Trust Policy		Worcestershire Acute Hospitals NHS Trust

GUIDELINE FOR THE PREVENTION, RECOGNITION & MANAGEMENT OF FEVER IN CHILDREN & YOUNG PEOPLE WITH CANCER

Department / Service:	Women & Children's – Paediatric Oncology
Originator:	Dr J Motwani, Consultant Paediatric Haematologist & Heather Petts Chief Nurse, Birmingham Children's Hospital (BCH)
Accountable Director:	Dr Kamalarajan
Approved by:	Women & Children's Governance
Date of approval:	15th January 2025
First Revision Due: **This is the most current document and should be used until a revised version is in place**	15th January 2028
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Paediatric medical, nursing and pharmacy staff
Target staff categories	

Policy Overview:

These guidelines provide a basis for the prevention, prompt recognition and effective treatment and management of patients presenting with a febrile neutropenic illness.

This guideline covers children & young people with cancer and other non-malignant haematological disorders treated with immunosuppressive therapies. The majority of patients will have neutropenia related fever. However these guidelines are also appropriate for non-neutropenic patients where a course of parenteral antibiotics is considered necessary. It should also be noted that some patients (particularly those who are post stem cell transplant or with non-malignant immunodeficiency conditions) may have an adequate neutrophil count but still have an inefficient immune system and high risk of sepsis.

Key amendments to this document

Date	Amendment	Approved by:
Sept 2015	*No amendments*	*Chemotherapy working group (BCH)*

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1. Introduction

Febrile neutropenia and neutropenic sepsis is a significant clinical risk for patients receiving immunosuppressive treatment, whether such treatment is treatment of their malignant disease or immunosuppression following stem cell, or other, transplantation.
A structured approach to the assessment of the patient and prompt and effective treatment are essential, and this guideline is intended to provide the basis for such an approach.

2. Purpose

These guidelines provide a basis for the prevention, prompt recognition and effective treatment and management of patients presenting with a febrile neutropenic illness. However, in common with other such clinical guidelines they are no substitute for the regular clinical assessment of patients - a vital part of the effective management of febrile neutropenia in children & young people – and appropriate response to such assessment. In all cases, advice from senior colleagues should be sought sooner rather than later if there is any uncertainty. Paediatric Oncology Shared Care Units (POSCUs) must contact the patient's Principal Treatment Centre (PTC) consultant or PTC on-call consultant for advice.

This guideline covers children & young people with cancer and other non-malignant haematological disorders treated with immunosuppressive therapies. The majority of patients will have neutropenia related fever. However these guidelines are also appropriate for non-neutropenic patients where a course of parenteral antibiotics is considered necessary. It should also be noted that some patients (particularly those who are post stem cell transplant or with non-malignant immunodeficiency conditions) may have an adequate neutrophil count but still have an inefficient immune system and high risk of sepsis.

3. Duties

3.1 Duties within the Organisation

This guideline covers a range of health professionals across the haematology / oncology service and staff and departments working in partnership with the service. Managers have a duty to ensure the guidelines are being followed.
Employees have a duty to undertake care as described in the guideline, or to consult with the consultant responsible for the patient to discuss individual variations, or with managers where practice is regularly not meeting the required standard, so that variations can be monitored.

3.2 Identification of Stakeholders

The following stakeholders have been identified within BCH: The Chemotherapy Working Group (CWG); the Cancer Locality Group; the Haematology Oncology Programme meeting; medical, nursing and support staff within the Haematology Oncology specialty; the Birmingham Children's Hospital Antimicrobial Prescribing Committee.
Outside BCH: The West Midlands Children's Cancer Network Group.

4. Method for development

4.1 Consultation and Communication with Stakeholders

The guideline was drafted by Dr. Jayashree Motwani (Consultant Paediatric Haematologist) following a number of discussions with consultant and other staff within both the Haematology Oncology specialty and the Microbiology department. The content was agreed at the Specialty programme meeting on 1st February 2023

5. Content

5.1 Introduction

Children receiving cytotoxic drugs are at risk from infection, particularly bacterial. This risk is greatest in those children undergoing intensive treatment such as bone marrow transplantation, high dose chemotherapy with stem cell support or during leukaemia induction treatment. Where leukaemia is concerned the problems tend to be more severe in children with AML than ALL.

