Acute Oncology Group
Hull University Teaching Hospitals NHS Trust
Queen's Centre

Acute Oncology Referral Guidelines 2019

Version Control

This is a controlled document please destroy all previous versions on receipt of a new version.

Review Date: January 2019

Version	Date Issued	Review Date	Brief Summary of Change	Owner's Name
1.0	July 2011	July 2013	Original draft	Network Acute Oncology Group
1.1	September 2011	August 2013	First Draft	Network Acute Oncology Group
1.2	September 2011	August 2013	Reviewed at NSSG	Network Acute Oncology Group
1.2a	January 2014	March 2015	Date Revised	Acute Oncology Clinical Expert Group
1.4	January 2017	January 2018	Date Revised	Acute Oncology Group HEY
2.0	May 2019	May 2021	Revised and No Change	AOG

Signature Sheet

Agreement of the Acute Oncology Referral Guidelines

These guidelines have been agreed by:	
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1. Introduction

These referral guidelines have been developed as a requirement to a number of national reports including the NCAG report, which has recommended that reform is required in the way urgent care is provided to patients with cancer.

The reports require all trusts with an Accident and Emergency (A&E) department to have an established Acute Oncology Service (AOS) by 2011.

The AOS brings together the skills and expertise of staff working in A&E, general medicine, oncology and palliative care. With an aim to provide timely management of acute treatment related to acute oncology presentation and to ensure that cancer patients / suspected cancer patients who are admitted as an emergency are assessed promptly and referred to the most appropriate team.

Acute Oncology encompasses the management of patients who develop complications from a consequence of their cancer diagnosis, present with complications from their cancer treatments, as well as the management of patients who present as an emergency with a previous undiagnosed cancer.

Figure 1 Acute Oncology Presentations

All of the following presentations are supported by individual management guideline.

<table>
<tr>
<td>
Those caused by systemic anti-cancer treatment (SACT).

Neutropaenic sepsis
Uncontrolled nausea and vomiting
Extravasation injury
Acute hypersensitivity reactions including anaphylactic shock
Complications associated with venous access devices
Uncontrolled diarrhoea
Uncontrolled mucositis
Hypomagnesaemia

The following, as caused by radiotherapy

Acute skin reactions
Uncontrolled nausea and vomiting
Uncontrolled diarrhoea
Uncontrolled mucositis
Acute radiation pneumonitis
Acute cerebral/other CNS, oedema.

</td>
<td>
The following as caused directly by malignant disease and presenting as an urgent acute problem. (This may refer to patients with known malignancy, whether or not they are picked up by the hospitals flagging system or not, or patients with previously unknown malignancy)

Pleural effusion
Pericardial effusion
Lymphangitis carcinomatosa
Superior mediastinal obstruction syndrome, including superior vena cava obstruction
Abdominal ascites
Hypercalcaemia
Spinal cord compression including MSCC
Cerebral space occupying lesion (s)

Any other cases where the A&E staff or acute Medical team decide an urgent oncology assessment is needed.
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The purposes of these AOS referral guidelines are to provide primary care clinicians and other hospital / services outside the Acute Oncology system with:

- Guidance on how and where to refer those patients who present with Acute Oncology complications.

These guidelines have been produced by the North East Yorkshire and Humber Clinical Alliance Acute Oncology Clinical Expert Group in consultation with acute trust clinicians working in acute medicine, surgery and oncology. They are applicable for the population of the North East Yorkshire & Humber Clinical Alliance area.

2. Background

The recent reports from National Confidential Enquiry into Patient Outcomes and Death 2008 (NCEPOD) and the National Chemotherapy Advisory group report 2009 (NCAG) have recommended the importance of reform in the way we manage those Cancer patients admitted as an emergency.

It recognises inpatient cancer care accounts for around 50% of all Cancer expenditure and that inpatient cancer care accounts for 12% of all acute in-patient bed stays. Inpatient admissions for cancer have risen by 25% over the past eight years, and are mostly related to emergency admissions. It is estimated that an average hospital will have 5 to 10 cancer patients admitted to A&E each week.

The NCAG report recommends that each trust should have defined Clinical pathways for the management and referral onwards for those patients who present with Acute Oncology emergencies into the A&E department.

