welsh Government. (2021). *National Clinical Framework: A Learning Health and Care System*. OGL. Digital ISBN 978-1-80082-997-8

[7] Welsh Government. (2023). *The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023*. Available at www.gov.wales/sites/default/files/publications/2023-04/duty-of-quality-statutory-guidance-2023_0.pdf

[8] https://vbhc.nhs.wales/value-based-healthcare-for-wales

[9] National Strategic Clinical Network for Cancer. (2023). *A Cancer Improvement Plan for NHS Wales 2023-2026*. Available at https://collaborative.nhs.wales/networks/wales-cancer-network/full-plan



Section 1:
An Introduction to Acute Oncology

What is Acute Oncology?

Acute Oncology (AO) patients are patients with cancer and who require urgent care due to:

A new/relapse diagnosis of cancer (diagnosis may follow admission).

A complication or side effects of their cancer treatment.

A complication of an existing cancer or undiagnosed cancer.

AO Teams provide a critical service for patients who require urgent and emergency treatment related to their cancer diagnosis or undiagnosed cancer. This may be an acute presentation of a new or undiagnosed cancer, a complication of a known cancer or a complication of cancer treatments. Cancer care has become more complex, with new and effective treatments meaning many more people are living with 'treatable but not curable cancer'. However, many patients with cancer need to access acute care in the last year of life, and 1 in 6 will experience more than three admissions.

AO patients present in several ways with complex clinical and social needs; for many patients there are few robust alternatives to the 'front door' of NHS services, which can include patients self-presenting or referrals from primary care (GP), but can also include patients that are referred to AO Teams from radiology, urgent and emergency care teams such as Emergency Departments, Assessment Units, or Rapid Diagnosis Clinics.

Modern non-surgical cancer care has developed as an outpatient speciality in the UK, with a focus on Multi-Disciplinary Team (MDT) delivery of systemic therapy and radiation therapy. In the last 10 years, the need for and recognition of specialist emergency oncology expertise and investment has emerged. On average, patients with cancer in Wales spend 25-30 days in an NHS setting in the last year of their life, the majority in emergency beds. For example for those with lung cancer, analysis covering 2018-2021 showed an average of 17 emergency and 3 elective bed days in last 30 days of life. During this period 46% of lung cancer patients died in an NHS setting.[10] Macmillan Cancer Support has also found that adults with cancer who survive an admission to hospital sadly have a 70% chance of dying in the subsequent 12 months[11].

AO Teams can bridge the gap between acute care and cancer expertise and ensure that patients and their families and carers receive the care they need. The AO Service can deliver a number of benefits to patients, clinicians and the wider system through improved communication and provision of timely access to expert advice, thus improving patient experience with use of more appropriate investigations, earlier discharge, and admission avoidance. Sadly, many acute cancer patients are in their last year of life, and honest discussions around prognosis and care escalation, with a focus on staying well in the community, can make a real difference to patient experience and wellbeing. However, assessing a patient's prognosis has become more challenging due to new treatment options.

[10] Phase 1 Last Year of Life Dashboard for Wales produced by DHCW on behalf of the Wales Value in Health Centre.

[11] Northern Ireland Cancer Registry; Macmillan - NICR Partnership: Emergency Admissions in the Last Year of Life for People Dying of Cancer in Northern Ireland in 2015. Available at https://www.qub.ac.uk/research-centres/nicr/FileStore/PDF/Filetoupload,914677,en.pdf

Immunotherapy is changing the face of metastatic cancer and has a rapidly widening role in treating many different cancers (Melanoma, Lung, Upper and Lower Gastrointestinal (GI), Breast, Urology and Head and Neck all have funded therapies). Novel toxicities can be challenging to recognise and require early intervention and specialist expertise.

NHS Wales Context

AOS cannot be delivered in isolation. They are part of a complex health and care system, working closely with oncology and haematology services, urgent and emergency care teams with links into primary care, community teams, palliative medicine, acute medicine, and emergency medicine.

When Health Boards are investing in AOS, they should consider how their plans align with Welsh Government strategic direction;

- A Healthier Wales (Welsh Government, 2021)[12]
- National Clinical Framework (Welsh Government, 2021)[13]
- Six Goals for Urgent and Emergency Care (Welsh Government, 2022)[14]
- The Quality Statement for Cancer (Welsh Government, 2021)[15]
- Improving health and social care (COVID-19 looking forward) (Welsh Government, 2021)[16]
- The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023 (Welsh Government, 2023)[17]
- A Cancer Improvement Plan for NHS Wales 2023-2026[18]

AO Services are currently hospital based, but one in three people in Wales lives in an area classed as rural and often correlated with increased health inequalities[19]. Therefore, services need to be configured to support equity of care across Wales. Service configuration needs to recognise that many AO emergencies are time critical (e.g. neutropenic sepsis), although some services can be provided safely in an outreach setting with upskilling of teams in community and local hospital settings. This is particularly important when patients live at a distance from larger cancer centres.

[12] Welsh Government. (2021). *A Healthier Wales: our Plan for Health and Social Care*. OGL Crown Copyright. Digital ISBN 978-1-80195-809-7. Available at https://www.gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf

[13] Welsh Government. (2021). *National Clinical Framework: A Learning Health and Care System*. OGL. Digital ISBN 978-1-80082-997-8

[14] Welsh Government. (2022). *Right care, right place, first time: Six Goals for Urgent and Emergency Care. A policy handbook 2021–2026*. OGL Crown Copyright. Available at https://www.gov.wales/sites/default/files/publications/2022-09/six-goals-for-urgent-and-emergency-care_1.pdf

[15] Welsh Government. (2021). The quality statement for cancer. Available at https://www.gov.wales/quality-statement-cancer

[16] Welsh Government. (2021). *Health and Social Care in Wales – COVID-19: Looking forward*. OGL Crown Copyright. Available at https://www.gov.wales/sites/default/files/publications/2021-03/health-and-social-care-in-wales--covid-19-looking-forward_0.pdf

[17] Welsh Government. (2023). *The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023*. Available at https://www.gov.wales/sites/default/files/publications/2023-04/duty-of-quality-statutory-guidance-2023_0.pdf

[18] National Strategic Clinical Network for Cancer. (2023). *A Cancer Improvement Plan for NHS Wales 2023-2026*. Available at https://collaborative.nhs.wales/networks/wales-cancer-network/full-plan

[19] *Wales Centre for Health; A profile of rural health in Wales*. Available at: http://www.wales.nhs.uk/sitesplus/documents/888/ruralprofile.pdf

Data Collection

To improve AOS capacity and reach across the NHS in Wales, accurate AOS activity data is essential. Very few health care providers in Wales can currently provide accurate quality data to identify the numbers of AO patients (including those diagnosed during an admission) or analyse AOS patient use of health care resources, in particular numbers and lengths of stay in acute inpatient beds. Urgent work needs to be undertaken to develop mechanisms to enable capture of this data, and further work with the National Data Resource and identification of patients is required. This urgent action has been included in the Cancer Improvement Plan (National Strategic Clinical Network for Cancer, 2023)[20].

Workforce

Acute Medicine, Surgery, and Emergency Departments provide the backbone of 24/7 acute care for many cancer patients, with community based teams playing an equally important role. The training curriculum for acute teams should include AO, and oncology specialists need to ensure an up-to-date knowledge of acute care and management of co-morbidities. The multi-disciplinary AOS brings together expertise in cancer treatments, imaging, emergency care, palliative care and primary care to allow patients to live well in the community, and proactively works with cancer patients and families to set realistic goals and avoid further admissions.

The importance of the AO skill set as part of the toolkit of a consultant oncologist has been formally recognised by the General Medical Council (GMC). This skill set is critical for a workforce fit for challenges of an aging and comorbid population[21]. The rapid rise in available and active novel drug therapies needs to be matched by a workforce equipped to manage toxicities, recognise when to start and stop treatments, and understand the impact of age and co-morbidity.

The key messages from a joint RCR, RCP, ACP paper on AOS, 2020[22]:

- AOS are vital for providing consistent and high-quality care for patients, for optimising clinician time and expertise, and for ensuring the best use of NHS resources.
- Meeting the complex needs of acutely presenting oncology patients across a wide variety of clinical contexts is challenging and deserves to benefit from the same strategic and operational clinical leadership that is already available to site-specific cancer teams.
- A clearly defined role for consultant oncologists within AO is essential for ensuring effective clinical leadership and oversight.
- The rising incidence of cancer in an aging population with multimorbidity will require a multi-professional approach to care, with AOS providing the critical cancer oversight for the majority of emergency cancer admissions.

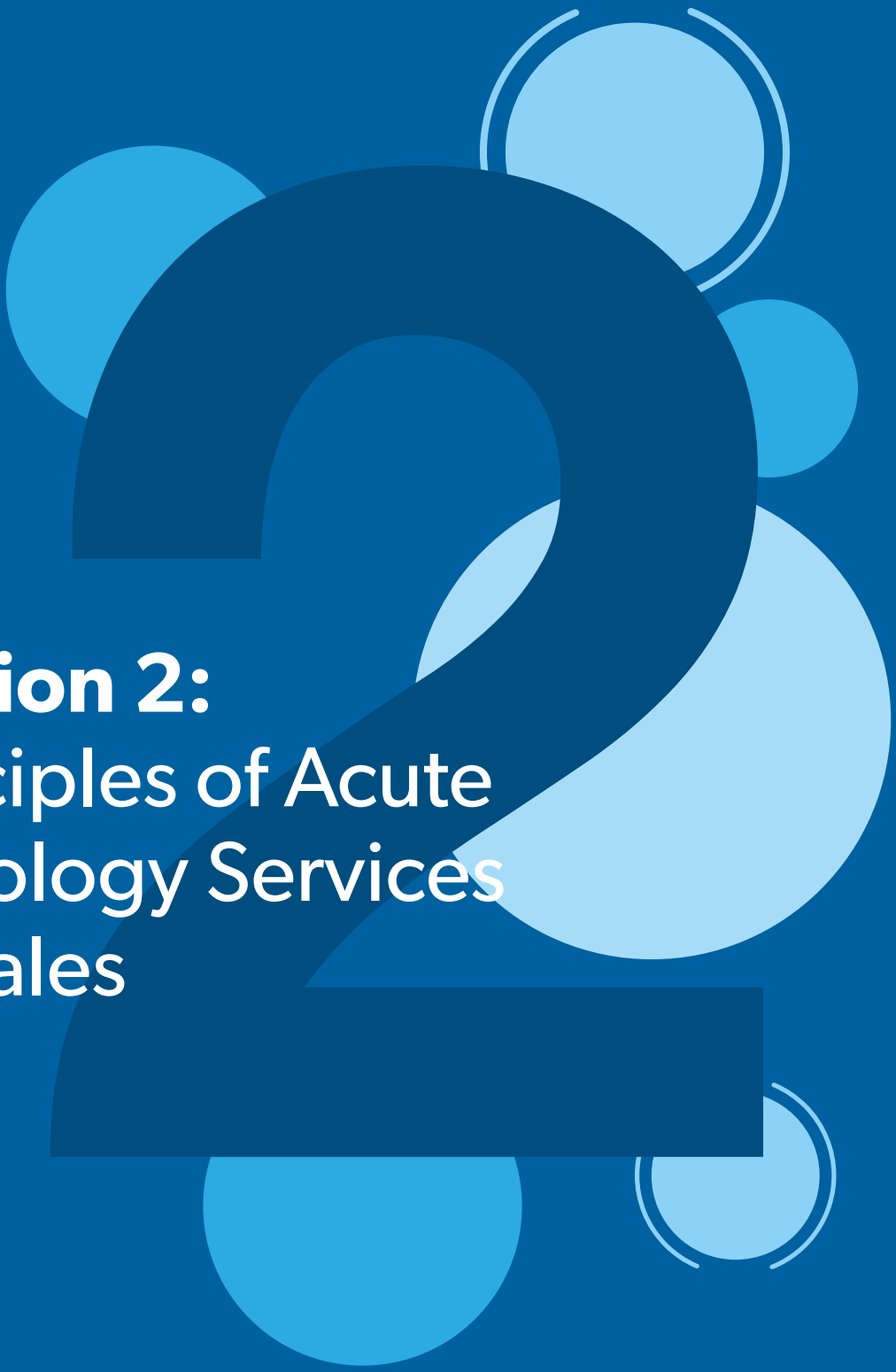
Additionally, a paper published in January 2023 by the Royal College of Physicians drew on the experience of patients, doctors, nurses and allied health professionals who called for investment in AOS to improve patient experience, outcomes and time spent in hospital.[23]

[20] National Strategic Clinical Network for Cancer (2023). *A Cancer Improvement Plan for NHS Wales 2023-2026*. Available at https://collaborative.nhs.wales/networks/wales-cancer-network/full-plan

[21] *Joint Royal Colleges of Physicians Training Board*. Available at: https://www.jrcptb.org.uk/sites/default/files/Medical%20Oncology%202021%20Curriculum%20FINAL.pdf

[22] *Royal College of Radiologists; Acute Oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020. Available at: https://www.rcr.ac.uk/posts/acute-oncology-increasing-engagement-and-visibility-acute-care-settings

[23] Royal College of Physicians. (2023). *Cancer Care at the Front Door: The Future of Acute Oncology in Wales*. Available at https://www.rcplondon.ac.uk/projects/outputs/cancer-care-front-door-future-acute-oncology-wales



Section 2: Principles of Acute Oncology Services in Wales

The eight overarching principles of Acute Oncology (AO) set out in the table below have been developed to ensure Acute Oncology Services (AOS) teams deliver the best possible care, place patients at the heart of decision making, and align with wider NHS Wales strategies to maximise impact.