5.2 Prophylactic antibiotics

- Prophylactic Cotrimoxazole (Septrin), for PCP is given to all children receiving treatment for leukaemia.

- Cotrimoxazole and antifungal agents (AmBisome/ voriconazole/ fluconazole/ itraconazole) are given to children who are expected to have a prolonged period of neutropenia. This includes patients with AML and those undergoing transplantation procedures and some other treatments such as ESPHALL.

- Children with Down"s syndrome and A.L.L. are given prophylactic ciprofloxacin at various stages in their treatment. (see current Leukaemia protocol, A2G or UKALL2019 interim guidance)

- Other children are not routinely given prophylactic antibiotics but may occasionally be prescribed these on an individual basis.

- Children with solid tumours can also become severely pancytopenic, although in general this is for a shorter period. In the majority of these children the blood count nadir usually occurs 10 to 14 days after a course of treatment, and recovery has occurred by day 21.

ANY SUGGESTION OF INFECTION IN CHILDREN AT RISK MUST BE URGENTLY INVESTIGATED AND TREATED.

5.3 Definitions

Fever - a temperature of ≥ 38ₒC)
Neutropenia - an absolute neutrophil count of ≤ 0.5 x 10^9/L. (NICE, 2012)

Unwell child: Any child receiving chemotherapy who appears unwell but is not febrile or neutropenic may still need treating with antibiotics. Children with Down's syndrome are at particular risk of sepsis; they may present with non-specific symptoms and may be afebrile even when septic.

Discuss with more senior colleague or the PTC if you are not sure.

5.4 Referral

If and when a child at home becomes febrile or unwell a parent will have been advised to phone the PTC or POSCU for advice. On-Call HCP must not ask parents to contact their GP without first discussing with a more senior colleague whether this is appropriate advice. All children on cancer treatment with fever must be assessed at their local POSCU or the PTC. Children with brain tumours on concurrent chemotherapy and radiotherapy must be treated at the PTC only.

Children attending the PTC at Birmingham children's Hospital should be advised to attend the Oncology Clinic in working hours or the Emergency Department out-ofhours. Notify the department of the patients expected arrival.

Children attending one of the designated West Midlands POSCUs have direct access to assessment within the POSCU children's ward(s). Notify the department of the patients expected arrival.

5.5 Initial review

The child will come to a POSCU ward or the PTC oncology day care unit (during working hours) or the PTC Emergency Department (out-of-hours) and be triaged as RED. Haem/Onc SHOs, called to review, should prioritise this child. Liaise with the Clinical Co-ordinators out-of-hours if they are unable to do so.

The child needs to have been assessed and receive parenteral antibiotics if appropriate within 1 hour of arrival. (NCAG, 2009)

When a child suspected of having an infection attends, take a history and do a full examination, specifically to document any history of symptoms such as diarrhoea or cough, or the presence of focal signs of infection such as skin sepsis.

Document all observations and calculate PEWS (Paediatric Early Warning Score). There may be rapid progression from fever to sudden deterioration in PEWS. Increase frequency of observations as necessary.

Assessment must be undertaken by a Doctor or appropriately trained Advanced Nurse Practitioner..

5.6 ***If the child has any signs of haemodynamic compromise,*** e.g. delayed capillary refill time, tachycardia (not explained by fever), or hypotension:

I. Inform the registrar or consultant immediately.
II. Oxygen should be administered to maintain adequate oxygen saturation.
III. Give a fluid bolus – 20 mls/kg of 0.9% sodium chloride IV and reassess.
IV. Inform PICU/PACE (if not already aware) as soon as the first bolus has been given, using the local "Observation & Monitoring policy." Utilise PEWS information and SBAR reporting structure. (SBAR = Situation, Background, Assessment, Recommendations)
V. Review the patient with a haematology/oncology registrar grade or above and discuss subsequent management with ICU staff as appropriate.
VI. Monitor vital signs and urine output closely (half hourly to hourly depending on patient status). Urinary catheterisation may be necessary if no urine output, despite improvement in haemodynamic status. Any patient this unwell MUST be discussed with the local consultant and the on call consultant at BCH if admitted to a shared care centre.
VII. If child **presents** with haemodynamic compromise – commence Meropenem See *PAGE 8*
VIII. If child **develops** haemodynamic compromise after initial assessment and whilst receiving Piperacillin/Tazobactam, change to Meropenem without waiting for cultures. This should be done as soon as the haemodynamic compromise occurs.

