

# ACUTE AND SUPPORTIVE ONCOLOGY

Clinical consensus statement



Royal College  
of Physicians

**MACMILLAN**  
CANCER SUPPORT



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# INTRODUCTION

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**Cancer care is changing rapidly. Advances in systemic therapies, radiotherapy and surgery mean that more people are living longer with and beyond cancer, including many who require ongoing support for cancer as a long-term condition.**

At the same time, an ageing population, rising multimorbidity and increasing frailty mean that cancer services must respond to more complex patient needs across hospital, community, primary care and urgent care settings.

Acute and supportive oncology services have developed to meet this challenge. Together, they help people with cancer to stay as well as possible, to access specialist support when they become acutely unwell, and to receive coordinated care after acute illness, during deterioration and towards the end of life. Current access to many of these services is inconsistent and there is unwarranted variation in acute and supportive oncology services, depending on where people live or when they need to access care.

This clinical consensus statement sets out what health systems should provide at a local, regional and national level, so that people with cancer can expect equitable access to high-quality acute and supportive oncology services, regardless of where they live.

It focuses on three aims:

- > keeping people with cancer well through proactive, holistic care that is closer to home
- > ensuring timely and equitable access to specialist advice and care when people with cancer become acutely unwell
- > providing effective support to people with cancer after unplanned care use – this may include maintaining recovery, planning for future deterioration or transition to end-of-life care.

The statement has been developed by clinicians and partner organisations working across acute and supportive oncology. They were convened by the Royal College of Physicians (RCP) and Macmillan Cancer Support in response to national policy commitments on cancer care, urgent care, neighbourhood health and prevention.

We thank everyone who gave their expertise and time to its development.



**Dr Hilary Williams**  
Clinical vice president, RCP  
Medical oncology consultant



**Dr Ashling Lillis**  
National clinical advisor,  
Macmillan Cancer Support  
Acute medicine consultant

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**‘Making a diagnosis and giving treatment are only part of what people with cancer need from the NHS. At the most difficult time in their life, it is essential that people are properly supported to deal with the effects of their cancer and its treatment. While they are having active treatment they need ready access to acute oncology, to make sure that they can stay at home if it is safe; avoid admission via accident and emergency if possible, and if they do need to be in hospital they have expert care from professionals who understand their illness and how to manage it. Properly organised support from other areas of the NHS is vital to make sure that people with cancer not only get the treatment they need, but in such a way that gives them the best quality of life. This statement sets out how care should be organised in order to make this possible.’**

**Professor Peter Johnson, national clinical director for cancer, NHS England**

# WHAT ARE ACUTE AND SUPPORTIVE ONCOLOGY?

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**Acute oncology and supportive oncology are complementary parts of modern cancer care.**

Supportive oncology aims to help people with cancer stay as well as possible across the cancer pathway, whereas acute oncology seeks to provide specialist support if they do become acutely unwell.

Together, these services provide a coordinated and person-centred approach to cancer care. Delivered effectively, they improve patient quality of life while proactively managing the impacts of cancer therapies to enable patients to complete their treatment course.

## Acute oncology

Acute oncology provides urgent specialist assessment, advice and coordination when people become acutely unwell because of cancer, its treatments or a suspected new cancer diagnosis.

To deliver comprehensive care, acute oncology teams work across emergency, acute medical, surgical, specialist oncology and community-facing pathways. Their core functions are to:

- > identify people with cancer or suspected cancer who need urgent specialist input
- > support timely assessment, diagnosis, treatment and escalation decisions
- > advise on complications of systemic anti-cancer therapy (SACT), radiotherapy and cancer-related emergencies
- > coordinate care between oncology, acute medicine, emergency medicine, surgery, palliative care and other specialties
- > support safe alternatives to admission and provide timely discharge and follow-up after acute illness where clinically appropriate.

In the UK, acute oncology has predominantly been developed and delivered by senior or expert nursing professionals with multidisciplinary support. It was established as a core part of urgent cancer care following an NCEPOD report published in 2009, which highlighted the need for earlier recognition of treatment complications, improved senior decision making and better coordination between oncology and acute services to improve patient outcomes.<sup>1</sup>

Service models vary depending on setting. In district general hospitals (DGHs), the admitting clinical team usually retains overall responsibility, with acute oncology providing specialist advice and coordination. In cancer centres, oncology teams often retain primary responsibility and work alongside acute and specialist teams. In all settings, acute oncology should provide timely access to expert cancer advice for patients at points of urgent need.