3. Acute Oncology Service Provision:

The Hull & East Yorkshire Hospitals NHS Trust provides outreach oncology consultant support to the established acute Trusts Cancer units, services and site specific Multidisciplinary teams within HEY and for Cancer Units supported by the QCOH. General guidelines are produced with the involvement of the leads of the acute oncology teams of relevant hospital sites and adapted for local requirements.

There is an Acute Oncology Service in:

- Hull Royal Infirmary
- Castle Hill Hospital
- Scunthorpe General Hospital
- Diana, Princess of Wales Hospital, Grimsby
- Scarborough General Hospital

The Acute Oncology Group, with the 2 sites across the HEY, has agreed that the AOS service will have the following features:

- A&E protocols for the management of acute oncology emergencies and training for A&E and medical staff. (see Figure 1 Acute Oncology Presentations)
- Early review by oncology consultant within 24 hours of admission.
- Access to 24/7 Consultant Oncologist telephone on call service for health professionals.
- Fast track clinic access from A&E to an oncologist for those patients suspected with a cancer.
- A Flagging system that alerts Oncology/Cancer services that an acute oncology patient has presented for assessment.
- Direct transfer to Queen's Centre for all acute oncology admissions within HEY, depending on bed situation and patient condition safe to transfer.

In delivering the AOS model of care the expected outcomes are;

- To reduce the average length of stay,
- Less investigations carried out
- Less delay to definitive treatment or progression to specialist palliative care as appropriate.

This will improve upon the patients experience as well as creating potential efficiency savings.

Metastatic Spinal Cord Compression (MSCC) Services

Treatment of MSCC by radiotherapy / surgery is carried out at the Hull and East Yorkshire Hospitals NHS Trust (Hull Royal Infirmary – HRI & Castle Hill Hospital – CHH)
MSCC presentations are defined in Figure 2

4. Referral Procedure and Contact Details

All patients suffering from acute oncology problems related to radiotherapy may be referred directly to the Queen's Centre for Oncology.

Patients thought to be suffering from malignant spinal cord compression (MSCC) should be managed and referred as per the MSCC guidelines. MRI should be performed urgently within the admitting Trust if available and if positive, immediate referral should be made to the MSCC coordinator service in the Queen's Centre for Oncology at bleep 500.

Patients thought to be suffering from any of the complications of cancer as listed in Figure 1 but have not yet been formally diagnosed or seen by an oncologist should be referred through the acute medical teams in the geographically relevant hospital.

Patients suffering from acute oncology problems primarily related to systemic chemotherapy should be referred to the oncology unit where these treatments have been delivered.

Cancer patients not suffering from any of the problems listed above can be referred directly to the Queen's Centre for Oncology & Haematology or any of the local unit acute medical teams.

The AOS team of Specialist Nurses and Oncology Consultants will see patients within 24 hours of admission. Currently the AOS runs 7 days per week.

It is important to note that the AOS does not replace the current arrangements for emergency transfer of patients to the oncology centre and works alongside current arrangements for 24 hour telephone advice to health professionals from on call oncology consultants for oncology related problems.

Consultant Oncologist 24/7 Telephone On Call service:

Consultant Oncologist 24/7 telephone On Call service for urgent advice is available to Healthcare professionals via 01482 875875.

Patient contact:

Patients that have an identified Cancer/ Palliative care Key worker / Clinical Nurse Specialist / Advanced Nurse Practitioner can contact them between 9am and 5pm Monday to Friday. After hours and on weekends patients should contact their 24/7 chemotherapy helpline. This information including contact details is given directly to the patient.
This process is also discussed in the Guidelines for Chemotherapy telephone triage. Please press control and click on the following link:

All patients who present with a suspected or diagnosed acute oncology presentation can be discussed with the Acute Oncology Telephone on Call service.