Intravenous antibiotics should be commenced after appropriate cultures and blood tests are taken as below:

- FBC
- Coagulation (especially if child septic and unwell)
- Group and Save if appropriate
- Chemistry, with CRP
- Blood cultures from all lumens of central lines, urine and stool cultures, viral respiratory swabs.

There is no need to wait for neutrophil count before starting antibiotics if the child is unwell or if blood results are taking longer than 1 hour to obtain.

If the central line will not bleed back and it appears that the child's condition warrants immediate antibiotics – DO NOT delay giving antibiotics whilst waiting for the line to be cleared with Urokinase. In this situation take a blood culture from a peripheral vein and start antibiotics via cannula. If it then becomes possible to sample from the central line, send a further blood culture from the central line.

- Clearly distinguish on bottles and forms if more than one set of cultures is taken.
- Throat swab, line site swab- as appropriate.

A chest X-ray is not mandatory on admission of all febrile neutropenic children but should be done in any child with respiratory symptoms, e.g. cough, tachypnoea, or if the fever persists for >24 hours after admission without any obvious focus.

Lumbar punctures are not part of routine screening for febrile neutropenia. However, if you think one is indicated, e.g. if the child has neck stiffness, discuss with a consultant oncologist or haematologist and neurosurgeon for children with brain tumours. Children with neutropenia are also likely to be thrombocytopenic which increases the risks from lumbar puncture.

If a child has respiratory symptoms (upper or lower) consider whether a nasopharyngeal aspirate (NPA) should be taken.

Oral chemotherapy should be discontinued on admission. In rare circumstances e.g. during intensification blocks for leukaemia or T-cell lymphoma a consultant at the PTC may authorise the continuation of oral chemotherapy. This decision must be taken at consultant level.

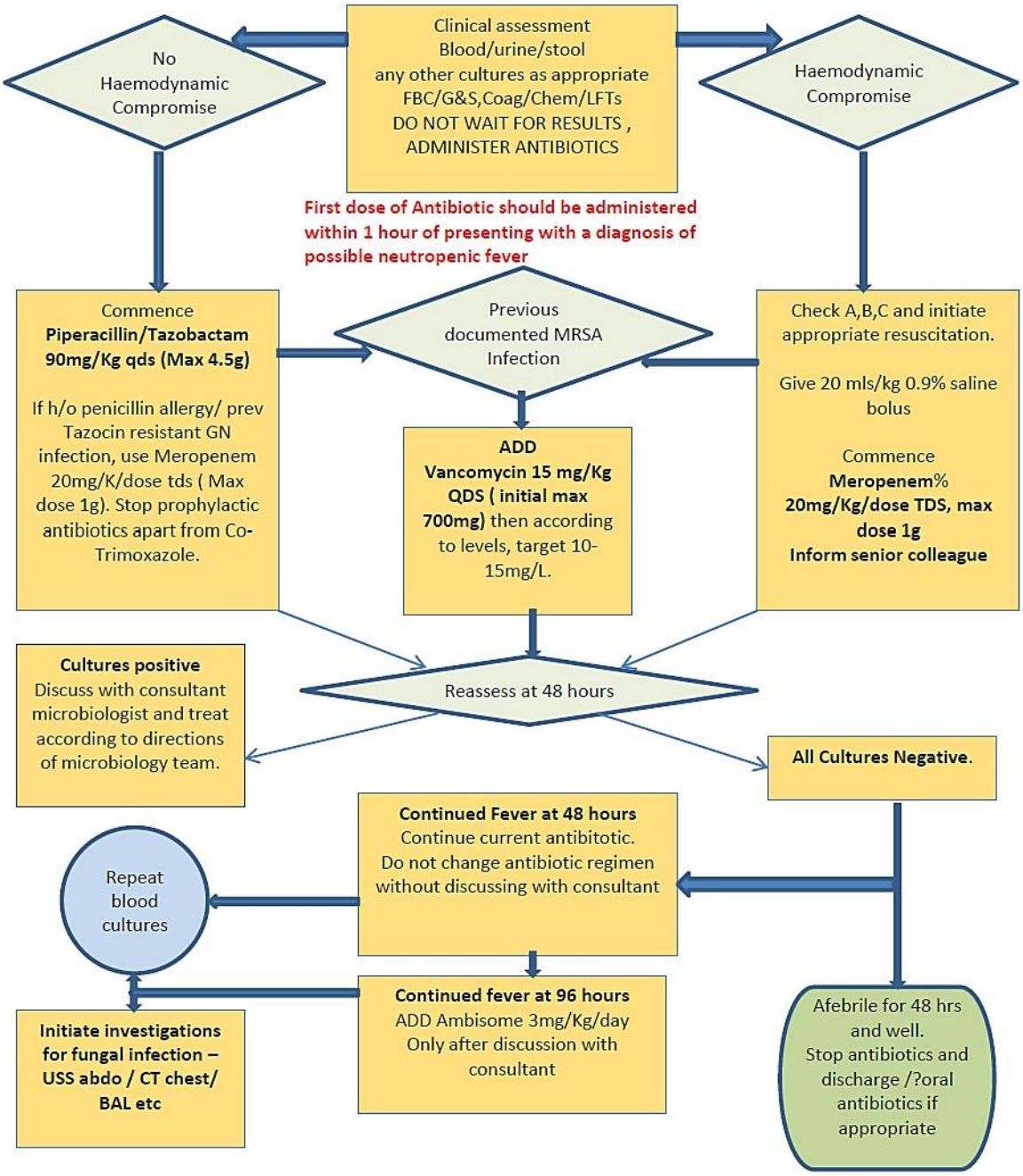
If a child is clinically well and stable with no haemodyanamic compromise, has no central line and has neutrophils >0.5-normal, discharge on oral antibiotics after discussion with PTC consultant may be considered.