## Supportive oncology

Supportive oncology, as a term, has two related meanings: it refers to a model of care and, in a limited number of settings, a dedicated specialist service. This distinction is important because most supportive oncology is delivered through collaboration between existing services, rather than through a single standalone team. While both meanings are explored below, unless stated otherwise, in this consensus statement 'supportive oncology' refers to the model of care.

### Supportive oncology as a model of care

Supportive oncology is the wider model of proactive, multidisciplinary cancer care and support, outside tumour-specific treatment, that helps people to live as well as possible with and beyond cancer.

It runs across the whole pathway from diagnosis onwards and aims to improve quality of life and prevent and/or manage complications, while supporting treatment decisions, reducing avoidable deterioration and helping people with cancer to remain as independent and well as possible.

Supportive oncology brings together services that people with cancer may need alongside any tumour-specific treatment, including:

- > acute oncology
- > specialist onco-toxicity management
- > specialist cancer pain services
- > enhanced supportive care and specialist palliative care
- > geriatric medicine, frailty and onco-geriatric services
- > surgery and other specialist medical services, including cardiology, respiratory medicine, gastroenterology, nephrology, neurology and endocrinology
- > psycho-oncology and psychological care
- > dietetics, physiotherapy, occupational therapy and speech and language therapy
- > prehabilitation, rehabilitation and late-effects services
- > primary care, community, social care and neighbourhood health services.

### **Supportive oncology as a specialist service**

In a limited number of settings, supportive oncology is a dedicated clinical service. These services provide specialist assessment and care for people with complex symptom, functional, psychological or social needs, and coordinate input from the wider supportive oncology network when required.

These services provide a model for proactive, holistic and coordinated care; where they do not yet exist, the principles of supportive oncology should still be embedded through collaboration between cancer, acute, primary care, community, palliative care and specialist services.

## **Why is this consensus statement needed now?**

Cancer care is at a pivotal moment, with more people living longer both with and beyond cancer. While this brings major benefits, it also means that increasing numbers of people need ongoing support to manage symptoms and deal with issues relating to treatment toxicity, frailty, multimorbidity and psychological wellbeing. They also need more complex rehabilitation and support to plan for future care.

Demand is also rising across the wider health system. People with cancer access health services more often than those without cancer, with evidence suggesting that they are more than twice as likely to use primary care, almost 50 % more likely to attend emergency departments, and three times more likely to be admitted to hospital.<sup>2</sup> They are also four times more likely to have a high, or very high, risk of frailty. Increasing incidence of frailty can lead to poorer outcomes, greater risk of complications and loss of independence. These pressures cannot be addressed by cancer services alone; they require an integrated response across cancer, acute, primary, community, palliative care and neighbourhood services.

Despite important progress, access to acute oncology and supportive oncology remains inconsistent. Varied service models mean that there can be numerous differences, including hours of operation, the level of integration with urgent and emergency care (UEC) and access to specialist supportive services. This can lead to people with cancer facing fragmented care, avoidable emergency attendance or admission, delayed specialist input, poor coordination after discharge, and inequitable patient experience.

Those people who are experiencing severe mental illness, deprivation and homelessness, along with people from other marginalised communities, are most likely to receive their cancer diagnosis as an emergency and at a late stage, leading to poor experience of care and worse prognoses. Acute and emergency services should be designed to meet the needs of the most vulnerable patient groups.

The National Cancer Plan for England recognises the need to expand and improve services to overcome variation.<sup>3</sup> This requires a shared vision of what acute and supportive oncology should deliver, and how services should operate as complementary parts of one coordinated model of care. To support delivery of the 10 Year Health Plan for England's ambitions to modernise the NHS, this vision must also enable progress towards providing more care in the community, digitising services where possible, and taking a preventative approach.<sup>4</sup>

This consensus statement establishes that shared vision. It defines the core functions of acute and supportive oncology, describes the standards of care that patients should expect, and supports commissioners, providers and clinical teams to develop services consistently. In turn, this will reduce unwarranted variation and ensure that people with cancer can access proactive support, urgent specialist advice and coordinated follow-up care, whoever they are and wherever they live.

