Trust Policy	Worcestershire Acute Hospitals NHS Trust

Acute Oncology Service (Same Day Emergency Care) Operational Policy

Department / Service:	Oncology – Acute Oncology Service
Originator:	Alison Jones Acute Oncology Service Lead
Accountable Director:	Jo Marriott, SCSD Divisional Director and Consultant Anaesthetist
Approved by:	• Specialised Clinical Services Quality Governance Committee *(For Information, Learning and Dissemination)* • Specialised Clinical Services DMT • Oncology Directorate Clinical Governance Group • Haematology & Palliative Care Clinical Governance Group
Date of approval:	27.09.23 SCSD Quality Governance Meeting 08.09.23 SCS DMT Business Approvals Meeting 21.07.23 Oncology Directorate Clinical Governance Meeting 19.07.23 Haematology & Palliative Care Clinical Governance Meeting
First Revision Due: This is the most current document and should be used until a revised version is in place	27th September 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All

Policy Overview:
The Acute Oncology Assessment Area is located on Laurel 2, Oncology Ward at Worcestershire Royal Hospital. It is a designated area for Haematology/Oncology patients who have been triaged by the Acute Oncology Service (AOS) as requiring urgent assessment. This policy also outlines the process needed when the Assessment Area is full or closed.

Key amendments to this document

Date	Amendment	Approved by:
27th Sept 23	New document approved	SCSD Governance Meeting

Contents page:

1. Introduction

This operational policy outlines the scope, protocols, escalations and work practices for the Acute Oncology Service Same Day Emergency Care (AOS SDEC) Assessment Area to be managed efficiently and effectively.

The Assessment Area has three Ambulatory Cubicle Assessment spaces (pods) and two chairs allowing for the Acute Oncology Nurse Practitioner Team to review and assess Oncology and Haematology patients with urgent acute oncological conditions.

The Assessment Area operates 7 days a week, 8.00am – 8.00pm. Patients will be accepted into the department from 8.00am – 5.00pm to allow for full and comprehensive assessment of clinical need.

2. Scope of this document

The Acute Oncology Service (AOS) provides specialist advice and expertise to manage patients who have received or are receiving Systemic Anti-Cancer Treatment (SACT) eg. chemotherapy or immunotherapy, other types of anti-cancer treatment such as radiotherapy, or patients who may be suffering from disease-related complications/conditions (ie. immunosuppression, hypercalcaemia, UKONS 2023).

The AOS Assessment Area (named as the AOS SDEC Haematology/Oncology Assessment Area) provides an assessment area on Laurel 2 for patients from across the county who require urgent review by the Acute Oncology Team. The working hours for this Assessment Area is 8.00am – 8.00pm, 7 days per week.

The AOS SDEC Service is managed by the Acute Oncology Nurse Practitioner Team. Patients may be seen by the Acute Oncology Nurse Practitioners, the Junior Doctors covering Laurel 2 and/or the Oncology/Haematology Consultants. Whilst in the Bay, they are cared for by the Nursing Team from Laurel 2. This has a positive impact on patient flow within the Trust where Oncology/Haematology patients are treated in the AOS Bay then transferred to Laurel 2/3 if admission is required and a bed is available.

Additionally, there is a Specialist Telephone Advice and Triage Service which is provided by a 24-hour Helpline on Laurel 3 at Worcestershire Royal Hospital. This Service uses the UKONS Triage Assessment Tool to evaluate patients who are receiving or who have recently received SACT or immunotherapy (UKONS 2023). This line will offer advice and support; some patients will require further physical assessment in the AOS SDEC.

This pathway has also been proven to reduce admissions to the Emergency Department (ED). AOS provides both medical and specialist nurse interventions for the majority of cancer patients across the Trust. The service ensures that patients who have complications from their treatment have rapid access to care at Worcestershire Royal Hospital. It also provides advice and guidance to other specialties ensuring that patients have appropriate and timely treatment.

However, due to limited capacity, there are times that patients cannot attend the Assessment Area as it is either full to capacity, or when patients attend out of the Assessment Area opening hours. There is no separate waiting area for patients to wait to either to be reviewed or wait for results. This is due to limited space on Laurel 2. Patients will be advised to attend ED or the Medical SDEC if open. Unassessed unwell patients cannot wait in the AOS SDEC area out of hours as there is no Oncology/Haematology on site medical cover for this area overnight. Medical cover is reliant on out of hours hospital cover. It would be a clinical risk to all patients to wait without an assessment.