This approach is NOT appropriate for children in the following categories:

- AML
- ALL not on maintenance treatment.
- Relapsed ALL
- Children with Down's syndrome
- Children post BMT
- Patients with focal signs of infection
- Patients with previous admissions for serious bacterial or fungal infection
- Patients unwilling or unable to take oral antibiotics
- Low confidence in carer response to changes
- Challenging social circumstances

If in any doubt – admit and give parenteral antibiotics.
Isolation of *Candida* or *Staph. Aureus* from a central line necessitates prompt discussion with the consultant about the need for line removal.

Haematology and Oncology Departments, Birmingham Children's Hospital
Management of Fever in the Neutropenic / Immunocompromised child



Previous MRSA	Add vancomycin	Review at 48 hours with microbiology results with a view to de-escalate if cultures remain negative
Previous ESBL	Use meropenem instead of piperacillin-tazobactam	
Previous bacteraemia or colonisation with piperacillintazobactam resistant organism	Use meropenem instead of piperacillin-tazobactam	

Previous carbapenemaseproducing (CPE) gram negative organisms	For New-Delhi Metallo-betalactamase (NDM) variety of CPE: Use ceftazidime +avibactam PLUS aztreonam For all other varieties (KPC or OXA-48 producing CPE): Use ceftazidime-avibactam	

BCH Febrile Neutropenia Guidelines V1.0.0 Review by 18/01/26
Approved by Clinical Leads at Haematology/Oncology Specialty Meeting 18/02/24.

5.7 GUIDELINE ON THE PRESCRIBING AND USE OF PROPHYLACTIC AND EMPIRICAL ANTIFUNGAL THERAPY.

Patient groups:

Three patient groups are proposed, based on current practice. However, there is little evidence that such a classification is based on a true stratification of risk. These are:

- Group 1: In-patients who are going through conditioning and/ or are following BMT/PBSCT
- Group 2: In-patients considered to be at higher risk of fungal infection in consequence of profound and/or prolonged neutropenia.
  - o AML
  - o Infant ALL
  - o Relapsed ALL on intensive chemotherapy o Ph positive ALL. o Aplastic Anaemia o ALL, Regimen B/C Induction
- Group 3: Patients who remain febrile and neutropenic after 72-96 hours of broad spectrum intravenous antibiotics.

Group 1: Patients who are post BMT/PBSCT:

These patients should receive prophylaxis with AmBisome at a dose of 2.5mg/kg twice a week.

At the time of discharge or when able to tolerate oral medications, **Itraconazole LIQUID SUSPENSION 5mg/kg**. daily, in one or two divided doses, should be substituted at the time discharge planning commences, or earlier as indicated.

Due to its relatively greater bioavailability, ALL patients should take the LIQUID formulation. (**no capsules)**

Itraconazole levels should be checked and doses altered accordingly. If Itraconazole is poorly tolerated, voriconazole can be used.