They have been informed by patients, healthcare professionals and relevant policies and strategies. All AOS across Wales should strive to design and deliver in accordance with these principles. Further details on these principles are provided in the following pages. These principles inform the Service Specification Standards in Section 3.

Themes	Principles	
Best Patient Care	1	Provide care which is tailored to the individual and the individual's goals to help make 'best choices'.
	2	Ensure the patient and family / carers are at the centre of decision making, and strategies of self-management are developed where possible.
The Acute Oncology Team	3	Ensure the Acute Oncology Team is multi-speciality and has allocated dedicated time in their job plans to enable effective delivery of care.
	4	Ensure the Acute Oncology Team is trained and skilled in managing cancer emergencies and has robust access to specialist oncology support to ensure appropriate and effective care for patients.
The Acute Oncology Service	5	Be configured to provide alternatives to admission, rapid assessment and diagnosis, and treatment on the same day where possible.
	6	Ensure there are clear clinical pathways to and from primary care, urgent and emergency care, and other specialities, in order to enable effective and timely patient care.
AOS Digital Systems, Data and Communication	7	Ensure all relevant clinical information and patient records are available to all staff managing acute care episodes 24/7.
	8	Ensure systems are in place to capture Acute Oncology activity and outcomes, including demand, length of stay, re-admission and survival following admission.

Best Patient Care

Delivering AO Principles 1 & 2:

1. Provide care that is tailored to the individual and the individual's goals to help make 'best choices'.

2. Ensure the patient and family / carers are at the centre of decision making, and strategies of self-management are developed where possible.

Patients being treated by AO teams are at a vulnerable point in their cancer journey, and many have a combination of physical and psychosocial challenges. Rapid agreement on a cancer treatment plan is vital as timely decision making and access or return to active therapy where possible, can prolong life. Patients, families and carers need to be at the centre of decision making so treatment should be tailored to the individuals' goals. It is important to support self-management of symptoms where appropriate for the patient, such as pain, breathlessness, anxiety, and fatigue.

AOS teams require expertise in person centred care and in developing shared decision making. Patients being supported by AOS can provide the opportunity to move the focus from 'what is the matter with me' to 'what matters to me'. AO care is also frequently provided by a wide range of non-cancer specialists, and closer working across specialities and upskilling will improve patient-centred care.

Patient Views and Priorities

To inform the development of the AO Service specification, patients and carers from across Wales were asked to respond to a brief survey (see Appendix 1 Survey). The detail from the survey responses has been used to inform every aspect of this specification.

Ensuring Excellent Patient Experience, Information and Support

It is crucial that patients are fully informed throughout their cancer journey, and that the use of jargon, acronyms and technical or medical language is avoided. Clinicians must pay attention to the level of understanding patients have about their condition, treatment options and likely outcomes, and communicate sensitively with patients (and families /carers) to ensure understanding is up to date. Patient Reported Experiences Measures (PREMs) should be used by all AOS Teams as a form of quality measurement for patient care. Work is ongoing with regards to the most effective way to capture meaningful patient experience, and a Once for Wales approach is being explored. The National Strategic Clinical Network for Cancer hosts a Patient Experience Survey which is available for Health Boards / Trusts in Wales to use[24].

The resources below represent best practice for communicating difficult or sensitive information with patients:

- Macmillan Ten Top Tips for Sharing Cancer Prognosis[25]
- Teenage and Young Adult Communication Poster[26]
- Cancer of Unknown Primary Foundation; Jo's Friends[27]

[24] National Strategic Clinical Network for Cancer; Patient Experience Survey. Available at: https://collaborative.nhs.wales/networks/wales-cancer-network/patient-hub/patient-survey

[25] National Strategic Clinical Network for Cancer; Ten Top Tips for Sharing Cancer Prognosis: A Guide for Health Care Professionals. Available at: https://collaborative.nhs.wales/networks/wales-cancer-network/clinical-hub/macmillan-primary-care-cancer-framework/education/online-resources/ten-top-tips-for-sharing-cancer-prognosis

[26] National Strategic Clinical Network for Cancer; Teenage and Young Adult Cancer Youth Advisory Forum: Young Person's Principle of Communication. Available at: https://collaborative.nhs.wales/networks/wales-cancer-network/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/tctyoung-persons-communicationposter

[27] Cancer of Unknown Primary Foundation; Jo's Friends. Available at: https://cupfoundjo.org/treatment/doctor-patient-relationships

The Acute Oncology Team

Delivering AO Principles 3 & 4:

3 Ensure the Acute Oncology Team is multi-speciality and has allocated dedicated time in their job plans to enable effective delivery of care.

4 Ensure the Acute Oncology Team is trained and skilled in managing cancer emergencies and has robust access to specialist oncology support to ensure appropriate and effective care for patients.

AO Teams are multi–disciplinary and must contain a wide range of skills, experience and clinical expertise to include at least:

- How to recognise and rapidly initiate management of patients presenting with common non-surgical complications of cancer.
- Knowledge of initial management steps, investigations and patient focused care of a new diagnosis of malignancy, Malignancy of Unknown Origin (MUO) and Cancer Unknown Primary (CUP). See Appendix 2 for further detail on MUO / CUP.
- Knowledge of how to access MUO/CUP services including Multi-Disciplinary Team (MDT), key worker and regular clinics.
- Ability to signpost to the correct site-specific pathway for new and relapsed cancers.
- Recognising and addressing holistic needs of patients or signposting to relevant service.
- Knowledge of cancer prognosis and available treatment options in the context of co-morbidity and frailty.
- Understand the role of and have rapid access to palliative radiotherapy.
- Specialist management of treatment toxicities, including Systemic Anti-Cancer Therapy (SACT), immunotherapy, and radiotherapy.
- Specialist management of disease related complications including Metastatic Spinal Cord Compression (MSCC), Superior Vena Cava Obstruction (SVCO), Cancer Associated Thrombosis (CAT), malignant brain lesions, hypercalcaemia and malignant effusions (see Appendix 3 for further detail on MSCC management, and Appendix 4 for CAT).
- Specialist palliative care experience in identifying and taking the first steps in palliation of symptoms of advanced cancer and ceilings of treatment, and advanced care planning where appropriate.
- Recognising when a patient's cancer trajectory is changing and consideration of the need for specialist palliative care for complex symptoms.
- Clinical leadership, service development and clinical decision making.
- Mentoring and educating others to develop their AO knowledge and skills.

One Team – One Goal

This document aims to set out the minimum requirement for an AO Service, to ensure AO Services have the resources required to best support patients.

The AO Team commonly works across boundaries, bridging the gap between acute care and oncology and needs the ability to work closely with a broad range of specialities. They require access to senior decision makers who have cancer specific expertise on a daily basis. Expertise will include decision-making regarding appropriate ceilings of treatment, management of complex presentations of metastatic disease, particularly unknown primary, and knowledge of cancer prognosis. Senior decision makers may include consultants in oncology / haematology / acute care / palliative care (with specialist interest and experience), registrars and Advanced Clinical Nurse Practitioners / senior nurses / nurse consultants. The current higher training curriculum for oncologists has detailed competencies in AOS, many of which are considered transferable to advanced nursing and AHP practice.

Core (Mandatory) AOS Team Members

All roles within the Core Team must be in place, with AO responsibilities stated in job descriptions and job plans.

- Consultant Clinical Lead for Service (medical or nursing)
- Acute Oncology Nursing Team:
  - Clinical Nurse Specialist (CNS)
  - Advanced Clinical Nurse Practitioner (ACNP) and / or Nurse Team Leader
- Consultant Oncologist / Consultant Haematologist / Palliative Care Consultant
- Immunotherapy Toxicity Lead
- Allied Health Professionals (AHPs)
- AOS Coordinator
- Administrative Support

(For further detail on these roles, please see Appendix 5).

Associate (Recommended) AOS Team Members

Clear referral pathways and prompt access to these staff is required to provide an effective AO service.

- Palliative Care (Physician / ACNP / CNS)
- Primary and Community Care Links
- Pharmacist
- Radiologist

Specialist / Tertiary / Regional AOS Support

Other specialist services that may be available on site or available by referral to a tertiary centre, or run at a regional level with clear referral pathways.

- Specialist services for the management of Immunotherapy Toxicities e.g. Endocrinologist with a specialist interest in immunotherapy
- MSCC service and capacity to co-ordinate pathway
- MUO/CUP service and MDT
- Clinical Psychologist

Environment and Facilities

AO Teams need to have the space to deliver an appropriate service, virtual and digital capabilities and access to all IT systems to access and document patient notes. Access to confidential space to have sensitive conversations with patients and relatives, or about them as a broader team, is essential.

Education

Education for the AO Teams

AO Team members require a broad base of knowledge in acute cancer and palliative care and advanced communication skills. They also need capacity for service development and improvement, and the knowledge and skill to implement service improvement. Allocated time for study should be provided, particularly for 'Core Team' members.

Formal training is rapidly developing and available for AO staff and currently includes:

- Medical and clinical oncology higher training curriculum[28].
- Postgraduate modules for Acute Oncology.

Additionally, there are future aspirations for work-based learning, to allow development of knowledge and skills, agreed competencies, and formal assessment in practice.

There is existing national guidance for all levels of staff working within AOS which has been developed by UKONS[29]. This guidance provides a framework for the knowledge and skills required to fulfil role requirements in an AOS.

AO Education for Wider Healthcare Teams

AO care is also frequently provided by wide range of non-cancer specialists, so increasing awareness of AOS and clinical expertise is required. AO Teams should be allocated time within their job plans to support the education of colleagues working across other healthcare teams and settings (both primary and secondary care settings). This will help to develop knowledge and understanding in the management of AO patients and improve care for those patients accessing wider services.

[28] *Joint Royal Colleges of Physicians Training Board*. Available at: https://www.jrcptb.org.uk/sites/default/files/Medical%20Oncology%202021%20Curriculum%20FINAL.pdf

[29] UK Oncology Nursing Society (UKONS) and Macmillan Cancer Support. (2018). *Acute Oncology Knowledge and Skills Guidance*. Available at: https://www.ukons.org/site/assets/files/1134/ukon1905_skills_framework_-_updated_changes_18_07_19.pdf

The Acute Oncology Service

Delivering AO Principles 5 & 6:

5 Be configured to provide alternatives to admission, rapid assessment and diagnosis, and treatment on the same day where possible.

6 Ensure there are clear clinical pathways to and from primary care, urgent and emergency care, and other specialities, in order to enable effective and timely patient care.