### **How can acute and supportive oncology improve patient outcomes?**

Effective acute and supportive oncology services create a proactive model of care that anticipates patient need, prevents deterioration and helps people with cancer live as well as possible throughout their cancer journey by:

- > **reducing avoidable emergency attendances and hospital admissions** through earlier identification and management of complications
- > **improving symptom control and quality of life** through timely multidisciplinary assessment and intervention
- > **supporting treatment tolerance and completion**, particularly for older and frail patients

- > **reducing treatment toxicity and unplanned care use** through proactive monitoring, frailty assessment and supportive interventions
- > **increasing access to care closer to home**, reducing travel burden and improving patient experience
- > **improving care coordination** across hospital, community and primary care settings
- > **ensuring earlier access to palliative care, rehabilitation and psychological support**, leading to better patient experience and reduced burden
- > **reducing health inequalities** by providing consistent standards, regardless of geography or service configuration.

## **Consensus statement**

This consensus statement seeks to outline what acute and supportive oncology services should deliver for people living with cancer, in response to a recommendation in the National Cancer Plan for England.<sup>3</sup> Given local variation, it sets out principles, standards and recommendations to be addressed across a healthcare system, rather than setting out specifications for local service models.

While the consensus statement was developed at the request of the UK government's Department of Health and Social Care and NHS England, the Acute and Supportive Oncology Collaborative (ASOC), which developed the statement, had representation from UK-wide organisations and so its implementation should be considered by each national UK government and the NHS.