The Acute Oncology Nurse Practitioner Team currently provide the service 7 days a week between the hours of 8.00am to 6.00pm. The Junior Doctors from Laurel 2 and Laurel 3 cover the AOS SDEC, alongside patients on both wards until 8.00pm, 7 days a week.

The Emergency Acute Oncology Helpline Service, staffed by Laurel 3 nursing staff, covers out of hours 7 days a week for patients between 6.00pm and 8.00am. Laurel 3 staff are rostered to attend ED to solely manage patients with suspected neutropenic sepsis. This aims to ensure a seamless service for patients at all times, in order to meet the Door to Needle Time receiving antibiotics, and treatment for neutropenic sepsis following Systematic Anti-Cancer Therapy (SACT). All other patients that are advised to attend ED are referred to the Medical Registrar by Laurel 3 Helpline staff, (refer to 3.1 exclusion criteria).

Staff will inform the ED of unwell suspected neutropenic sepsis patients asked to attend the ED. This can be done by either contacting the Triage or SIAN area or bleeping the ED Co-ordinator on Bleep 419 or ED Matron on Bleep 777 at Worcestershire Royal Hospital. Staff will contact the Co-ordinator at the Alexandra Hospital on ext 44200 or 42116 (or alternative via Switchboard).

The Out of Hours' Helpline staff on Laurel 3 should be contacted on Bleep 398 when a suspected neutropenic sepsis patient arrives on site, either in the Department or in an ambulance. Staff are provided with a high-vis jacket to wear if they need to attend to patients waiting in an ambulance.

3. A statement of function

The AOS SDEC Bay is located on Laurel 2. It has capacity to assess up to five patients at any one time. The area will be supported by the Acute Oncology Nurse Practitioners and medical cover. The medical cover will comprise of Laurel 3 doctors for Haematology patients and Laurel 2 doctors for Oncology patients. The Oncology Consultant or Haematology Consultant on-call are also available for advice.

The majority of patients attending will have been triaged by the Acute Oncology Helpline, but countywide admissions from other routes such as Out-Patient areas ie. chemotherapy and radiotherapy departments, clinics, and GP/CNS referrals also occur.

Patients attending for assessment will meet the following criteria:

- Receiving or have received SACT within the last 6 weeks or immunotherapy (for up to one year)
- Patients who may be suffering from disease related complication/conditions (eg. neutropenic sepsis, hypercalcaemia).

Any patient that presents to ED having not been referred in by the Emergency Helpline must be discussed with the Acute Oncology Team prior to transfer to the AOS SDEC. There are exclusions for admission to the AOS SDEC where patients would be directed to ED. A list of exclusion criteria of patients not deemed appropriate for the area is provided in 3.1.

Treatment and management of the acute complaint will be provided and the patient will be either discharged or admitted following medical review between 9.00am – 5.00pm. After 5.00pm this may be via a telephone discussion with the Consultant on-call or review by the Junior Doctor covering both Laurel 2 and Laurel 3 up to 8.00pm.

In the event that a patient attending the AOS SDEC requires admission, the following pathways will be followed:

- The Nurse in Charge of Laurel 2 (Oncology) and Laurel 3 (Haematology) will be asked to identify a bed.
- A review or discussion via telephone by a senior grade doctor will have taken place and a plan for on-going care made.
- If the Trust is on Level 4, patients can be assessed and care provided within the Assessment Area for up to 23 hours but will then need to be transferred to a ward-based bed if on-going care is required.
- If the flow of patients within the Bay is compromised, other patients requiring assessment will need to be directed to the most appropriate place, either ED or Medical SDEC if open.

When the AOS Assessment Area is full, then the AOS Escalation Process is undertaken. The Acute Oncology Nurse Practitioner Team will attend a daily Bed Huddle with both on-call Consultants, and the Nurse in Charge of both Laurel 2/3 for any discharges, transfers (see Appendix 2).