Referral Contact Points

Referral can be made by phone call or faxed referral to:

Queen's Centre for Oncology CHH	Phone Number: 01482 875875 Bleep 500 Fax Number: 01482 461023
Princess Diana of Wales Hospital	Phone Number: 01472 875301 Phone Number: 01472 874111 Ext: 2569 Fax Number: 01472 875480
Scunthorpe Hospital (Ward 18)	Phone Number: 01724 290105 Phone Number: 01724 282282 Ext: 2263
Secretary direct dial	01724 290180 Fax Number: 01724 387823 or Internal 5312
Scarborough Hospital	Phone Number: 01723 342609

Fax Number: 01723 385360

HEY Consultant Oncologist On Call Telephone Line For Healthcare Professionals
(24 hour 7 days a week)

PHONE NUMBER 01482 875875

MSCC Coordinators

MSCC Coordinator	Site	Bleep Number
Nurse bleep holder	CHH	500

Care Pathway

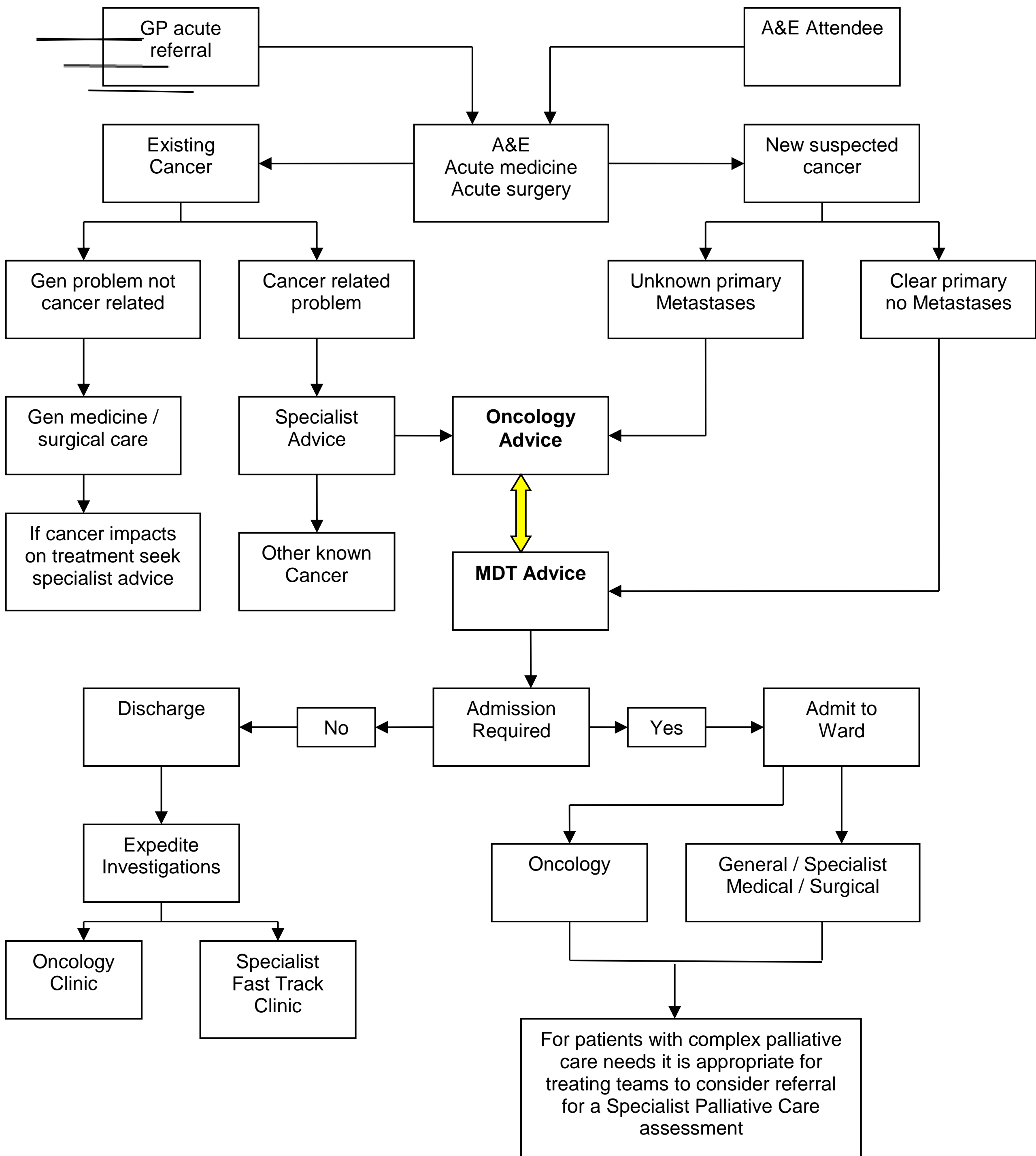


Figure 2 MSCC Presentations

(Reference: CG75 Metastatic spinal cord compression: Diagnosis and management of patients at risk of or with metastatic spinal cord compression. NICE 2008)