**1**

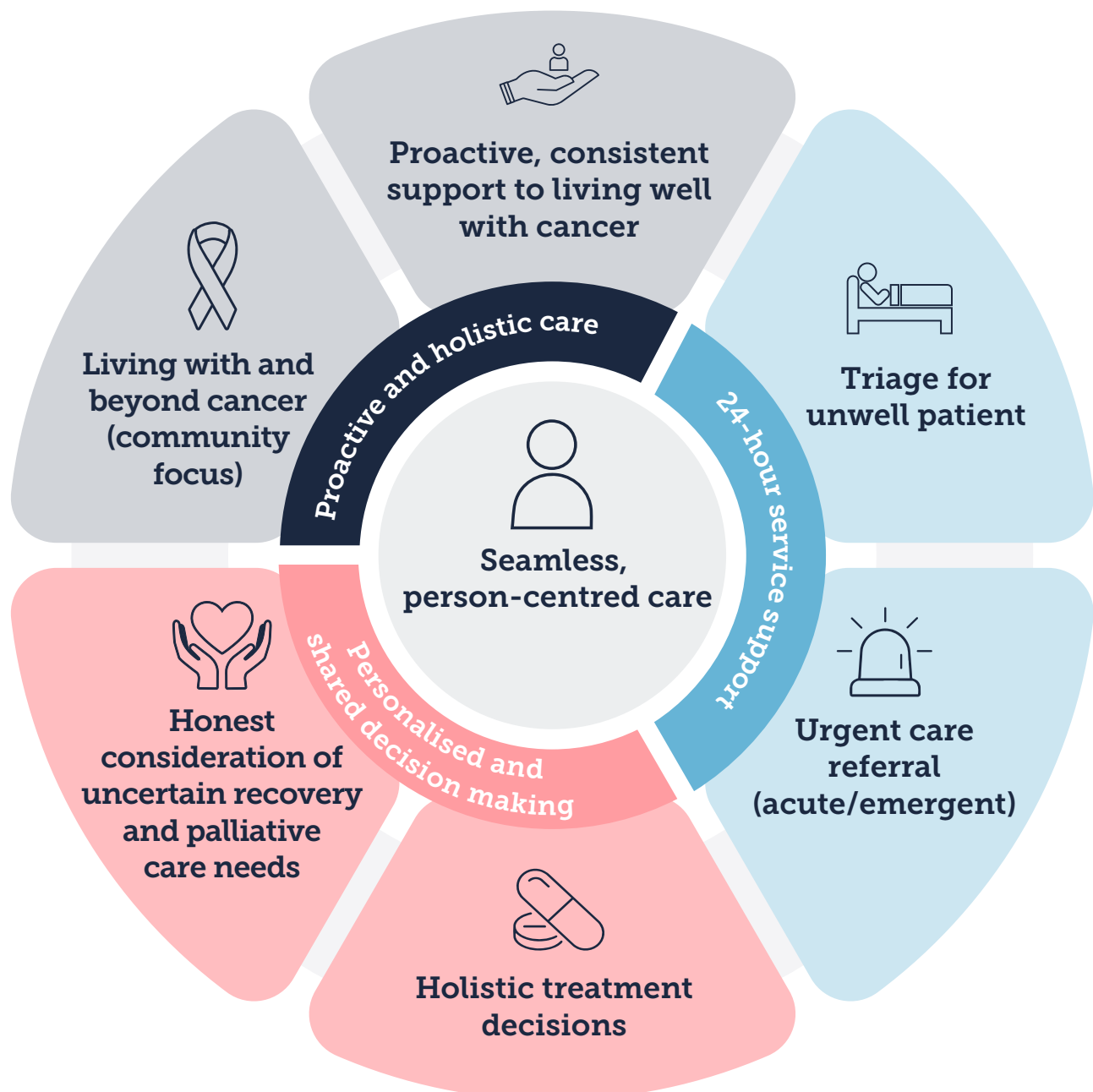
## **THE IDEAL PATHWAY**



The ideal pathway should support people throughout their individual journey following a cancer diagnosis. The following principles underpin this pathway, from staying well with cancer and preventing avoidable deterioration, through timely access to specialist care when acute illness occurs, to appropriate support afterwards.

- > Keeping people with cancer well and preventing acute illness by providing care closer to home, aligned with a proactive approach to comorbidity, frailty and psychological health.
- > Ensuring equitable access to the services and specialists required when people with cancer become acutely unwell, and clear integration with local acute services to enable ambulatory care where possible.
- > Recognising and providing support services required after acute illness, including end-of-life care.
- > Relationship-centred care, including family and carer support networks.

## Living well with cancer: person-centred acute and supportive oncology pathways



## 2

# CROSS-SERVICE FACTORS



The following elements of care are relevant to both acute and supportive oncology.

## 2.1 Person-centred care

Person-centred care supports patients to have their individual needs met and can impact their quality of life and experience of care.<sup>5</sup> It has also been shown to improve trust in doctors among people affected by cancer.<sup>6</sup>

- 2.1.1 Patients should have a needs assessment at the start of their pathway and at key pathway transition points, to surface any medical, psychological, financial, practical and spiritual concerns that they may have. These conversations should include people close to the patient, and should generate a personalised care and support plan (PCSP) with signposting and/or referrals onto support services as required.
- 2.1.2 Patients should have the opportunity to indicate their needs and wishes in the event that they need emergency or urgent care. These should be documented in an anticipatory crisis care plan (detailed in 4.4), and shared electronically across settings, to inform future clinical decisions.
- 2.1.3 Patients should be supported and encouraged to complete patient-reported outcome measures (PROMs) at regular frequencies, so that they can make their healthcare teams aware of their symptoms and progress. PROM data should be collated and fed back to clinical teams to support responsive care. PROMs are a commitment in the National Cancer Plan for England, but the commitment is to deliver this by 2029.
- 2.1.4 Patient records should be accessible across care settings to enable joined-up care that is aligned to a patient's needs and wishes, and regardless of the service where they initially present, in line with the NHS 10 Year Plan for England's ambition for a unified single patient health record.

- 2.1.5 Healthcare professionals working within acute and supportive oncology should communicate with patients using sensitive, clear and jargon-free language, both in person and in writing. They should consider patients' health literacy, language barriers and digital skills, among other factors, and adapt their approach as needed.

- 2.1.6 Given increases in early-onset cancer,<sup>7</sup> acute and supportive oncology services should consider the specific needs of adult patients with cancer aged under 50, including in relation to any caring responsibilities and employment, and signpost as relevant.

## 2.2 Named leads

As committed to in the National Cancer Plan for England,<sup>3</sup> by 2027 all patients should have a named lead to support them through diagnosis and treatment. Currently, this would default to a tumour-specific treatment team. Tumour-specific teams should ensure that patients have needs assessments and an anticipatory crisis care plan that are updated at key points, such as if there is a change in a patient's prognosis or pathway.

As this role, and the proposed neighbourhood care leads, are developed within cancer pathways, they should include a clear focus on prevention and early intervention so that patients can, where possible, avoid unplanned care. To deliver this, they should have links to specialist and support services in both secondary and community settings to meet the full spectrum of patient needs.

## 2.3 Health inequalities

Unequal access to, and use of, healthcare services linked to a person's demographics, alongside wider determinants of health, are increasingly recognised. Deprivation is linked to lower rates of early diagnosis and higher rates of emergency diagnosis in England.<sup>8</sup>

- 2.3.1 Acute and supportive oncology services should be designed and delivered to be accessible to – and to meet the needs of – all patients, regardless of who they are and where they live, so that no services inadvertently increase inequity.
- 2.3.2 Healthcare professionals working in acute and supportive oncology should proactively seek to address health inequalities through asking patients, their families and carers about wider factors that may impact the patient's health. They should be offered information, assessment of support needs and signposting. The RCP's guide, *Bridging the gap*, may support this.<sup>9</sup>

## 2.4 Multidisciplinary team (MDT) approach

Cancer and its treatments are becoming increasingly complex and patient needs can change rapidly. This is especially the case for the increasing number of older adults and those people with multiple other long-term conditions who are undergoing cancer treatment. An MDT approach is essential to address this, and evidence demonstrates that it can improve clinical outcomes.<sup>10</sup>

- 2.4.1 Healthcare professionals in acute and supportive oncology services should be able to quickly and readily access and draw on the expertise of a range of specialties to meet patient needs. This should include support with symptom management, psycho-oncology, frailty, cognition and palliative care.