Those patients who are unable to take itraconazole/ voriconazole due to liver GVHD/ photosensitivity etc, should receive posaconazole. If they are unable to tolerate posaconazole, then individualised antifungal prophylaxis plan needs to be put in place after MDT discussion along with Consultant microbiologist input. There is no role for ambisome 1mg/kg 3 times a week for this group of patients.

Group 2a: Patients who are profoundly neutropenic, or likely to become so, and ARE NOT receiving chemotherapy which includes Vincristine:

These patients should receive prophylaxis with ORAL Itraconazole, liquid at 5mg/Kg/day in 2 divided doses. Levels should be checked.

If itraconazole is not tolerated orally, whilst inpatient, these patients should receive prophylaxis with AmBisome 1mg/kg. on THREE days of each week

Group 2b: Patients who are profoundly neutropenic, or likely to become so, and ARE receiving chemotherapy which includes Vincristine (e.g. A2G, ESPHALL):

These patients should receive prophylaxis with AmBisome 1mg/kg. on THREE days of each week until no further doses of Vincristine (or other Vinca alkaloids) are scheduled. If continued long-term prophylaxis is required -Itraconazole liquid at 5mg/kg. daily, in one or two divided doses, should be substituted 48 hours after the last dose of Vincristine has been given.

ALL PATIENTS SHOULD HAVE ITRACONAZOLE LIQUID PREPARATION.

Condition	Prophylaxis regime
AML, HLH, APLASTIC ANAEMIA	Itraconazole liquid at 5mg/Kg/Day
ALL Regimen B/C Induction	Week 1-5 ambisome 1mg/kg/day M/W/F
R3 HR arm	Week 1-4 itraconazole Week 5-10 ambisome 1mg/kg/day M/W/F Week 10-15 Itraconazole Antifungal prophylaxis to be continued in between courses.
R3 SR/IR ARM	Week 1-5 ambisome1mg/kg/day M/W/F Week 6-13 Itraconazole
Interfant	Induction- ambisome 1mg/kg/day M/W/F Protocol1B Itraconazole MARMA- Itraconazole OCTADAD- ambisome 1mg/kg/day M/W/F
Ph+ ALL	Post Induction Itraconazole, apart from around VCR of HR blocks. (Itra CI in dasatinib trial)
HSCT	Ambisome 2.5mg/Kg twice a week until able to take itraconazole
Post HSCT at discharge	Itraconazole liquid at 5mg/Kg/Day
Post HSCT unable to have Itra/Vori	Posaconazole
Post HSCT unable to tolerate Posaconazole	Individualised prophylaxis regime after MDT discussion (eg micafungin/ daily ambisome/ HD 3/wk ambisome)

Group 3: Patients who remain febrile and neutropenic after 72-96 hours of intravenous antibiotics and require empirical antifungal treatment:

These patients should receive treatment with AmBisome 3mg/Kg/day, if clinically indicated, until they have been apyrexial for 48 hours (according to Specialty policy).

USS abdomen/HRCT chest/ Galactomannan tests /Broncheo-alveolar lavage, should be organised as needed, as soon as possible.

5.8 Patient / Parent Education

Patients / parents must be educated about the risks of neutropenic sepsis and how to detect and respond to signs & symptoms of fever and infection. Their understanding should be checked by asking them to re-iterate information. The “Going Home Chat” should be delivered by nurses who have been trained to deliver accurate information. Suitable training would be the BCH Practical Oncology Programme foundation supportive care module or similar.

Verbal information should be backed up with written information with consideration to the need for interpreters for non-English speaking / reading families.

The medical “Alert Card” for risk of neutropenic sepsis should be provided with an explanation of how to use the card, particularly if using an emergency department while on holiday / visiting other regions.

A digital thermometer is provided for use at home to assist families with monitoring for fever. A normal home life should be encouraged and parents should be counselled about not needing to do routine monitoring at home but to use the thermometer if they suspect the child is unwell or hot. Families who do not find reading the thermometer easy can be taught to put their face against the child’s to see if the child feels a lot hotter than their own skin.

Families should be counselled to call the PTC or POSCU if the child has fever or is unwell and present for review even if this is during the night. Modes of transport should be discussed, along with the need to use the 999 emergency ambulance service if their child is very unwell or if the cannot get to hospital by their own means.