However, if no patients are identified for discharge, then escalation to Oncology/Haematology Matron will be undertaken. The Capacity Hub/Site Team will also be contacted if no patients are identified for discharge/transfer. Unwell patients will then be advised to attend the ED, and the ED will be informed, and the patient (out of hours) will be referred to the Medical Team. Between 8.00am and 6.00pm the Acute Oncology Nurse Practitioner Team will attend ED to review the patient.

3.1 Exclusions

The following exclusion criteria are in place for patients who are unable to directly attend the AOS SDEC. Patients triaged with the following will be directed to the ED (see Appendix 1, Referral Criteria for Oncology/Haematology)

Exclusions include:

- High Risk MSCC (those requiring an MRI within 24 hours).
- New onset chest pain of likely cardiac aetiology.
- Patients with FAST positive symptoms/suspected stroke/head injuries/stroke.
- Unresponsive patients.
- Heavy bleeding.
- Severe acute shortness of breath/suspicion of stridor/airway compromise.
- Clear signs or symptoms of bowel obstruction.
- Frank haematuria.

- Haemodynamically unstable patients.
- Conditions unrelated to cancer diagnosis/treatment eg. exacerbation of COPD.
- Any condition that is likely to require intensive management by the Surgical/Orthopaedic Team.
- Severe electrolyte imbalances (see parameters in Appendix 3).

If a patient is clinically stable in the ED, following discussion with the Acute Oncology Team, these patients could be transferred to the AOS SDEC Assessment Area for on-going assessment and management. This will be a cross-county service to include those patients that present to the ED at the Alexandra Hospital site.

3.2 Infection Control

The three pods in the AOS SDEC allow for the assessment of patients with possible infective causes for their presenting symptoms including possible COVID and Clostridium Difficile.
Trust policies will be followed in relation to isolation, PPE and cleaning. Amber cleaning will take place in the cubicles if any patient is proven or suspected of any infective process.

3.3 Workload

Workload is variable and dependent on patient need.

- On-going audits are being undertaken to collate data on the numbers of patients seen in the AOS Bay during its opening hours, the numbers of patients admitted and the numbers of patients transferred from ED awaiting admission to both Laurel 2 and Laurel 3.
- The Acute Oncology Nurse Practitioner Team will visit the ED each morning to check if any Acute Oncology cancer patients have been admitted to ED overnight, and to review any patients sent in by the AOS Helpline staff.
- The Acute Oncology Nurse Practitioner Team will also access patient first to check on patient admissions throughout the day, to optimise patient flow to its fullest capacity.

3.4 Hours of Operation

The Assessment Area operates 7 days a week, 8.00am – 8.00pm.

4. Management and Staffing

The Acute Oncology Team comprises Acute Oncology Nurse Practitioners Monday to Friday, 8.00am to 6.00pm who can be contacted on Ext 30058/30395 or Bleep 398/491. Outside these hours, the Junior Doctors on Laurel 2 and Laurel 3 will review patients in the AOS SDEC area until 8.00pm.

The Assessment Area will be overseen by the Acute Oncology Nurse Practitioners working alongside the Laurel 2 nursing staff. The initial management of patients will be undertaken by the Nurse Practitioners (in hours) and the Laurel 3 staff manning the Emergency Acute Oncology Helpline Service will carry Bleeps 398/491 out of hours. They can be contacted on Ext 39111.

5. Interdepartmental relationships/Specialist and Support Services Clinical

• Pharmacy	A clinical Pharmacy Service of providing a full Medicine Management Service.
• Microbiology	Advice, analysis of samples and direction for treatment.
• Haematology	Analysis of samples, early warning phone call of abnormal results, blood products for infusion.
• Biochemistry	Analysis of samples, early warning phone call of abnormal results.
• Radiology	To be referred to for imaging – urgent or routine.
• Dietician	Can be referred to for nutritional advice.
• Palliative Care	Advice on any palliative issues – eg. pain control, nausea/vomiting.
• MAU/ED	A minority of patients are admitted via this route on request of either medical or nursing staff.

Non-Clinical – ISS

• Housekeeping	
• Catering	
• Porters	Escort immobile patients to other departments

External

- Other Cancer Centres/Networks
- GPs
- Hospices/Community Palliative Care Teams

6. Implementation

6.1 Plan for implementation

This policy is disseminated in both the Oncology and Haematology Governance meetings.

6.2 Dissemination

This policy will be disseminated throughout the haematology and oncology directorate.