Contact the MSCC coordinator urgently (within 24 hours) to discuss the care of patients with cancer and any of the following symptoms suggestive of spinal metastases:

- pain in the middle (thoracic) or upper (cervical) spine;
- progressive lower (lumbar) spinal pain;
- severe unremitting lower spinal pain;
- spinal pain aggravated by straining (for example, at stool, or when coughing or sneezing);
- localised spinal tenderness;
- nocturnal spinal pain preventing sleep.

Contact the MSCC coordinator on bleep 500 immediately to discuss the care of patients with cancer and symptoms suggestive of spinal metastases who have any of the following neurological symptoms or signs suggestive of MSCC, and view them as an oncological emergency:

- neurological symptoms including radicular pain, any limb weakness, difficulty in walking, sensory loss or bladder or bowel dysfunction;
- neurological signs of spinal cord or cauda equina compression.

Figure 3 Children, Teenagers & Young adults pathway

IOG Key Principles

Who does this apply to?

- All patients aged 16-24 with cancer
- (2 age groups 16-18 years and 19-24 years)

What needs to happen?

- All patients aged 16-18 years inclusive should be referred to a Principal Treatment Centre (Young People) for treatment

- All patients aged 19-24 years inclusive should be offered referral to a Principal Treatment Centre (Young People) for treatment.

- All patients aged 16-24 years inclusive should be discussed at both a site-specific MDT meeting and a TYA MDT meeting.

- Referral of patients to a PTC (Young People), or review by both a site-specific and a TYA MDT should not be allowed to delay the start of urgent cancer treatment.

- For each patient, a lead medical clinician should to be identified, who will have overall responsibility for their treatment.

Ref: Children &Young People's Improving Outcomes Guidance - Implementation - August 2008

- Why?
  - The 2005 NICE IOG on Children and Young People mandates this model of decision-making and care (key principles)
  - These young people have particular needs in terms of communication, supportive care and environment of care, that are best served by referral
  - The particular spectrum of diseases between MDTs
  - This is what young people want to happen, when asked

- When does referral need to happen?

- As soon as you are aware of (or have a high suspicion of) a diagnosis of cancer & in time for the TYA team to be involved in decisions about pattern and place of care i.e. before the management plan is negotiated with the patient.

- How is this referral made?
  - Referral to be made using process agreed in the Standard Operating Procedure (Set up in conjunction with the York Cancer Network)

Standard Operating Procedure

http://www.ycn.nhs.uk/html/publications/guidelines_paediatric.php

Yorkshire & Humber Children and Young People's Cancer Network Children's Cancer (0-16) pathway – Version 1.2 (Jun 2010)

(excludes CNS tumours, bone sarcomas and retinoblastomas. Also excludes skin cancer which should follow the skin cancer referral pathway)

Humber and Yorkshire Coast Cancer Network

Yorkshire Cancer Network

Maximum timeline in days

Primary Care Assessment
GP/optician/community practitioner/secondary care specialist ©

Direct Referral

0

Urgent Referral ©
Urgent referral from GP/Dentist, with a suspicion of cancer.
Received by the Trust and given appointment within a working day.