When discussing the prevention of infection parents should be advised about the need to balance avoiding obvious sources of infection (e.g. relatives with D&V, colds, flu) and the need to maintain normal routines (e.g. attending school when well). Refer to the West Midlands Childrens Cancer Network Schools Policy.

5.9 Medical “Alert Card” for risk of neutropenic sepsis

The West Midlands Childrens Cancer Network has implemented the recommendations of a 1hour „door to needle“ time for cancer patients presenting with fever and suspected neutropenia (NCAG, 2009). Patients are issued with an “Alert Card” to show to Emergency Departments or Assessment units when they present with symptoms. This includes the contact details of the PTC and local POSCU and basic guidelines on initial care.

The PTC and POSCUs should implement local actions to ensure the NCAG recommendations are followed.

6. Monitoring Compliance With and the Effectiveness of the policy

6.1 Process for Monitoring Compliance and Effectiveness

Routine audit.

6.2 Standards/Key Performance Indicators

Audit

7. References

CCLG – PONF (2008) Treatment of low risk febrile neutropenia in paediatric oncology: a framework document *Accessed September 20, 2010* http://www.cclg.org.uk/members/wg/files/SC_FebrileNeutropeniaFrameworkGuideline_08.pdf

BNF for children, 2010-2011:
Piperacillin with tazobactam („Tazocin"): p.324
Meropenem: p.334
Vancomycin: p.349 Vancomycin is dosed qds rather tds (as recommended in the BNFc) based on local audits, showing that tds dosing does not provide a therapeutic level of 5mg/L. in the majority of patients.

National Chemotherapy Advisory Group (August 2009) Chemotherapy services in England: Ensuring quality & safety DH Best Practice Guidance *Gateway no: 12208*

National Collaborating Centre for cancer (2012) Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients Clinical Guidelines Guideline for the prevention, recognition & management of fever in children & young people with cancer 5.0.0 12

8. Appendices

Note: The Specialty guideline contains two further sections on „Patient / parent education" and the „Medical "Alert Card" for risk of neutropenic sepsis". Consult the guideline as necessary.

Appendix C: Policy Review Group Checklist for the Review and Approval of Procedural Document. To be completed by the Policy author prior to submission for approval/ratification

Title of document being reviewed:	Yes/No/ Unsure	Comments
1. State Title:		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document	Yes	
stated?		
3. Development Process		
Is the method described in brief?	Yes	
Are people involved in the development identified?	Yes	
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
Is there evidence of appropriate consultation with stakeholders and users?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	

Title of document being reviewed:	Yes/No/ Unsure	Comments
Are the references cited in full?	Yes	
Are supporting documents referenced?	Yes	
6. Approval		

If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/a	
7. Dissemination and Implementation		
Is there an outline/plan to identify how this will be done?	Yes	
Does the plan include the necessary training/support to ensure compliance?	Yes	
8. Document Control		
Does the document identify where it will be held?	Yes	
Have archiving arrangements for superseded documents been addressed?	Yes	
9. Process to Monitor Compliance and Effectiveness		
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	N/a	
Is there a plan to review or audit compliance with the document?	Yes	
10. Review Date		
Is the review date identified?	Yes	
Is the frequency of review identified? If so is it acceptable?	Yes	
11. Overall Responsibility for the Document		
Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?		

Policy Review Group Ratification

If you are happy to ratify this document, please sign and date.	
Committee /Other Approval	
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.	
Name	Date
Signature	

Appendix D – Equality Impact Assessment

To be completed and attached to any procedural document when submitted to the Policy Review Group for consideration and approval.

EQUALITY IMPACT ASSESSMENT FORM

SECTION 1: Department	**Assessor:**
Policy/ Service Title:	**Date of Assessment:**
1. Describe the purpose of this policy or function	The Childrens Cancer Measures 2009 requires the PTC (principal treatment centre) to have a range of policies in place to support the safe and effective delivery of chemotherapy from the perspective of patients, carers and staff. This policy has been in place for a number of years and has been reviewed and brought to Trust standard as part of the peer view process for cancer services. There is now new NICE clinical guidelines which recommend the definitions and choice of antibiotics now reflected in this policy.
2. Who is affected by this policy?	Medical, nursing and pharmacy staff within the Haematology Oncology specialty at BCH and paediatric oncology shared care units.
3. What are the outcomes or intended outcomes of this policy/ function?	This policy will ensure that staff managing patients presenting with febrile neutropenia have available a clinical guideline for effectively managing such patients. Secondarily, compliance with Children's Cancer Measures 2009.