6.3 Training and awareness

Refer to training as identified in the Trusts Training Needs Analysis, Appendix A of the Trusts Mandatory Training Policy.

7. Monitoring and compliance

The NHSLA requirements are;

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
3	Optimisation of full use of AOS SDEC	Spot checks	Weekly	AOS Nurse Practitioner Team	Oncology and Haematology Governance meetings	10 times a year

8. Policy Review

This policy will be reviewed bi-annually or following a required change.

9. References

Code:

United Kingdom Oncology Nurses Society Acute Oncology Initial Guidelines 2023 available at: https://www.ukons.org/site/assets/files/1067/ukons_ao_initial_management_guidelines_final_version_2023.pdf	

10. Background

10.1 Equality requirements

See supporting Document 1.

10.2 Financial risk assessment

See supporting Document 2

10.3 Consultation

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Haematology Consultants
Oncology Consultants
Directorate Management Team including Matron and Lead Chemotherapy Nurse
Clinical Nurse Specialists and Acute Oncology Nurse Practitioner Team
Divisional Directorate Management team

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Haematology Governance meeting
Oncology Governance meeting

10.4 Approval Process

This document has been circulated to those described in Section 10.3 and will be submitted for ratification to the Specialised Clinical Services Division DMT Business Approvals meeting then for final sign off at the Implementation Plan meeting.

Appendix 1: Referral Criteria for Oncology/Haematology

ONCOLOGY/ HAEMATOLOGY

- Patients with known cancer undergoing treatment should be referred to Acute Oncology Service.

- However, patients known to Oncology/ Haematology on active treatment, but presenting with following symptoms should be referred to the appropriate specialty:

    - New onset chest pain of likely cardiac aetiology
    - Patients with FAST positive symptoms/suspected stroke/head injuries
    - Unresponsive patients
    - Heavy bleeding
    - Severe acute shortness of breath/suspicion of stridor/airway compromise
    - Clear signs or symptoms of bowel obstruction.
    - Frank haematuria
    - Haemodynamically unstable patients
    - Conditions unrelated to cancer diagnosis/treatment eg. exacerbation of COPD
    - Any condition that is likely to require intensive management by the Surgical/Orthopaedic Team
    - Severe electrolyte imbalances
    - Pleural effusions requiring drainage

- Decision to admit under Oncology /Haematology will be made after review by the Acute Oncology Team.

- Suspected High Risk MSCC (those requiring an MRI within 24 hours), known to oncology ideally admit to Laurel 2 or Laurel 3.

- If no beds available on Laurel 2/Laurel 3, then Acute Oncology Service will review in working hours and make decision to transfer to Laurel 2/Laurel 3, when bed available.

- Suspected High Risk MSCC (those requiring an MRI within 24 hours), **not** known to Oncology – admit to any available bed and Acute Oncology Service will review in working hours and advise regarding further management.

- The Acute Oncology Service is available between 08:00 – 17:00, 7 days a week. Out of these hours there is only non-residential consultant on-call available for advice via Switchboard. Patient will be initially admitted under medicine and reviewed in the morning by the Acute Oncology Service.

Appendix 2: Acute Oncology Escalation Process Flowchart

Acute Oncology Bay = full
Acute Oncology Service Nurse Practioner (AOS NP) Team

AOS Nurse Practitioner Team to check bed state on Laurel 2 and Laurel 3 (Bed Huddle) with Nurse in Charge (NIC) occurs 8.00am and 1.00pm

- Updated discharges
- Updated Transfers
- Identify Potential Discharges awaiting pathways.
- Identify any suitable patients for PDU.

Patients in AOS SDEC area requiring a bed will be accommodated on either Laurel 2/3. Reverse boarding will be undertaken as required.

If no bed availability and AOS SDEC still full then escalate to Matron on Bleep 629 to review bed state on both wards.
If Matron is not on duty – escalate to AOS Service Lead/Ward Managers

Escalate to Capacity Hub/Site Team on Ext 30286 and Bleep 557/401
AOS Nurse Practitioner to inform Nurse in Charge of ED that AOS Bay is at capacity and will send unwell patients to ED (Ext 30503 or Bleeps 419 or 777)

Patients advised to attend ED process:

- Inform ED to inform pt. coming in:
  - SIAN if 999 crew (Ext 39340)
  - Triage if own transport (Ext 39235/39350)
- Call Reception on Ext 30505 and ask them to Bleep AOS on Bleep 398/491 to attend ED
- AOS/RN to Bleep RMO on Bleep 697/698 or Bleep MAU Triage Registered Nurse on Bleep 417 to refer patients to Medical Team (RMO Accepted)

Acute Oncology Bay

This is an Assessment Area on Ward Laurel 2.