The development of an AO Service Specification is an opportunity to reconsider traditional NHS boundaries, be it across hospitals, specialities, or between primary and secondary care. In particular, the AOS focus of patient care and aims align with Six Goals for Urgent Emergency Care, the Duty of Quality, and the principles of Value Based Healthcare. As Six Goals for Urgent Emergency Care pathways develop across Wales, there is an opportunity to realise benefits to cancer patients and families and ensure inclusion of their need in wider acute care developments. Centres in Wales are pioneering Same Day Emergency Care (SDEC) models for cancer care, and current experience suggests up to 50% of AOS patients may benefit from this approach. Up to 70% of AOS patients are in their last year of life, and the benefit of the SDEC approach is that it can reduce days spent in hospital, provide an opportunity for holistic assessment, and prevent re-admission through better onward care planning. Additionally, close integration of SDEC models with telephone triage services will support 'first place right time' and the scheduling of urgent care.

Health Boards / Trusts should enable access to SDEC)for AO patients, so staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the day of admission.

SDEC provision should enable:

- Cancer patients with urgent and emergency care to have routine access to SDEC within a general or oncology specific unit. Services should be accessible from primary, secondary care and telephone helplines.
- AOS teams to make digital referrals.
- Timely and appropriate radiological and diagnostic support.
- MDT 'Hot Clinics' and virtual wards which can lead to admission avoidance or early discharge.
- Closer working with surgical SDEC to develop streamlined pathways for a patient with a new cancer diagnosis.
- Staff access to clear pathways for high volume referrals and common presentations.
- Patients, carers and wider clinical teams to have access to up-to-date information concerning patient oncology treatment plans.
- Patients, carers and wider clinical teams to have access to up-to-date information on care plans at discharge.

Acute Oncology and 7 day working:

- Acute hospital sites should have access to core AOS teams on a daily basis from Monday to Friday, with built in cross cover and ability to review patients within 24 hours of referral. Ideally there should be digitally enabled alerts or referral to expediate rapid review. Sites or regions with high numbers of emergency attendances will likely benefit from extended working day arrangements for the team.
- Patients become unwell 24/7 and there is an expectation that Health Boards and Trusts are working towards solutions for extended working days and weekends. This is challenging, but regional working, virtual support, and the ability to provide safe discharge and follow up when teams are not on site would all be useful approaches. Development of a named AOS link in emergency departments and assessment units for each Health Board with a Type 1 Emergency Department, and agreed integrated clinical AOS pathways will strengthen 7/7 cover.

Acute Oncology Service and Acute Presentation of Cancer

At least one in three new cancer diagnoses are made in acute hospitals[30] and AOS have a key role in ensuring rapid and patient centred routes to diagnosis. Frequently, such patients have advanced disease so rapid diagnosis and decision making ensures active therapy is delivered where possible to help patients live longer with treatable cancer.

All patients should be managed on a National Optimal Pathway[31]. In many instances the diagnosis is clear cut and referral to the relevant site specific cancer team, surgical team or diagnostic procedure should be expedited. However, at times the primary diagnosis and most appropriate clinical pathway or team may be less clear.

AOS responsibilities for patients with an acute presentation of cancer include:

- Advising on management of clinical presentations of Malignancy of Unknown Origin (MUO).
- Advising where rapid access to treatment is time critical, for example lymphoma, germ cell tumours (male and female).
- Advising where early intervention will prolong life (e.g. ovarian cancer, myeloma, and melanoma).
- Advising where the benefit of treatment may be limited.
- Advising on rare presentations where diagnosis may be delayed i.e. Teenage and Young Adult (TYA) and sarcoma.

- Providing expertise on potential treatment options and their benefits, risks, and outcomes; underpinned by well-established links to site specific teams or senior oncology expertise. The aim here is to reduce the time spent in hospital, particularly for those who have limited time by providing ambulatory pathways (SDEC).
- Providing holistic support to patients and families during the process of diagnosis; acting as the key worker during admission and undertaking a full assessment of patient needs.
- Ensuring standardised pathways for common emergency presentations e.g. MSCC, Cancer Unknown Primary (CUP), malignant brain lesions, Superior Vena Cava Obstruction (SVCO), and hypercalcaemia of malignancy.
- Recognising the rapidly deteriorating or dying patient, addressing medical and holistic needs.

[30] *Risk factors and prognostic implications of diagnosis of cancer within 30 days after an emergency hospital admission (emergency presentation): an International Cancer Benchmarking Partnership (ICBP) population-based study*; The Lancet Oncology: Volume 23, Issue 5 (P-75600) - 2022. Available at: https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(22)00127-9/fulltext

[31] National Strategic Clinical Network for Cancer: Cancer Site Group; National Optimal Pathways. Available at: https://executive.nhs.wales/functions/networks-and-planning/cancer/workstreams/suspected-cancer-pathway

AOS, in particular MUO / CUP services, and Rapid Diagnosis Clinic (RDC) teams should work collaboratively to understand and review their respective pathways and consider where closer working may improve resilience and opportunities to provide a structured and more rapid route to cancer diagnosis to their populations.

Acute Oncology and Frailty

There is a rising incidence of cancer in an ageing population with multimorbidity requiring a multi-professional approach to care; frailty needs to be identified, and a comprehensive multi-professional geriatric assessment will help ensure future care needs are planned for and addressed, older cancer patients may present with atypical symptoms and have a higher risk of delirium.

A cancer diagnosis inevitably comes with additional drug therapy and reviewing medication to avoid risks of polypharmacy is important, particularly the benefits of long term preventative medications as patients approach last months of life. Early recognition of deterioration and frailty should be prioritised to reduce both the risk of admission, and the associated risks of deconditioning and current challenges of social care delivery. The role and expertise of the AHP workforce are essential in assessing and delivering frailty needs.

24/7 Triage and Advice for Systemic Anti-Cancer Therapies (SACT) and Radiotherapy Toxicities (24/7 cancer treatment symptom telephone triage services)

Systemic Anti-Cancer Therapies (SACT) and radiotherapy can result in distressing and potentially life-threatening toxicities. All SACT and radiotherapy services should ensure that patients have 24/7 access to specialist advice and triage of symptoms. Currently across Wales, services for SACT patients are provided by telephone triage, by each individual Health Board / Trust, and vary in approach and guidance. Consideration should be given to using novel communication methods, as this allows for more scope for the clinician to assess patient needs. There is now much opportunity around video consultation and telemedicine given the learning and advances since COVID-19.

The 24/7 cancer treatment symptom telephone triage services have a crucial role in admission avoidance by providing immediate management advice, or liaising with ambulatory care or community services with regards to alternative care pathways.

A comprehensive review of the 24/7 cancer treatment symptom telephone triage services is currently being undertaken by the National Strategic Clinical Network for Cancer and will provide further recommendations for the model across Wales. The key principles of the service should be:

1. All patients receiving SACT and radiotherapy should be given access to 24 hour telephone triage assessment and specialist advice about treatment related side effects.
2. All patients receiving SACT and radiotherapy should be given a clear explanation about what side effects they should be reporting.
3. 24/7 telephone triage for side effects should be provided for a period of six weeks after chemotherapy and / or radiotherapy and eighteen months after immunotherapy (checkpoint inhibitors).

4. Healthcare professionals working with patients who are acutely unwell following SACT and radiotherapy should also be able to access specialist advice via the triage line to support in the management of treatment related side effects.
5. The telephone triage staff should receive training and competency assessment in telephone triage using an approved cancer treatment symptom triage tool. Competency re-assessment should be regularly undertaken.
6. The telephone triage staff should have timely access to a multidisciplinary team of healthcare professionals to support with complex decision making.
7. There should be access to a range of guidelines for managing SACT and radiotherapy toxicities available to all staff managing calls to the triage line.
8. The telephone triage staff should have electronic access to information regarding the past medical history and treatment received by the patient.
9. Calls from patients who are experiencing side effects and the advice given, should be documented in their medical records.
10. Quality and safety standards should be agreed and monitored.
11. For patients that require an acute assessment, the telephone triage staff should be able to actively manage the pathway of care and triage into 'right place first time' following locally agreed escalation and referral pathways.
12. Processes should be in place to ensure patients receive follow up according to local / national protocols and guidance.
13. There should be a dedicated space to deliver the 24 hour telephone triage service, with the technical and digital resources and privacy to manage calls.

AOS Digital Systems, Data and Communication

Delivering AO Principles 7 & 8:

7 Ensure all relevant clinical information and patient records are available to all staff managing acute care episodes 24/7.

8 Ensure systems are in place to capture Acute Oncology activity and outcomes, including demand, length of stay, re-admission and survival following admission.

AO patients cross many services and systems, and the goal should be that information follows the patient. Digital systems are a key enabler to allow clinicians to work across boundaries. An AO admission is commonly linked to changes in treatment plans and prognosis. Clear communication between patients, their family and carers and care providers, can help reduce risk of further admission and enable better patient-centred decision making.

Clinical information and patient records must be available for all AO patients in a clear and understandable format for non-cancer specialists. This will enable informed decision making on the best course of treatment and patient care, and reduce error.

Services are required to adhere to the All Wales Cancer Minimum Reporting Requirements, covering both the Core and AOS datasets to enable the appropriate national cancer reporting. This supports cancer registration, cancer clinical audits, cancer waiting time reporting (suspected cancer pathway) and monitoring of quality outcome indicators for Wales.

Sharing Information Between Organisations and Across Systems

- The Welsh Clinical Portal (WCP) should allow sharing of records, including treatment plans, treatment intent, prognosis documentation, and importantly what is understood by the patient and their family. It is important to note that primary care staff do not routinely access WCP and so documentation may need to be shared with primary care colleagues by other means.
- Consideration should be given to developing systems to provide electronic alerts to primary, specialist and palliative care services when oncology patients are admitted or discharged.
- Comprehensive discharge summaries should be communicated with primary and secondary care colleagues to facilitate seamless ongoing care. Discharge summaries should include AOS decision making, plans for future care, any referrals made, interface with palliative care where appropriate, and direct contact details of the appropriate treating team. Discharge summaries should be sent to the patient's key primary care clinicians as the patient leaves the hospital, with the patient being offered a copy if possible. Information should include what the patient understands themselves and if this differs to what relatives and carers understand. If a Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) has been put in place a copy of the form should be attached to the discharge summary, a copy sent to the GP surgery, and a copy given to the patient. If the patient is to be followed up, it should be clear who this is to be with and the timeframe, and similarly if there is not to be follow up.

Quality Standards

Data Sets

Secondary and tertiary services are expected to capture data in line with the following:

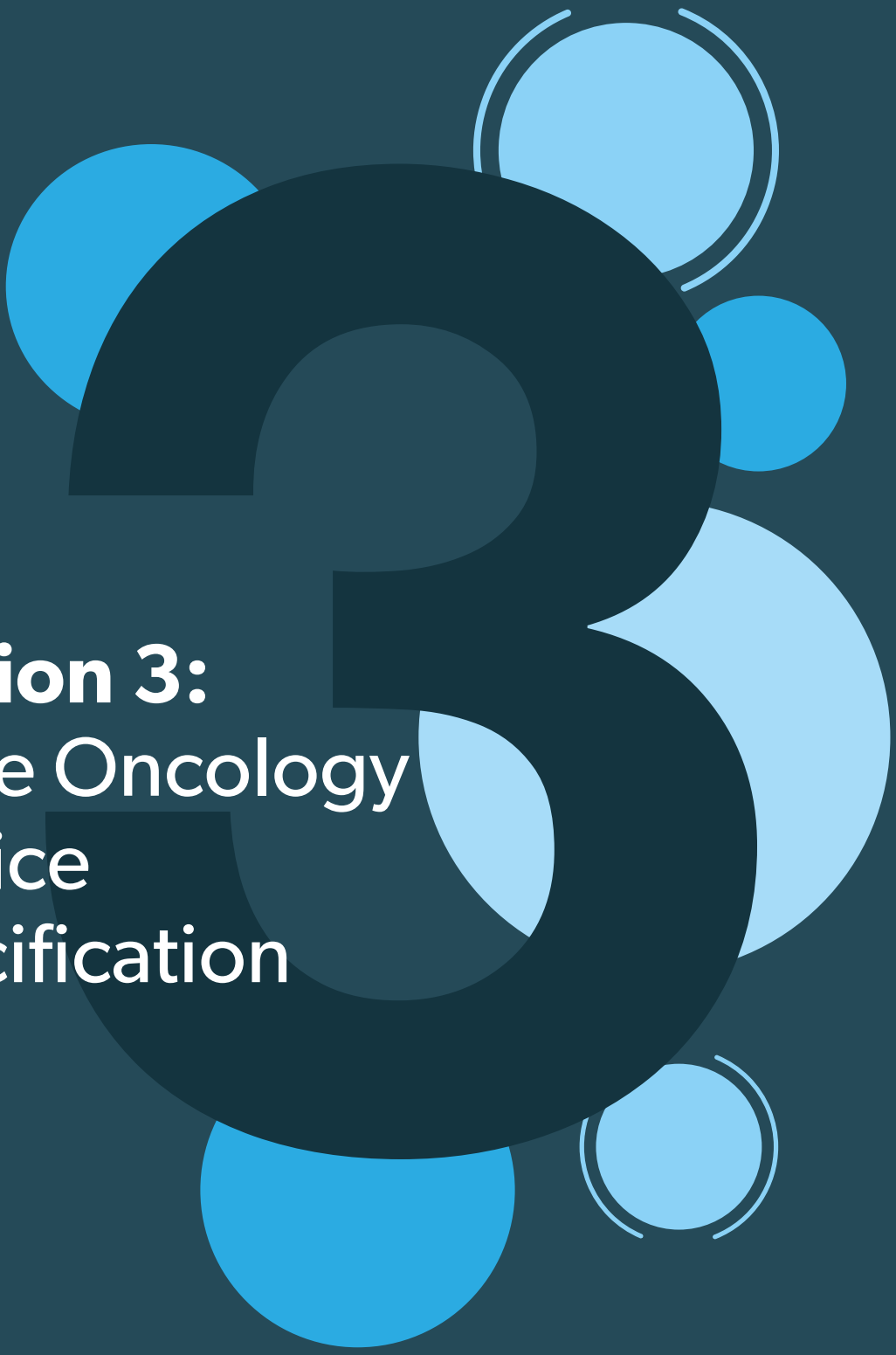
- National Cancer Data Standards for Wales – Core[32]
- National Cancer Data Standards for Wales – Acute Oncology Service (AOS)[33]

Currently there is no data system agreed with Digital Health Care Wales (DHCW) that can capture this data, and no timetable is available for when a data system can be implemented.

This significantly inhibits data collection, analysis monitoring and evaluation of AOS. The National Strategic Clinical Network for Cancer are leading work with DHCW to establish a timetable for establishing data flows for AOS into a central data repository. Currently, to ensure that accurate data is captured in a timely manner, teams depend on additional clinical and / or administrative support being made available to AO Teams.

[32] DHCW: Welsh Information Governance and Standards Board; National Cancer Data Standards for Wales – Core. Available at: https://dhcw.nhs.wales/information-services/information-standards/data-standards/data-standards-files/data-standard-change-notices-docs/dscns-2020/20200622-dscn-2020-06-core-reference-data-d2-3-pdf

[33] DHCW: Welsh Information Governance and Standards Board; National Cancer Data Standards for Wales – Acute Oncology Service (AOS). Available at: https://dhcw.nhs.wales/information-services/information-standards/data-standards/data-standards-files/data-standard-change-notices-docs/dscns-2020/20201210-dscn-2020-30-national-cancer-ds-aos-v1-0-pdf



Section 3: Acute Oncology Service Specification

This section outlines the minimum requirements for an Acute Oncology Service (AOS) for the NHS in Wales.

Services should be able to evidence that they meet these requirements and will be measured against them, as well as other relevant national standards, through Peer Review. These standards have the eight AOS principles themed throughout.

Best Patient Care / Person Centred Care			
Reference Number	**Quality Standard**	**Rationale**	**Evidence**
AOS01	**All acutely unwell cancer patients referred to the AOS Team should be seen, assessed and a plan of care developed within 24 hours of the referral.** *Referrals must be documented clearly on electronic patient administration system within 24 hours. Clinical plans must be developed, and detail be made available on electronic patient records.*	AOS patients waiting longer than a period of 24 hours could deteriorate quickly and may require admission. This potentially could be avoided by ensuring they are seen, assessed and a plan of care developed within 24 hours of the referral. Additionally, many AO emergencies are time critical (e.g. neutropenic sepsis, MSCC) and therefore acutely unwell cancer patients need to be seen and assessed quickly.	Time from admission to onward referral. Target is 100% within 24 hours. Evidence of referral guidelines or protocols in place i.e. Standard Operating Procedure (SOP) or referral pathway.
AOS02	**All patients with a new cancer diagnosis as an acute admission should be transitioned to the care of the appropriate tumour site team, in line with the National Optimal Pathways (NOPs), and the patient informed of next steps.** *For patients with new diagnosis, a clear plan must be communicated so they are clear who is responsible for feeding back the outcome of the MDT to them and when that will happen, what the plan for follow up is and who their contact will be in the interim, until they are seen by the site-specific team.*	NOPs support delivery of timely, effective, and patient-centred care.	Evidence that cancer pathway data demonstrates timely referral to tumour site team.

Reference Number	Quality Standard	Rationale	Evidence
AOS03	**All cancer patients that are admitted acutely unwell with a cancer related presentation should be given an opportunity to have their needs assessed and interventions or referrals made where appropriate.** *All patients' needs should be assessed using supported conversations / assessment tool e.g. holistic needs assessment or any other appropriate tool. Patient needs should be reviewed regularly, taking a patient-centred rehabilitative approach.*	Patients' needs should be assessed at regular intervals as defined in the National Optimal Pathways (NOPs), to ensure that they have no new unmet needs.	Evidence that patients' needs have been assessed and documented, either in writing or electronic format. Evidence of onward referral where necessary.
AOS04	**An AO Service should measure and respond to patient experience.** *Patient Reported Experience Measures (PREMS) should be captured through informal feedback, surveys, or digital platforms. AOS PREMS should focus on communication skills, feeling supported, and key worker.* *PREMS should be undertaken at regular intervals across the patient pathway as defined in the National Optimal Pathways (NOPs).*	Patient experience feedback is essential to assist in framing service improvement plans and inform shared learning.	Evidence of informal patient / carer feedback, surveys etc. Evidence that improvement plans are in place in response to PREMs review. Evidence of working across AOS in Wales to develop standardised PREMs.

The Acute Oncology Team

Reference Number	Quality Standard	Rationale	Evidence
AOS05	**AO Services should ensure that there is a funded 'Core AOS Team' in place.** *Roles include at least the following:* • *Consultant Clinical Lead for Service (medical or nursing)* • *Acute Oncology Nursing Team:* – *Clinical Nurse Specialist (CNS)* – *Advanced Clinical Nurse Practitioner (ACNP) and / or Nurse Team Leader* • *Consultant Oncologist. Palliative Care Consultant* • *Allied Health Professionals (AHPs)* • *AOS Coordinator* • *Administrative Support*	Through national consultation, these roles were identified as 'core' to an AOS Team and are required to deliver a robust multi-professional AO Service.	Evidence that all roles of the 'Core Team' are in place. Evidence of the roles and responsibilities in job descriptions and job plans. Evidence that teams have plans to flex capacity at times of increased pressure or absence i.e. a resilient AOS staffing model.
AOS06	**AO Services should have timely access to 'Associate AOS Team members' and 'Specialist/ Tertiary / Regional AOS Support'.** *Associate AOS Team members:* • *Palliative Care (Physician/ ACNP / CNS) if not in core team* • *Haematology if not in core team* • *Rapid access to radiotherapy services* • *Pharmacist* • *Radiologist* *Specialist / Tertiary / Regional AOS Support:* • *Specialist services for the management of Immunotherapy Toxicities* • *MSCC co-ordination* • *MUO/CUP service and MDT* • *Clinical Psychologist*	Through national consultation, these roles and services were identified as essential to deliver a robust AO support service.	Documented evidence of referral pathways / routes that AOS can use to access **'Associate AOS Team members' and 'Specialist/ Tertiary / Regional AOS Support'** (see Appendix 5 for details)

Reference Number	Quality Standard	Rationale	Evidence
Education and Training			
AOS07	**An AO Service should offer professional development to the team and wider organisation to increase the knowledge, skills and competency of their role and how healthcare teams within the organisation manage cancer patients who present acutely unwell.** *AOS should promote the UKONS Acute Oncology Knowledge and Skills Framework (or equivalent) to all members of the AO Team.*	An Acute Oncology Team should provide an education and training work programme that is inclusive of the team and wider organisation to increase knowledge, skills and competency within healthcare teams, to ensure consistent high quality care for cancer patients.	Evidence of continuous professional development (CPD) provided and undertaken. Evidence of an education and training work programme in place. Training needs analysis undertaken.

The Acute Oncology Service

Reference Number	Quality Standard	Rationale	Evidence
AOS08	**AO Services should have a Standard Operating Procedure (SOP) to describe the delivery model within their organisation.**	Services should have a clear delivery model which is accessible to colleagues across the organisation to ensure consistent care for patients.	Evidence of a SOP which includes the relevant criteria and information, including: • Access routes to the service • Clinical guidelines for use in acute admission units, ED, MAU and SAU • Referral pathways • Core and out of hours provision • Access to specialist advice and services • Safety netting for discharge.
AOS09	**All acute admission units, EDs, Assessment Units, SDEC and SAUs should have access to AOS.** *Hospitals with acute admission units, EDs, MAU and SAUs should have access to AOS seven days a week with hospitals with high emergency demand providing extended hours, based on demand patterns. There should be clear processes to access specialist AOS advice and safety netting to facilitate appropriate management of patients, including timely discharge.*	Services should have clear and timely access to AOS within their organisation to ensure acutely unwell cancer patients are given timely and effective care.	Evidence of core hours cover in job plans and rotas. Evidence of pathways and SOPs for the management of AOS patients out of core hours (this may include on call rotas for specialist AOS advice).

Reference Number	Quality Standard	Rationale	Evidence
AOS10	**Cancer patients with urgent and emergency care needs should have routine access to Same Day Emergency Care (SDEC) within a general or oncology specific unit.** *Pathways to SDEC should be available and accessible from primary, secondary care and 24/7 cancer treatment symptom telephone triage services.*	To provide rapid assessment, diagnosis and treatment on the day of admission. SDEC can reduce days spent in hospital, provide an opportunity for holistic assessment, and prevent re-admission through better onward care planning.	Documented evidence of referral pathways / routes that all acute sites can use for AOS patients to access SDEC services. Documented evidence of referral pathways / routes that primary care can use to access SDEC services for AOS patients. Documented evidence of referral pathways / routes that 24/7 cancer treatment symptom telephone triage services can use to access SDEC services.
AOS11	**All AO Services should have guidelines and pathways to support the management of cancer treatment complications.** *These should include at least the following:* • *Anorexia* • *Chemotherapy induced nausea and vomiting* • *Diarrhoea* • *Extravasation* • *Hypersensitivity reactions* • *Immunotherapy Toxicity* • *Mucositis* • *Neutropenic Sepsis* • *Skin Radiotherapy reactions* • *Tumour Lysis Syndrome*	To ensure acutely unwell cancer patients are given consistent, timely and effective care. Having clear and standardised guidelines and pathways that are readily available across the Health Board / Trust will mean that there should be no delay to the management of the cancer treatment complications.	Evidence that guidelines for the management of cancer treatment complications are in place, are updated, and are used by teams involved. UKONS guidelines are broadly accepted as a UK standard, and services can consider using these as a baseline to add in local nuances and governance arrangements, for example antibiotic use in sepsis and use of local sepsis bundle for neutropenic sepsis. *As national guidelines are agreed they will be made available via the National Strategic Clinical Network for Cancer website. When national guidelines have been agreed, services will be expected to work to this standard. Guidelines can also be accessed via the UK Acute Oncology Society (UKAOS) website*[34]*.*

[34] *UK Acute Oncology Society (UKAOS); Acute Oncology Guidelines*. Available at: https://www.ukacuteoncology.co.uk/information-hub/ao-guidelines

Reference Number	Quality Standard	Rationale	Evidence
AOS12	**All AO Services should have clear pathways or guidelines for the management of patients who present to AOS due to a complication of cancer.** *These should include at least the following:* • *Metastatic Spinal Cord Compression (MSCC)* • *Malignant Bowel Obstruction* • *Hypercalcaemia* • *Malignant Ascites and Malignant Pleural Effusion (including provision of indwelling catheters)* • *Superior Vena Cava Obstruction (SVCO)* • *Raised intracranial pressure due to malignant lesion* • *Cancer Associated Thrombosis (CAT)* • *Autonomic Dysreflexia.*	To ensure consistent, timely and effective care. Having clear and standardised guidelines and pathways that are readily available across the Health Board / Trust will mean that there should be no delay to the management of patients who present due to a complication of cancer.	Evidence that guidelines for the management of patients who present to AOS due to a complication of cancer are in place, are updated, and are used by teams involved.
Metastatic Spinal Cord Compression (MSCC) service in secondary care			
AOS13	**Adults with suspected MSCC who present with neurological symptoms should have an MRI of the whole spine and any necessary treatment plan agreed within 24 hours of the suspected diagnosis.** *NICE Guidelines (National Institute for Health and Care Excellence (NICE), 2023)*[35]	Adults with suspected MSCC who present with neurological symptoms or signs need rapid access to imaging that will accurately identify spinal cord compression. Whole-spine MRI is central to the diagnosis, staging and planning of treatment. Neurological deficit at initial presentation is an important predictor of long-term functional outcome. To reduce the risk of avoidable disability for adults with suspected MSCC, it is important that both an MRI is performed and treatment is planned by senior clinical advisers, within 24 hours of the suspected diagnosis.	Audit of all MSCC patients against NICE guidelines measure. Evidence of referral pathways to spinal surgical opinion to facilitate development of an appropriate and timely treatment plan.