14

First seen (Paediatrician) i ©
Undertake haematological investigations, biochemical investigations and imaging.
If index of suspicion is high, discuss with on call consultant in LTHT PTC, then refer to PTC.
For suspected solid tumours, if imaging has been carried out, send to PTC.
Family informed that referral is being made to PTC and to expect OPA within 5 days. (in writing or by telephone) or admission directly to the ward at the PTC (consultant decision)

Seen at Leeds Principal Treatment Centre (PTC) i a © ♦
OPA/in patient
Diagnostic investigations, imaging, biopsy, central line insertion

SMDT Review
Diagnosis confirmed
Treatment plan discussed and agreed with patient and care

31

First Definitive Treatment i a © ♦
Surgery/Chemotherapy/RT

Treatment in Shared care
Supportive Care and Chemotherapy

MDT Follow UP/Further Assessment

Second Line Treatment (if appropriate)

Follow Up i a © ♦
By PTC for 5 years then referral to late effects follow up protocol
Follow up in designated Paediatric Oncology Shared Care Unit (POSCU)*

Survivorship/End of Life Care

CNS support and patient assessment/ information offered at all appropriate stages of the patient pathway & YCN Supportive and Palliative Care Pathway followed

Quality Criteria

Criteria 1
Urgent referrals are usually made by phone call or fax followed up with a letter

Criteria 2
If leukaemia or lymphoma is probable, send bloods or tissue directly to HMDS.

Criteria 3
For lymphoma and leukaemia, fresh tissue to be sent from HMDS to cytogenetics.

Criteria 4
If diagnosis made by HMDS or haematologist before transfer, the results should be communicated with the family.

Criteria 5
For extracranial solid tumours all suspicious or unusual pathology for <16s, should be referred to LTHT paediatric pathology for specialist review immediately and within 5 days. Diagnosis made and/ or confirmed by PTC.

Criteria 6
All patients to be reviewed at PTC MDT, including pathology and imaging review.

Criteria 7
Consent for chemotherapy / clinical trials.

Criteria 8
Communication from PTC to referring clinician and GP informing of diagnosis and treatment plan.

Those who are long-term inpatients – monthly update
Those who are discharged – discharge summary within 3 weeks.

Criteria 9
Refer to late effects follow up protocol.

Criteria 10
Shared care provided in accordance with YCN protocols.

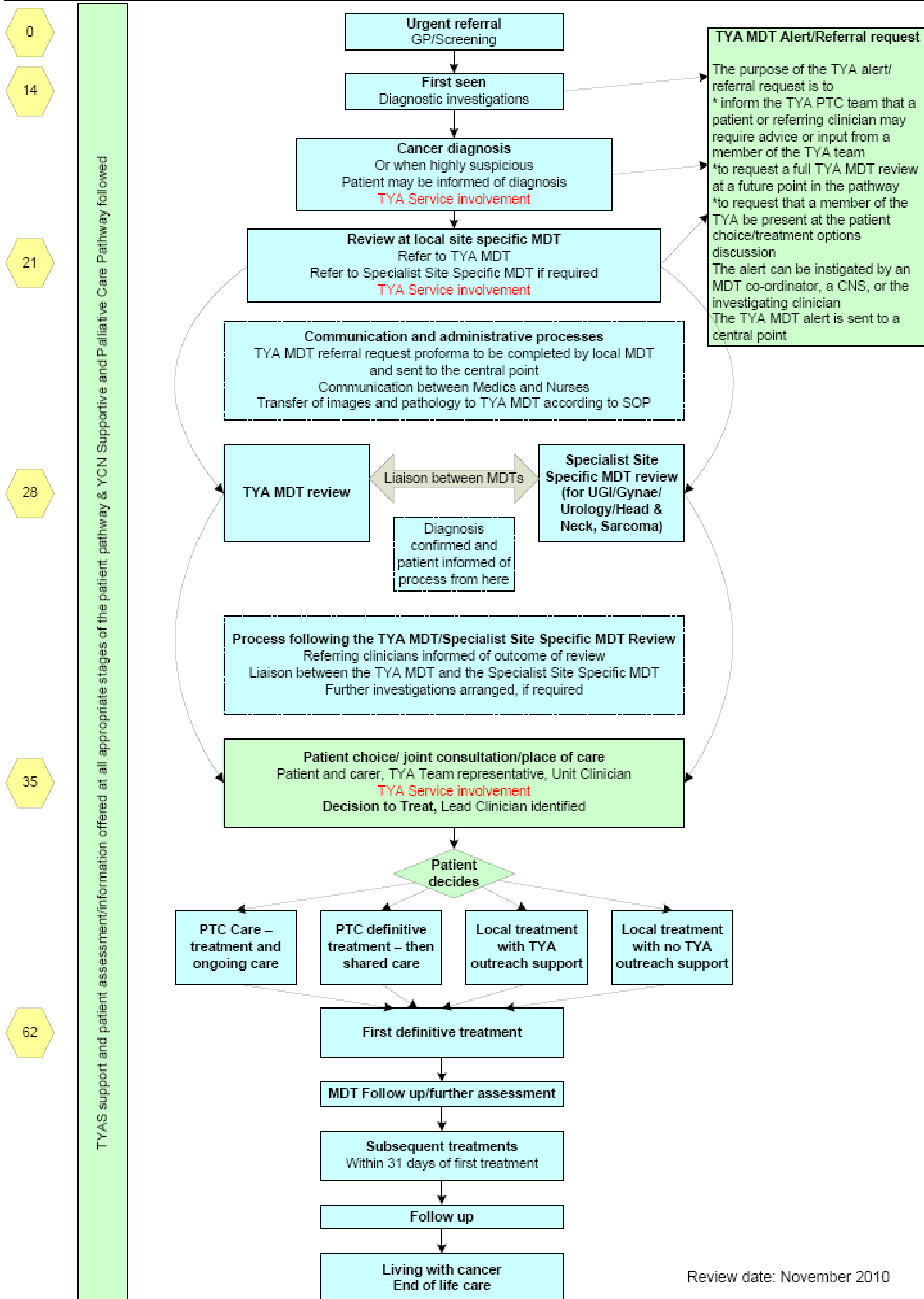
Criteria 11
Review at local shared care MDT.