It contains 3 separate Pods which can hold patients in isolation. It also has 2 chairs in an open area (patients cannot be isolated here).

The AOS Bay is open between 8.00am and 8.00pm.

The AOS Nurse Practitioner Team is available 8.00am to 6.00pm, and the area is covered by the Ward Doctors from 6.00pm until 8.00pm.

This area does not have any waiting rooms or additional capacity to decant patients to.

Appendix 3: AOS Patient Biochemical abnormalities exclusions

	Normal Range	Acceptable Range for AOS	Symptoms (if symptomatic – discuss with AOS NP team)	Range requiring ED/MAU
Sodium	133 - 146	>125	confusion, <GCS, headaches, profuse vomiting	<125
Potassium	3.5 – 5.3	2.5 – 6.0	Low - muscle weakness, cardiac symptoms, paralysis High - <renal function, cardiac symptoms	<2.5 >6.0
Magnesium	0.7 – 1.0	>0.3	ventricular arrhythmias, convulsions, acute asthma	<0.3
Adjusted Calcium	2.2 – 2.6	1.8 – 4.0	Low – cardiac symptoms, muscle twitching, spasms High – cardiac symptoms, confusion, seizures, coma	<1.8 >4.0
Phosphate	0.8 – 1.	<0.59	muscle weakness, tremor, convulsions	<0.32

Supporting Document 1 – Equality Impact Assessment form

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Alison Jones Acute Oncology Service Lead**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Alison Jones	Acute Oncology Service Lead	Alison.jones18@nhs.net
Date assessment completed	**25/08/2023**		

Section 2

Activity being assessed	**Title: Acute Oncology Service (Same Day Emergency Care) Operational Policy**			
What is the aim, purpose and/or intended outcomes of this Activity?	The Acute Oncology Assessment area is located on Laurel 2 Oncology Ward at Worcester Royal Hospital. It is a designated area for Haematology/Oncology patients who have been triaged by the AOS service as requiring urgent assessment. This policy outlines the process needed when the Assessment area is full or closed.			
Who will be affected by the development & implementation of this activity?	x x x x	Service User Patient Carers Visitors	x ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity X New activity ❑ Planning to withdraw or reduce a service, activity or presence?			

What information and evidence have you reviewed to help inform this assessment?	• Acute Oncology Service Business case • Activity data • Comments from, Consultants, Matron and Divisional Management Team and Emergency Department.
Summary of engagement or consultation undertaken	• Reviewed by consultants via email and comments fed back • Draft SOP submitted to Directorate Governance Meetings • Local review/team input.
Summary of relevant findings	

Section 3

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		Adult admissions only
Disability			✓	Limited space for any mobility aids.
Gender Reassignment		✓		Separate pods.
Marriage & Civil Partnerships		✓		Separate pods.
Pregnancy & Maternity		✓		Separate pods.
Race including Traveling Communities		✓		Separate pods.
Religion & Belief		✓		Separate pods.
Sex		✓		Separate pods.
Sexual Orientation		✓		Separate pods.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		Separate pods.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		Separate pods.

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Limited space in pod for any mobility aids.	*1 POD able to fit bed. Would priories this for disabilities.*	AOS Lead	Completed
How will you monitor these actions?	Monitored at time of admission will submit incident report if unable to accommodate patient.			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	In line with policy review.			

Section 5

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	29/08/2023
Comments:	
Signature of person the Leader Person for this activity	
Date signed	29/08/2023
Comments:	

Supporting Document 2 – Financial Impact Assessment

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources?	No
2.	Does the implementation of this document require additional revenue?	No
3.	Does the implementation of this document require additional manpower?	Yes – already in place following business case
4.	Does the implementation of this document release any manpower costs through a change in practice?	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff?	No
6.	Other comments:	