4. What consultation has been undertaken during the development of this policy/function?	Oncology/ haematology clinicians and Shared care oncology clinicians consulted throughout developments.
5. What information or evidence has been used to assess the potential impact across the equality strands?	This policy will have no implications with respect to Equality Impact

IMPACT

1. What is the impact or likely impact, either positive or negative, of the initiative on individuals, staff, or the public at large?

2. Please complete the following list and identify if there is, or likely to be, an impact on a group

a) Grounds of race, ethnicity, colour, nationality or national origins.	Yes ☐ No☐	Adverse? Provide further details:
b) Grounds of sexuality or marital status	Yes ☐ No ☐	Adverse? Provide further details:
c) Grounds of gender	Yes ☐ No ☐	Adverse? Provide further details:
d) Grounds of religion or belief	Yes ☐ No ☐	Adverse? Provide further details:
e) Grounds of disability	Yes ☐ No ☐	Adverse? Provide further details:
f) Grounds of age	Yes ☐ No ☐	Adverse? Provide further details:

If you have stated that there is an adverse impact a Full Impact Assessment is Required. Complete Section 2

SECTION 2: Modifications

1. If you stated that the policy/ function has or could have an adverse impact on any group, how could you modify it to reduce or eliminate any identified negative impacts?
2. If you make these modifications, would there be an impact on other groups, or on the ability of the policy to achieve its purpose?
Consultation **Under the Race Relations (Amendment) Act 2000 you are required to consult on the impact of new policies, functions and service change.**
3. How do you plan to consult on these modifications? Specify who would be involved, timescales and methods.
Decision Making
1. Who will make the decision?
2. What is the decision? ☐ Reject the policy/ function ☐ Introduce the policy/ function ☐ Amend the policy/ function ☐ Other (Please explain)

Monitoring and Review
1. How will the implementation of the policy/ function and its impact be monitored?
2. What are the overall learning points from this assessment?
3. What actions are recommended from this assessment?
4. When is the review date?

For advice in respect of answering the above questions, please contact the Equality and Diversity Officer on Ext: 8611. A completed form must be returned with your procedural document.

Appendix E – Plan for Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the Policy Review Group for consideration and approval.

Title of document:	Guideline for the prevention, recognition & management of children & young people with cancer & fever.		
Date finalised:		**Dissemination lead: Print name and contact details**	Heather Petts
Previous document already being used?	**Yes / No** (Please delete as appropriate)		
If yes, in what format and where?	In specialty handbook and on oncology file on the Trust intranet		
Proposed action to retrieve out-of-date copies of the document:	Out of date hardcopies will be removed. Out of date electronic copies will be archived on v drive with restricted access.		

To be disseminated to:	How will it be disseminated, who will do it and when?	Paper or Electronic	Comments
Oncology / haematology medical staff	Clinical Leads and Lead Cancer Nurse March 2024	E	
Oncology nursing staff	Lead Cancer Nurse, March 2024	E	
POSCU lead clinician	Lead Cancer Nurse, March 2024	E	

Disseminated Record – To be used once document is approved.

Date put on register library of procedural documents		Date due to be reviewed	

Disseminated to: (either directly or via meetings, etc.)	Format (i.e. paper or electronic	Date Disseminated	No. of Copies sent	Contact Details/ Comments
Haem/ onc policies file	E	12.03.2024		Tasmin Aston

Appendix F: Summary of Significant Changes to previous version of Policy

Policy Title			
Version	**Date**	**Author**	**Comment (Identify any significant changes to the procedural document)**
4.0.1	12.03.2024	Dr J Motwani / Heather Petts Lead Cancer Nurse	• Additional antibiotic advise as per micro. • • • • • •

Monitoring

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?
P1	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

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	

Details of individuals completing this assessment	Name	Job title	e-mail contact
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title:			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑	Service User Patient Carers	❑ ❑ ❑	Staff Communities Other _____

	❑	Visitors	❑	
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.				
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)				
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

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				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities				
Religion & Belief				
Sex				
Sexual Orientation				
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
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)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce /	Who will lead on the action?	Timeframe

		eliminate negative impact		
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

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	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact AssessmenT

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
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	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.