[35] National Institute for Health and Care Excellence (NICE). (2023). Spinal metastases and metastatic spinal cord compression {NG234]. Available at: https://www.nice.org.uk/guidance/ng234

Reference Number	Quality Standard	Rationale	Evidence
AOS14	**Adults with MSCC, who present with neurological symptoms or signs, should start definitive treatment (if appropriate) within 24 hours of the confirmed diagnosis.** *NICE Guidelines (National Institute for Health and Care Excellence (NICE), 2023)*[36]	Treatment while patients are still able to move or walk is effective in maintaining their ability to walk and functional independence. Delay in treatment may have irreversible consequences, such as loss of motor and bladder functions. Starting definitive treatment as a matter of urgency is important for adults with MSCC because it will prevent further neurological deterioration, which may lead to paraplegia. People who develop paraplegia have a significantly impaired quality of life and shortened survival, and so it is important to identify possible ways of preventing or improving the outcome of MSCC.	Evidence of local arrangements and written protocols to ensure that adults with MSCC who present with neurological symptoms or signs start definitive treatment (if appropriate) within 24 hours of the confirmed diagnosis. Proportion of adults with MSCC who present with neurological symptoms or signs who start definitive treatment (if appropriate) within 24 hours of the confirmed diagnosis (audit).
AOS15	**Adults with MSCC should have a management plan that includes an assessment of ongoing care and rehabilitation needs.** *An assessment that considers all aspects of a person's wellbeing, their spiritual, cultural, and health and social care needs. Undertaking a holistic needs assessment ensures that the person's concerns and problems are identified so that support can be provided to address them.* *NICE Guidelines (National Institute for Health and Care Excellence (NICE), 2023)*[37]	It is important that personalised management planning for adults with MSCC starts on admission because rehabilitation and supportive care are integral to the promotion of independence and quality of life for adults with MSCC. Therefore AOS Teams need clear access to AHPs as members of the Core Team to support rehabilitation needs. Communication between secondary, primary and tertiary care needs to ensure a seamless transfer between services and continuity of care for patients.	Evidence of local arrangements and written protocols to ensure that management planning for adults with MSCC includes an assessment of ongoing care and rehabilitation needs. Proportion of adults with MSCC who are discharged from hospital with a management plan that includes an assessment of ongoing care and rehabilitation needs.

[36] National Institute for Health and Care Excellence (NICE). (2023). Spinal metastases and metastatic spinal cord compression [NG234]. Available at: https://www.nice.org.uk/guidance/ng234

[37] National Institute for Health and Care Excellence (NICE). (2023). Spinal metastases and metastatic spinal cord compression [NG234]. Available at: https://www.nice.org.uk/guidance/ng234

Reference Number	Quality Standard	Rationale	Evidence
Malignancy of Unknown Origin (MUO) and Carcinoma of Unknown Primary (CUP) service			
AOS16	**All patients presenting with MUO / CUP should have prompt referral to a weekly CUP MDT. This should align to the MUO / CUP National Optimal Pathway (NOP).** *Local protocols need to be in place to support discussion at specialist/ regional MDT.* *It is imperative that a referral to an MDT does not delay the judgement of the responsible clinician.*	To ensure that patients are moved through the diagnostic pathway as promptly as possible and to allow a plan of care to be put in place. This process should reduce the time taken to diagnose MUO patients and get them to the appropriate specialist team as quickly as possible.	Evidence of a Standard Operation Procedure (SOP) or pathway which describes the process to refer MUO / CUP patients to the specialist/regional MDT.
AOS17	**Health Boards and Trusts should provide access to outpatient care pathways for patients presenting with MUO/CUP (based on imaging results) who do not require admission.** *Clear communication with primary care colleagues is required to raise awareness of the pathways.*	To ensure equity of access for all patients presenting with MUO / CUP and prevent unnecessary admission or delay in further diagnostics or treatment.	Evidence of clear outpatient pathways for patients presenting with MUO / CUP. Audit of a selection of patient pathways.
AOS18	**For patients presenting with MUO / CUP who subsequently receive a cancer site diagnosis, the NOPs are followed and Cancer Waiting Times (CWT) reported.**	NOPs support delivery of timely, effective, and patient-centred care.	Evidence provided from NOP and cancer pathway data.

Reference Number	Quality Standard	Rationale	Evidence
Immunotherapy			
AOS19	**Guidelines for the recognition and management of immunotherapy toxicities should be readily available for all staff managing patients presenting unwell following immunotherapy.** *Guidelines should include:* • *Diarrhoea* • *Pneumonitis* • *Endocrinopathies* • *Neuropathies* • *Myositis* • *Renal* • *Hepatitis* • *Skin* • *Cardiovascular* *Guidelines should be electronic and cover the full range of immunotherapy toxicities and use of steroids, and should be made available to wider teams (i.e. emergency care teams, primary care).*	To ensure consistent, timely and effective care, regardless of where the patients present. Having clear and standardised guidelines and pathways that are readily available across the Health Board / Trust will mean that appropriate and evidence based care will be provided and without delay.	Evidence that guidelines for the recognition and management of immunotherapy toxicities are in place, updated, and are being used by those involved.
AOS20	**Standard Operating Procedures (SOP) or referral pathways should be available in each Health Board / Trust for access to a range of clinical specialties required for immunotherapy toxicity management.** *These will include gastroenterology, respiratory physicians, endocrinology and cardiology.*	To ensure consistent, timely and effective care. Having a clear SOP and / or standardised guidelines and pathways that are readily available across the Health Boards / Trust will mean that there should be no delay in accessing specialist advice and specialist care for AOS patients with immunotherapy toxicities.	Evidence of a documented SOP or referral pathway.

Reference Number	Quality Standard	Rationale	Evidence
AOS21	**All services offering immunotherapy should have a designated immunotherapy clinician with allocated time in their job plan.** *This role must be held by an expert practitioner with extensive experience in immunotherapy management.*	Through national consultation, this role was identified as essential to deliver a robust AO Service. Having a designated immunotherapy clinician will enable early recognition of immunotherapy toxicities to better manage patients on immunotherapy treatments which will improve outcomes, and reduce emergency admissions.	Evidence of dedicated roles for immunotherapy, with evidenced sessions in job plans.
24/7 Cancer Treatment Symptom Telephone Triage Services			
AOS22	**Patients receiving SACT and radiotherapy should be given access to 24 hour telephone triage assessment and specialist advice about treatment related side effects** *Patients should have access to this support throughout their active treatment, and for a period of six weeks after chemotherapy and radiotherapy, and eighteen months after immunotherapy. After this period patients should be signposted to other services.* *See 24/7 Triage and Advice for Systemic Anti-Cancer Therapies (SACT) and Radiotherapy Toxicities (24/7 cancer treatment symptom telephone triage services) for full details.*	Systemic Anti-Cancer Therapies (SACT) and radiotherapy can result in distressing and potentially life-threatening toxicities. These services ensure that patients have 24/7 access to specialist advice and triage of symptoms. The 24/7 cancer treatment side effect telephone triage service has a crucial role in identifying those who need urgent clinical assessment as well as those who can be given self-care advice to manage symptoms safely at home. SACT and radiotherapy patients may be managed through a combined SACT / radiotherapy telephone triage service or by separate telephone triage services. Treatment related toxicities may be evident for 4- 6 weeks post chemotherapy and radiotherapy but may occur up to 18 months following checkpoint inhibitor immunotherapy.	Evidence that the cancer treatment symptom telephone triage line is in place with 24 hour arrangements. Evidence that patients are given a 24 hour contact number.

Reference Number	Quality Standard	Rationale	Evidence
AOS23	**Health Boards and Trusts should enable access to 24 hour telephone support for health care professionals (primary and secondary care) to enable them to manage treatment related side effects.** *Healthcare professionals without specialist cancer treatment knowledge should be able to access information and advice for the management of cancer treatment toxicities.* *If advice is required for anything other than the management of treatment related side effects the telephone triage service is not the appropriate route of contact.* *Services should ensure that that the contact information for the triage lines is shared widely across primary and secondary care.* *See 24/7 Triage and Advice for Systemic Anti-Cancer Therapies (SACT) and Radiotherapy Toxicities (24/7 cancer treatment symptom telephone triage services) for full details.*	The 24/7 cancer treatment side effect telephone triage service can provide other health care professionals (e.g. GP, Physiotherapist, district nurse) with advice for the management of treatment related side effects. This will enable the best and most appropriate care for cancer patients with distressing and potentially life-threatening toxicities.	Evidence that health care professionals routinely have access to the triage line.
AOS24	**The telephone triage staff should have rapid electronic access to information regarding the medical history and treatment received by the patient.**	Information about co-morbidities, results of blood tests and scan results as well as the cancer treatment received will inform a comprehensive, safe, and appropriate triage and advice at the point of call.	Evidence that the telephone triage staff have electronic access to up-to-date patient records (audit).

AOS Digital Systems, Data and Communication

Reference Number	Quality Standard	Rationale	Evidence
AOS25	**AOS Teams should capture data in line with the agreed Acute Oncology Services (AOS) Data Standards.** *These include the All-Wales Core Cancer Minimum Reporting Requirements and the Acute Oncology Service (AOS) Data Standards.*	Services are required to adhere to the All Wales Cancer Minimum Reporting Requirements, covering both the Core and AOS datasets to enable the appropriate national cancer reporting. This supports cancer registration, cancer clinical audits, cancer waiting time reporting (suspected cancer pathway) and monitoring of quality outcome indicators for Wales	Evidence of captured data in line with the Acute Oncology Services (AOS) Data Standards[38].
AOS26	**The primary cancer treating team should be informed within 24 hours of a patient's admission or assessment by the AO Team.** *There should be a system in place to capture and record the relevant details about a patient care episode in a timely way and make them available to all clinicians involved in a care pathway.*	To support safe, seamless care for patients throughout their cancer journey, as all appropriate teams will have access to up to date and relevant information regarding patients care.	Evidence that communication with the primary cancer treating team is routinely undertaken following an acute admission.
AOS27	**On a patient's discharge, communication of any of the following should be sent to primary care (and accessible to secondary care):** • **new cancer diagnosis** • **advanced care plan / decisions** • **changes to treatment plans** *Formal processes for communication are in place and communication happens in a timely manner for safe transition of the patient's care. This should be electronic where possible (Welsh Clinical Portal (WCP), local Patient Administration Systems (PAS)).*	To support safe care for patients throughout their cancer journey, as all appropriate teams will have access to up to date and relevant information regarding patients care.	Evidence that processes are in place within Health Boards and Trusts for communication of all of these documents.
AOS28	**Referral methods to and from AOS should include electronic alerts, electronic referrals and direct clinical referrals.**	To facilitate rapid same day assessment, management of care and discharge for patients.	Evidence of a systematic referral system in place.