REVIEW: June 2011

Key
- i Patient information
- a Holistic assessment
- © Key discussion point
- ♦ Single contact with key worker

Shared Care
* Designated POSCUs and Level of care in YCN are agreed by the Yorkshire and the Humber Specialised Commissiong Group, the PTC and the local Hospital. POSCUs in YCN are:

Airedale
Calderdale and Huddersfield and
York
Hull
Scarborough



Maximum timeline in days
YCN & HYCCN Teenage and Young Adult with Cancer Pathway 16-24
Version 1.0 (November 2009)
0
14
21
28
35
62
TYAS support and patient assessment/information offered at all appropriate stages of the patient pathway & YCN Supportive and Palliative Care Pathway followed
Urgent referral
GP/Screening
First seen
Diagnostic investigations
Cancer diagnosis
Or when highly suspicious
Patient may be informed of diagnosis
TYA Service involvement
Review at local site specific MDT
Refer to TYA MDT
Refer to Specialist Site Specific MDT if required
TYA Service involvement
Communication and administrative processes
TYA MDT referral request proforma to be completed by local MDT and sent to the central point
Communication between Medics and Nurses
Transfer of images and pathology to TYA MDT according to SOP
TYA MDT review
Liaison between MDTs
Specialist Site Specific MDT review (for UGI/Gynae/ Urology/Head & Neck, Sarcoma)
Diagnosis confirmed and patient informed of process from here
Process following the TYA MDT/Specialist Site Specific MDT Review
Referring clinicians informed of outcome of review
Liaison between the TYA MDT and the Specialist Site Specific MDT
Further investigations arranged, if required
Patient choice/ joint consultation/place of care
Patient and carer, TYA Team representative, Unit Clinician
TYA Service involvement
Decision to Treat, Lead Clinician identified
Patient decides
PTC Care – treatment and ongoing care
PTC definitive treatment – then shared care
Local treatment with TYA outreach support
Local treatment with no TYA outreach support
First definitive treatment
MDT Follow up/further assessment
Subsequent treatments
Within 31 days of first treatment
Follow up
Living with cancer
End of life care
TYA MDT Alert/Referral request
The purpose of the TYA alert/ referral request is to
* inform the TYA PTC team that a patient or referring clinician may require advice or input from a member of the TYA team
*to request a full TYA MDT review at a future point in the pathway
*to request that a member of the TYA be present at the patient choice/treatment options discussion
The alert can be instigated by an MDT co-ordinator, a CNS, or the investigating clinician
The TYA MDT alert is sent to a central point
Review date: November 2010