[38] DHCW: Welsh Information Governance and Standards Board; National Cancer Data Standards for Wales – Acute Oncology Service (AOS). Available at: https://dhcw.nhs.wales/information-services/information-standards/data-standards/data-standards-files/data-standard-change-notices-docs/dscns-2020/20201210-dscn-2020-30-national-cancer-ds-aos-v1-0-pdf

Section 4:
Appendices

Appendix 1:
Patient views and priorities

To inform the development of the AO Service Specification, patients and carers from across Wales were asked to respond to a brief survey in November 2022, asking:

1. If you were unwell as a result of a cancer or were experiencing a cancer treatment related problem and needed urgent medical assessment, what are the key things that would be important to you?

2. Have you or a close family member had any experience of needing urgent medical care as a result of cancer or cancer treatment?
   a. What went well during this episode?
   b. What could have been better?

3. Do you have any other comments / feedback relating to acute oncology services?

The findings of this survey have informed the content of this Service Specification.

Appendix 2:
Malignancy of Undefined Primary Origin (MUO) / Carcinoma of Unknown Primary (CUP)

Malignancy of Undefined Primary Origin (MUO) refers to a metastatic malignancy without a clear primary site which has been identified following a limited number of tests but before a comprehensive investigation. Carcinoma of Unknown Primary (CUP) refers to a metastatic epithelial or neuro-endocrine malignancy.

This can be a provisional CUP based on histology or cytology, where no primary site is detected following initial investigations but before specialist review and possible further specialised investigations; or a confirmed CUP based on final histology, where no primary site is detected following initial investigations, specialist review and further appropriate specialised investigations. CUP is the fourth most common cause of cancer death and over 10,000 CUP cases are diagnosed in England and Wales annually[39]. Patients who present acutely with a suggested primary site cancer should be signposted on to the appropriate site-specific cancer team for further investigations, support and management plans. Patients who are confirmed CUP should continue to be supported by the CUP team.

Common routes of referral for MUO / CUP patients

MUO / CUP patients are often referred in via Rapid Diagnosis Clinics (RDCs), Emergency Departments or Assessment Units, but many are also referred from primary care. It is vital that all Health Boards and Trusts provide pathways for patients presenting with MUO/CUP (based on imaging results) that do not require admission. Following diagnosis, CUP patients are often supported in the primary care setting in addition to the CUP teams in secondary care, therefore diagnosis notifications should be sent promptly to primary care after a patient's presentation.

The Cancer Network All Wales MUO / CUP Group has developed a National Optimal Pathway for MUO/CUP which will help streamline these referral processes and reduce the time to diagnosis and treatment (where appropriate) for CUP patients. The pathway will be published and formally reported against in 2023-24. Once approved and published, MUO and CUP patients should follow this pathway.

[39] *National Institute for Health and Care Excellence (NICE). Metastatic malignant disease of unknown primary origin in adults: diagnosis and management; Clinical guideline [CG104]. Published: 26 July 2010.* Available at: https://www.nice.org.uk/guidance/cg104

The CUP team and its functions

Each Health Board / Trust should have a CUP team that can take responsibility for MUO / CUP patients. Additionally, each CUP Team must have access to a regional CUP MDT. A member of the CUP team should also assess inpatients with MUO or offer specialist advice to the admitting team by the end of the next working day after referral. The CUP team should take responsibility for ensuring patients are discussed at the MDT (held weekly) and that a management plan exists which includes:

- any appropriate future investigations.
- symptom control with palliative care advice / presence in MDT.
- access to support and information via a named key worker.
- access to ongoing care pathways for patients who are appropriate to discharge.

Appendix 3: Metastatic Spinal Cord Compression (MSCC)

The following section has been aligned to the NICE Guideline [NG234] Spinal Metastases and Metastatic Spinal Cord Compression.

Metastatic spinal cord compression (MSCC) is defined as "spinal cord or cauda equina compression by direct pressure and/or induction of vertebral collapse or instability by metastatic spread or direct extension of malignancy that threatens or causes neurological disability"[40]. The exact incidence of MSCC in Wales is unknown because cases are not recorded systematically in the Cancer Registry. Macmillan report 3-5% patients with cancer may develop MSCC during their cancer journey[41].

For approximately 20% of patients with MSCC, cord compression is the first indication of them having cancer[42]. Public Health Wales reported approximately 20,000 patients diagnosed with cancer (excluding non-melanomatous skin cancer) in 2018. This equates to potentially 600-1000 cases of MSCC each year in Wales. With cancer incidence rising and advances in cancer treatments prolonging survival, this number is expected to rise in the coming years. A proportion of patients with MSCC present as a new diagnosis of cancer including both solid and haematological malignancy.

Early identification and referral of patients with MSCC is crucial in determining good patient outcomes and quality of life. Clinicians need to consider the possibility of spinal metastases or MSCC in patients with any of the following pain factors and signs and symptoms:

Pain Factors:

- progressive pain in the spine
- severe unremitting spinal pain
- mechanical pain (aggravated by standing, sitting or moving)
- spinal pain aggravated by straining (for example, when passing stools, when coughing or sneezing, or when moving)
- localised spinal tenderness
- nocturnal spinal pain preventing sleep
- claudication (muscle pain or cramping in the legs when walking or exercising)
- neurological symptoms: radicular pain, any limb weakness, difficulty in walking, sensory loss, or bladder or bowel dysfunction[43].

[40] *National Institute for Health and Care Excellence (NICE). Metastatic spinal cord compression in adults: risk assessment, diagnosis and management; Clinical guideline [CG75]. Published: 26 November 2008.* (Not published)

[41] *Macmillan Cancer Support; Malignant Spinal Cord Compression – Information for patients.* Available at: https://be.macmillan.org.uk/downloads/bemacmillan%20pdfs/MSCC_leaflet_New%20brand.pdf

[42] *Journal of Supportive Oncology; Assessment and Treatment of Patients with Malignant Spinal Cord Compression 2004 (p377-401).* Available at: https://pubmed.ncbi.nlm.nih.gov/15524067

[43] *National Institute for Health and Care Excellence (NICE). Metastatic spinal cord compression in adults; Quality standard [QS56]. Published: 27 February 2014.* Available at: https://www.nice.org.uk/guidance/qs56

Signs and Symptoms:

- bladder or bowel dysfunction
- gait disturbance or difficulty walking
- limb weakness
- neurological signs of spinal cord or cauda equina compression
- numbness, paraesthesia or sensory loss
- radicular pain.

Key principles in the assessment and management of MSCC include:

- Clinicians should ensure existing cancer patients receive information and advice regarding the signs and symptoms of MSCC to aid early diagnosis.
- All patients who present as potential MSCC who fit the criteria, should have a whole spine MRI and treatment decided within 24 hours (NICE 2023)[44].
- Planning for discharge and ongoing care, including rehabilitation, should be undertaken on admission to hospital.
- Treatment options will be individually decided but surgery, chemotherapy, radiotherapy, pharmacological management or best supportive care are the common treatment modalities.
- Access to rapid surgical decision making and surgery has been limited in Wales. With the establishment of the South Wales Spinal Network in 2023 this should be begin to address this in South Wales, but work will be required to ensure equity for patients in North Wales who access these services across the border.
- It is important that thorough exploration of the holistic impact on the patient is conducted with timely referral to relevant members of the MDT, including Allied Health Professionals (AHPs) s and palliative care. For many patients MSCC occurs in the last months of life.
- Physiotherapy expertise is required for the assessment and management of patients with MSCC but due to the functional, psychological and physiological implications, other AHPs including Occupational Therapists, Dietitians and Speech and Language Therapists may need to also provide timely access.
- All Health Boards and Trusts should have a MSCC guideline developed from the most up to date NICE guidelines. This should include access and indications for whole spine MRI, use of steroids and analgesia, guidance on role of radiotherapy and surgery, rehabilitation and palliative care.
- MSCC standards should be audited based on standards set by NICE.

Considerations for specialities and patient pathways include:

- Given the cross-speciality nature of MSCC, timely coordination of care is essential e.g. communication and input from spinal surgery, and information sharing.
- NICE Guidelines (2023) recommend that an MSCC Coordinator facilitates diagnostic tests and coordinates team involvement across primary, secondary and tertiary care[45]. The role of the MSCC Coordinator is currently not commissioned within Wales but it is listed as a role in gold standard in the NICE Guidelines[46].
- Clinicians at all levels need to be educated and skilled in recognition of the signs and symptoms of MSCC.
- When MSCC is the first sign of cancer, rapid access to biopsy is required and should not delay definitive treatment.

[44] *National Institute for Health and Care Excellence (NICE). Metastatic spinal cord compression in adults; Quality standard [QS56]. Published: 27 February 2014.* Available at: https://www.nice.org.uk/guidance/qs56

[45] *Macmillan Cancer Support and NSH West of Scotland Cancer Network; West of Scotland Guidelines for Malignant Spinal Cord Compression 2018.* Available at: https://www.woscan.scot.nhs.uk/wp-content/uploads/2013/08/Final-Published-WoS-Guidelines-for-Malignant-Spinal-Cord-Compression-v2.0.pdf

[46] *National Institute for Health and Care Excellence (NICE). Metastatic spinal cord compression in adults; Quality standard [QS56]. Published: 27 February 2014.* Available at: https://www.nice.org.uk/guidance/qs56

Appendix 4:
Cancer Associated Thrombosis (CAT)

CAT is a common complication of cancer and its treatments, and may convey significant symptom burden on patients. Due to the advances in oncology treatments patients are surviving longer with cancer with a subsequent increase in incidence of CAT. CAT affects up to 20% of cancer patients with treatment outcomes improved by early diagnosis and initiation of appropriate anticoagulation.

Anticoagulation has several goals which include the immediate stabilisation of the blood clot and prevention of clot extension, embolism and clot recurrence, while minimizing the risk of bleeding. In the general population, if left untreated, symptomatic Deep Vein Thrombosis (DVT) carries a 50% percent risk of Pulmonary Embolism (PE). Untreated PE is associated with a mortality of 30%, usually due to recurrent embolism.[47]

Appendix 5:
AO Team Roles

Consultant Clinical Lead for Service

Core AOS Team Members

All roles within the Core Team must be in place, with AO responsibilities stated in job descriptions and job plans.

This could be the Consultant Oncologist, Consultant Haematologist, Palliative Care Consultant, Consultant Nurse/AHP or other medical specialist such as Acute Medicine, with adequate training provided and dedicated time in their job plan for AO to provide day to day clinical support for the AO Team.

Acute Oncology Nursing Team

Acute Oncology nurses are the core of AOS Team. The scope of practice and responsibilities of the Acute Oncology nurse team will vary between different organisations depending on the configuration and requirements of local services. The nurse team will typically consist of Acute Oncology Cancer Nurse Specialists (CNS) and / or Acute Oncology Advanced Clinical Nurse Practitioners (ACNP), and each team of AO nurses should have a nurse team leader.

Clinical Nurse Specialist (CNS)

Key requirements for anAO CNS are:

- Providing safe holistic patient assessment in the acute setting and managing their own patient case load.
- Identifying a patient problem list, plan agreed care and outcomes, and assisting in implementing that care either directly or by providing expert advice to other healthcare professionals.
- Using advanced communication skills to liaise with patients, their carers and other appropriate health care professionals.
- Providing education for patients and their carers and for colleagues, thus supporting others to develop knowledge and skills.
- Evaluating the care they provide.

The CNS may sometimes also act as the keyworker for patients with CUP.

The AO CNS will be suitably trained Band 7 nurses working independently, with developmental roles at Band 6.

[47] *Ref; Noble S, Pease N and Chinn-Yee N, Oxford Textbook of palliative medicine 6th Edn. Oxford University Press.*

Advanced Clinical Nurse Practitioner (ACNP)

AO nursing is rapidly becoming an advanced clinical practice role, particularly where AO has developed in units with no, or only visiting, consultant oncologists. The title of Advanced Clinical Nurse Practitioner refers to a level of practice; they must be educated to Masters level (Credit and Qualification for Wales (CQFW) level 7) and assessed as competent in practice. Advanced Clinical Nurses represent a senior resource within the team and should have job plans and scopes of practice to maximise the use of their knowledge and skills.

The Advanced Clinical Nurse Practitioner works as an autonomous practitioner with the necessary knowledge, skills, education and experience to carry out holistic clinical patient assessment, take a clinical history, create a list of differential diagnosis, request and interpret investigations/diagnostics and prescribe any required medication. They will then refer onwards to other specialities as appropriate. The Acute Oncology Service Advanced Clinical Nurse Practitioner has admission and discharge rights within their organisation. They will formulate clinical decisions and complex treatment plans to manage acute admissions for patients who meet the AO criteria. Service development, education, and research/audit are also key components of the role. Due to the level of knowledge, training and experience required to fulfil an Advanced Practice Clinical Nursing role, posts should be banded as a minimum Band 7.

Nurse Team Leader

The Nurse Team Leader has responsibility for leading the AOS Service on a day-to-day basis and requires capacity in their job plans for strategic planning, leading and implementing service and professional development. This role will usually be undertaken by a nurse at Band 8 (minimum of Band 7).

Consultant Oncologist / Consultant Haematologist / Palliative Care Consultant

The Consultant Oncologist has the responsibility for safely assessing and managing the immediate and ongoing care of patients presenting acutely with complications of cancer and its treatment. This may be as direct patient care or as advisory part of the wider AOS Team pending local service need and configurations.

The Consultant Oncologist manages targeted investigation and rapid triage of patients presenting with a possible new diagnosis of malignancy, Malignancy of Undefined Origin (MUO) and Carcinoma of Unknown Primary (CUP). They liaise effectively with other specialist services as appropriate, regarding ongoing management. They assess the appropriate ceiling of care, taking the cancer context and the holistic patient assessment into account, and sensitively discuss this with the patient and their advocates. The Consultant Oncologist supports teams in decisions around end of life care and has experience in first steps of palliative care.

AOS span haematological and solid tumour patients. Haematological malignancies commonly present both as CUP (lymphoma) and MSCC (multiple myeloma and more rarely lymphoma). Clinical Haematology service configuration varies, but close working between AOS and Haematology is required, ideally with dedicated time from haematologists in the Core AOS Team.

Consultant Oncologist / Palliative Care Consultant sessions can be a combination of dedicated in-house sessions and virtual support to provide specialist cancer expertise. Additionally, capacity in job plans for leadership and training must be provided.

A Consultant Haematologist is ideally part of the Core Team but local arrangements may vary.

Immunotherapy Toxicity Lead

Immunotherapy, and in particular checkpoint inhibitors, have quickly changed the landscape of cancer care with the possibility of durable remissions in patients treated. An Immunotherapy lead clinician / team (depending on patient demand) is recommended with designated time in their job plan (either Oncology consultant, CNS or AHP).

Allied Health Professional (AHP)

AHPs include dietitians, occupational therapists, physiotherapists, speech and language therapists as well as and other relevant AHP specialities. Integrated and cohesive AHP involvement in AOS care is essential to reduce the complications of cancer and its treatment, and support for living with cancer. Early referral and access to these services is vital to holistic care, specifically to reduce a patient's length of stay, improve quality of life, maximise independence, and will also reduce care costs. AHPs should work alongside the nursing and medical staff providing timely, holistic assessment and intervention. Their role is to support early discharge, and to enable patients to live well in the community and remain as independent as possible.

The role of the AHP is also to:

- Provide expert care.
- Have continuous engagement with the MDT and share a joint vision of care.
- Incorporate a strategic approach to develop the AHP role and promote services.
- Ensure robust data collection (including PREMS and PROMS) and evaluation mechanisms.
- Adopt flexible working models which meet population needs.
- Provide and participate in education and research, embracing UK and international networking opportunities.
- Contribute to key governance and auditing processes including Peer Review.

AOS Coordinator

The role of the AOS Coordinator is to co-ordinate the work of the AOS Team to ensure there is effective and efficient co-operation between departments and directorates across the whole pathway for patients requiring AO input. They are vital members of the team who take responsibility for ensuring patients are efficiently navigated through the correct pathways. The AOS Coordinator is also responsible for ensuring all activities in relation to the AOS are recorded and validated in the appropriate information system.

Administration Support

All AOS teams should have administrative support to act as medical secretary for the team to maximise clinical time. This may be included within the AOS Coordinator role but may be required in addition, depending on the size of the AOS Team and/or number of AOS patients who are supported by the service.

Associate (Recommended) AOS Team Members

Clear referral pathways and prompt access to these staff is required to provide an effective AO Service.

Palliative Care (Physician / ACNP / CNS)

AO Teams and palliative care teams frequently work very closely together. In many situations an AOS admission marks a point when further active treatment options are limited or may confer minimal benefit. In these circumstances, following initial triage and assessment, palliative care will be the mainstay of care. The main benefits of palliative care are in holistic assessment of the physical, psychological, social and spiritual aspects of care as well as advanced care planning (ACP). ACP is a key part of patient care, especially in those whose aims are palliative (either having active palliative treatment or for best supportive care). Palliative care has been shown to reduce inappropriate emergency attendance or admission, especially at the end of life, and increase rates of achieving preferred place of death for patients. For others, living with still treatable but not curable cancer, proactive earlier involvement of palliative care, holistic support and early ACP is a key factor in helping to maximising quality of life, providing ongoing support, and avoiding inappropriate admissions.

Developing close working between palliative care (including hospice care), Same Day Emergency Care (SDEC) and AOS is essential to provide community access to investigations and treatment as day cases to facilitate symptom control, prevent escalation of medical issues e.g. hypercalcaemia, and prevent inappropriate acute admissions for palliative care patients. This should include those who are under/known to the oncology service but also those never known to the oncology service.

This will ensure equity of care across all patients with a cancer diagnosis irrespective of whether they are receiving active oncological treatment.

AOS capability within SDEC should be accessible for a wide variety of healthcare professionals through defined channels, including but not limited to GPs, district nurses, palliative care teams (community, hospital, oncological centre and specialist inpatient), dieticians etc. SDEC should be as close to home as practicable and have access to diagnostics and treatment to facilitate appropriate and timely interventions appropriate to the context of the person's phase of illness, and ACP wishes.

Mutual education and upskilling of AOS members by the palliative care team, and vice versa, will help improve and streamline the patient experience, along with improving confidence of non-palliative care teams in managing a person and their family holistically, and engaging in ACP discussions and appropriately setting ceilings of treatment. This should be factored into resource provision.

Rapid access to Radiotherapy Services

Patients with a diagnosis of metastatic cancer may benefit from palliative radiotherapy to relieve symptoms, including bone pain, bleeding and MSCC. In Wales the role of specialist palliative Radiographers is developing to enable quicker and more consistent access to palliative radiotherapy, and close working between AO Teams, palliative care and palliative radiotherapy teams supports timely and effective patient care.

Primary and Community Care Links

Most of a patient's journey through cancer happens in primary care. Cancer care can be a protracted and complex journey across many organisations, and it is important that patients are well informed and guided in what to expect from the whole process and supported through this journey. Evidence demonstrates that where patients are truly informed and engaged in planning and managing their care, experience and outcomes are improved. Primary Care colleagues need to have access to patient information, communication from secondary and tertiary care, and capacity to manage the patient. AOS need to work closely with primary and community care colleagues to upskill them, advise them of the role and benefit of AOS, and how they can support primary and community care colleagues to manage patients. As teams become firmly established, closer working with primary care clinicians should develop, for example to enable rapid triage in and out of acute care, establishing ambulatory care pathways for common presentations, and closer working with telephone triage services and virtual wards. Pre-emptive patient focused support and education can reduce risk of admission.

Pharmacist

Within secondary care, pharmacists play a key role in accessing supportive care medications at the right place and the right time for patients undergoing treatment for cancer. In acute care, pharmacy staff can identify patients who have received treatment for cancer and may well refer directly to AOS. They also have a role in the development of guidelines and pathways to support the delivery of high quality, safe and equitable care and treatment.

In primary care, community pharmacies are often the first place of contact for patients who may require the input of the AOS, particularly given the increasing availability and uptake of minor ailment schemes.

There is an opportunity to strengthen education within community pharmacies and raise awareness of red flag symptoms and referral pathways which could promote earlier intervention, particularly with respect to new or delayed drug toxicities.

Radiologist

Radiology expertise is critical to cancer management decisions, and AOS require ringfenced/timely access to radiologist capacity from dedicated sessions (for example as part of MUO/CUP MDT) to ensure the right expertise is available.

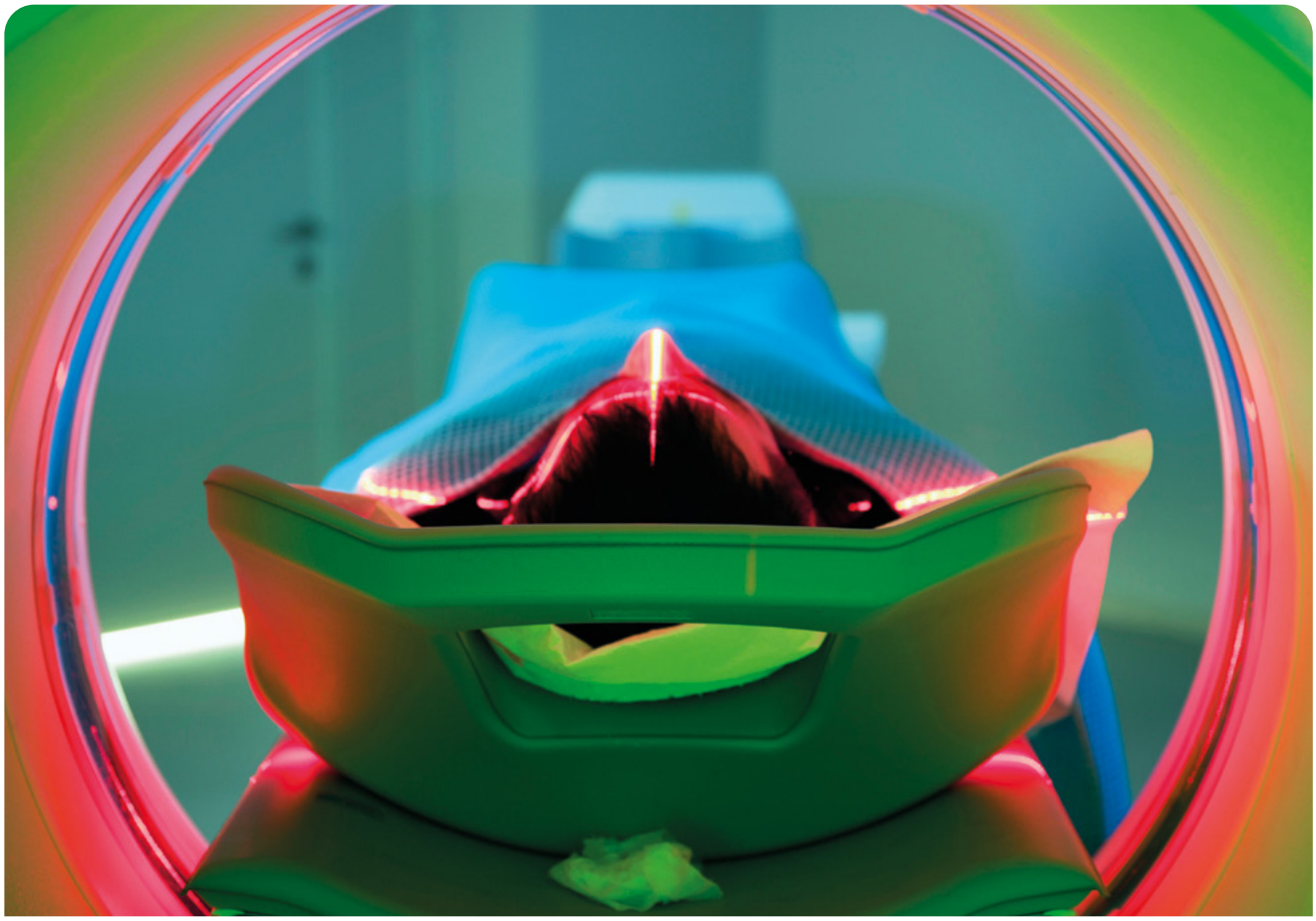
Clinical Psychologist

Most cancer patients will suffer social, emotional, and psychological distress as a result of cancer diagnosis and treatment. Psychological and emotional support can help address any mental health or wellbeing issues experienced by cancer patients during this difficult time.

Clinical Psychologists can provide specialist psychological assessment, intervention and support to cancer patients who have complex psychological needs. Clinical psychologists can offer a variety of psychological therapies, to manage feelings, worries, and living with uncertainty, and develop coping mechanisms.

In addition to helping patients, Clinical Psychologists can support staff by co-working, by offering advice, through teaching/training to provide psychological and emotional support to patients, and by escalating any complex psychological need cases to the Clinical Psychologist, ensuring the correct level of support can be provided to those who may require more complex assessment and care.

Case discussion, supervision, and consultation can be provided either on a one-to-one basis or in peer group meetings.



Specialist / Tertiary / Regional AOS Support

Other specialist services that may be available on site or available by referral to a tertiary centre, or run at a regional level with clear referral pathways.

Specialist Services for the Management of Immunotherapy Toxicities

Clear pathways to access advice on acute and chronic toxicity including endocrinology, gastro-enterology, hepatology, cardiology, dermatology, ophthalmology and respiratory are an essential pillar to AOS. Configurations will vary across Wales and upskilling generalist teams and virtual support may be appropriate.

MSCC Co-ordination

Robust MSCC Services are essential in the support of all cancer treatment pathways, but particularly for the support and advice for AOS Teams. There needs to be clear pathways in place for the coordination of MSCC diagnosis and care, and with timely (daily) access to radiology and reporting, spinal surgery, and radiotherapy. See Appendix 3 for further detail on MSCC pathways.

MUO/CUP Service and MDT

Robust MUO/CUP processes must be in place to ensure patients are referred to the CUP team in a timely manner. It is essential that there are clear and accessible pathways for appropriate patients to be discussed at MDT. See Appendix 2 for further detail on MUO/CUP Services.

Section 5: Authors and Contributors

Authors

Name	Role	Organisation
Dr Hilary Williams	AOS Clinical Lead	National Strategic Clinical Network for Cancer, NHS Wales Executive
Kayleigh Chainey	Cancer Treatment Programme Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dr Rosie Roberts	AOS Lead Nurse	National Strategic Clinical Network for Cancer, NHS Wales Executive
Claire Birchall	Cancer Network Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive

Contributors

Name	Role	Organisation
Amy Jordan	Macmillan Senior Project Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dr Angharad Treharne-Jones	SSC Medical Student	Velindre NHS Trust
Ann Jones	Senior Project Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive
Anne May	Strategic Lead Cancer Nurse	Aneurin Bevan University Health Board
Annette Beasley	Lead Cancer Nurse	Cardiff and Vale University Health Board
Anthony Cadogan	SACT Lead Pharmacist	National Strategic Clinical Network for Cancer, NHS Wales Executive
Bethan Hawkes	Macmillan Lead Cancer Nurse	National Strategic Clinical Network for Cancer, NHS Wales Executive
Bethan Ingram	TYA Interim Lead Nurse	Cardiff and Vale University Health Board
Brenda Basweti	Senior Project Support Officer	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dr Calum Forrester-Paton	Cancer Clinical Lead	Cwm Taf Morgannwg University Health Board
Dr Catherine Bale	Clinical Lead for the Cancer Treatment Programme and SACT Clinical Lead	National Strategic Clinical Network for Cancer, NHS Wales Executive
Cathryn Lewis	SACT Clinical Lead Macmillan Clinical Lead Occupational Therapist	Velindre NHS Trust
Dr Ceri Bygrave	Consultant Haematologist	Cardiff and Vale University Health Board

Name	Role	Organisation
Ceri Stubbs	Lead Advanced Nurse Practitioner, Acute Oncology	Velindre NHS Trust
Christine Sillman	Radiographer	Swansea Bay University Health Board
Claire Gilfillan	Clinical Nurse Specialist	Aneurin Bevan University Health Board
Clare Small	Regional Project Manager for SE Wales AOS	Velindre NHS Trust
Mr Conor Marnane	Cancer Network Deputy Clinical Director	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dawn Casey	Macmillan Lead Nurse for Cancer	Cwm Taf Morgannwg University Health Board
Dr Elaine Hampton	Macmillan GP Facilitator	Betsi Cadwaladr University Health Board
Elaine Penaluna	Acute Oncology CNS	Cwm Taf Morgannwg University Health Board
Dr Elise Lang	Macmillan GP Cancer Lead	Velindre NHS Trust
Emma Radford	Cancer Service Manager	Cardiff and Vale University Health Board
Erica Thornton	Allied Health Professional Cancer Lead	Cardiff and Vale University Health Board
Gail Povey	SACT Lead Pharmacist	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dr Gemma Eccles	Macmillan GP Cancer Lead	Swansea Bay University Health Board
Mr George Eralil	Consultant Neurosurgeon and Brain and Central Nervous System Cancer Site Group (CSG) Lead	Cardiff and Vale University Health Board / National Strategic Clinical Network for Cancer
Gina Beard	Lead Cancer Nurse	Hywel Dda University Health Board
Grace Robbins	Senior Project Support Officer	National Strategic Clinical Network for Cancer, NHS Wales Executive
Greg Pycroft	Policy and Public Affairs Manager	Tenovus Cancer Care
Helen Mcmillan	Clinical Nurse Specialist	Cardiff and Vale University Health Board
Hilary Wilderspin	Management Consultant	External Organisation
Ian Langfield	Associate Programme Director for Tertiary and Specialist Services Planning Partnership	Swansea Bay University Health Board

Name	Role	Organisation
Dr Idris Baker	Palliative Care Consultant	Swansea Bay University Health Board
Jacqueline Pottle	Allied Health Professional Therapy Cancer Lead	Betsi Cadwaladr University Health Board
Dr James Davies	Consultant, Palliative Medicine	City Hospice, Velindre NHS Trust
Jane Whittingham	Macmillan Oncology Nurse	Cardiff and Vale University Health Board
Jennifer Sharp	Cancer Treatment Project Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive
Jenny Stock	Programme Manager	Velindre NHS Trust
Jessica Morris	Cancer Treatment Project Manager	National Strategic Clinical Network for Cancer, NHS Wales Executive
Dr Jonathan Kell	Haematologist	Cardiff and Vale University Health Board
Dr Jo Mower	National Clinical Director, Unscheduled Emergency Care	National Collaborative Commissioning Unit
Karen Phillips	Deputy Head of Nursing	Swansea Bay University Health Board
Karen Wingfield	Acute Oncology CNS	Cwm Taf Morgannwg University Health Board
Kate Baker	Macmillan Head of Therapies	Velindre NHS Trust
Kate Williams	Macmillan Specialist Physiotherapist	Velindre NHS Trust
Kay Wilson	Acute Oncology Lead Nurse	Aneurin Bevan University Health Board
Kerrie Phipps	National AHP Lead for Primary and Community Care	Hywel Dda University Health Board
Louise Hymers	Macmillan Lead Nurse for Cancer and Palliative Care	Powys Teaching Health Board
Lowri Jackson	Head of Policy and Campaigns for Wales	Royal College of Physicians
Dr Mary Craig	GP Cancer Lead	Aneurin Bevan University Health Board
Melanie Barker	Assistant Director of Therapies and Health Science	Cwm Taf Morgannwg University Health Board
Melanie Simmons	Cancer Quality & Standards Manager	Swansea Bay University Health Board
Dr Najmus Sahar Iqbal	Clinical Oncologist	Velindre NHS Trust

Name	Role	Organisation
Nia Blackborow	Advanced Nurse Practitioner	Betsi Cadwaladr University Health Board
Dr Nikki Pease	Consultant in Palliative Medicine and Clinical Lead for Cancer Associated Thrombosis	Velindre NHS Trust
Olwen Williams	Vice President for Wales Academy of Medical Royal Colleges Wales	Wales Academy of Medical Royal Colleges Wales
Pat Evans	User Involvement Facilitator	Betsi Cadwaladr University Health Board
Rachel Evans	Macmillan Lead Cancer Allied Health Professional	National Strategic Clinical Network for Cancer, NHS Wales Executive
Rachel James	AOS Lead Advanced Nurse Practitioner (ANP)	Swansea Bay University Health Board
Rachel Lewis	Macmillan AHP Lead Cancer Rehabilitation	Hywel Dda University Health Board
Rebecca Griffiths	Clinical Nurse Specialist	Cardiff and Vale University Health Board
Rhian Collins	Macmillan Allied Health Professional Lead	Cwm Taf Morgannwg University Health Board
Rachel Lewis	Allied Health Professional Cancer Lead	Hywel Dda University Health Board
Dr Ricky Dylan Frazer	Medical Oncologist	Velindre NHS Trust
Dr Ruth Alcolado	Medical Director	NHS Wales Shared Services Partnership
Dr Ruth Williams	Respiratory Consultant	Cwm Taf Morgannwg University Health Board
Sally Jones	Macmillan Acute Oncology Specialist Nurse	Cardiff and Vale University Health Board
Sarah Grady	Acute Oncology CNS	Cardiff and Vale University Health Board
Dr Sarah Gwynne	Consultant Clinical Oncologist	Swansea Bay University Health Board
Sian Hughes-Jones	Head of Nursing	Betsi Cadwaladr University Health Board
Sian Lewis	Macmillan Lead AHP for Cancer Services	Aneurin Bevan University Health Board
Prof Simon Noble	Professor Supportive and Palliative Medicine	Cardiff University

Name	Role	Organisation
Dr Sonali Dasgupta	Consultant Oncologist / Cancer Network CUP Clinical Lead	Velindre NHS Trust / National Strategic Clinical Network for Cancer
Sophie Norton	Macmillan Acute Oncology Specialist Nurse	Cardiff and Vale University Health Board
Tim Davies	Head of Corporate Business	Cardiff and Vale University Health Board
Prof Tom Crosby	National Cancer Clinical Director for Wales	National Strategic Clinical Network for Cancer, NHS Wales Executive
Tracy Parry	SACT Lead Pharmacist	National Strategic Clinical Network for Cancer, NHS Wales Executive
Valerie Harris	Macmillan Immunotherapy Lead Nurse	Velindre NHS Trust

Glossary

AO	Acute Oncology
AOS	Acute Oncology Service
ACP	Advanced Care Planning
AHP	Allied Health Professional
ACNP	Advanced Clinical Nurse Practitioner
CAT	Cancer Associated Thrombosis
CNS	Clinical Nurse Specialist
CUP	Carcinoma of Undefined Primary
CWT	Cancer Waiting Times
DHCW	Digital Health and Care Wales
DNA CPR	Do Not Attempt Cardio Pulmonary Resuscitation
ED	Emergency Department
MAU	Medical Assessment Unit
MDT	Multi-Disciplinary Team
MRI	Magnetic Resonance Imaging
MSCC	Metastatic Spinal Cord Compression
MUO	Malignancy of Undefined Primary Origin
NICE	National Institute for Health and Care Excellence
NOP	National Optimal Pathway
PE	Pulmonary Embolism
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
QPI	Quality Performance Indicator
RCR	Royal College of Radiologists
RCP	Royal College of Physicians
RDC	Rapid Diagnosis Clinic
SACT	Systemic Anti-Cancer Therapy
SAU	Surgical Assessment Unit
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedure
SVCO	Superior Vena Cava Obstruction
TYA	Teenage and Young Adult
UKAOS	United Kingdom Acute Oncology Service
UKONS	United Kingdom Oncology Nursing Society
Cancer Network	National Strategic Clinical Network for Cancer
WCP	Welsh Clinical Portal

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Y Weithrediaeth
Executive