## 2.5 Digital and data

Local studies show that between 5–10% of all patients admitted have an active cancer diagnosis, and 17% of new cancer diagnoses are made at the time of admission. However, service planning is hindered by a lack of routinely reported data on acute cancer activity – Cancer Outcomes and Services Data Set (COSD) returns require manual input from acute oncology teams, and further work is required to provide an automated link to unplanned care data systems to support service evaluations at a local or regional level. This has been done in some cancer alliances (CAs), such as Cheshire and Merseyside, and should be replicated across the UK.

- 2.5.1 Population health management (PHM) systems should be developed to accurately understand acute and supportive oncology activity. This should include using data to enable early identification of those patients with the greatest unmet need and those most likely to use acute care, to help to address health inequalities.
- 2.5.2 National Cancer Audit Collaborating Centre (NATCAN) audit data should be routinely included as regional oversight and governance structures develop, linking acute and supportive oncology with UEC delivery.
- 2.5.3 Linking SACT prescribing information to acute care service use datasets would provide invaluable data on use of acute care by those on active cancer treatments, to both plan and improve service provision in line with the Model Acute Pathway.<sup>11</sup>
- 2.5.4 Patient-reported experience measures (PREMs), alongside other relevant available data, should be used to monitor and improve service provision.
- 2.5.5 PROMs should be embedded across the pathway, in line with the National Cancer Plan for England, to support symptom monitoring.<sup>3</sup>

- 2.5.6 PROM and PREM data should be analysed at an aggregate level within trusts to surface any trends that warrant service-, regional- or national-level attention and, if identified, these should be escalated and addressed accordingly. These data should also be reviewed as part of local governance arrangements.
- 2.5.7 Data on all unplanned admissions should be reviewed for any trends that may warrant investigation.
- 2.5.8 There should be the appropriate administrative support to take data and information on admissions, to optimise clinical capacity for patient care.

## 2.6 Education

Education is vital within acute and supportive oncology to ensure that healthcare professionals within these services can develop their own knowledge and skills, as well as support the education of others, including medical generalists. Given that unwell patients with new or yet-to-be-diagnosed cancers will encounter a range of clinicians, it is important that all clinicians can recognise possible new cancers and cancer-related complications that require referral, to improve outcomes. Professionals working in acute and supportive oncology need to have reciprocal skills and expertise in recognition and management of common presentations related to long-term conditions.

- 2.6.1 Acute and supportive oncology teams working with cancer alliances should advance the knowledge and skills of healthcare professionals in other relevant specialties, as well as medical generalists, to support them in recognising new cancers and cancer-related complications, such as treatment toxicities, in patients. This should include those in wider acute care and cancer teams.
- 2.6.2 Acute and supportive oncology teams should have the time and resource for continuing professional development (CPD) and for the education of others as per 2.6.1.

## 2.7 Neighbourhood health

The shift from hospital to neighbourhood care, as outlined in the 10 Year Health Plan for England,<sup>4</sup> has the potential to bring acute and supportive oncology care closer to, or within, home. This would enable those with cancer to benefit from local resource such as 'social prescribing', local tests and prescriptions, and would therefore reduce the burden of travel while bringing other possible benefits, such as better enabling patients to work or study. Equity of access is important here across health systems so that all patients can benefit.

- 2.7.1 Acute and supportive oncology services should be delivered in neighbourhood settings where this is clinically appropriate and meets patient wishes, with a clear focus on equity of access across health systems.
- 2.7.2 Acute and supportive oncology services should take an active role in shaping new service models that enable their services to be delivered in neighbourhood settings, and should be ready to adapt to new models as they are developed. There should be strong working relationships between these services and the evolving models of care, such as neighbourhood frailty services.
- 2.7.3 Acute and supportive oncology services should adapt to scientific and technological advances that support the delivery of care and support in community settings, including developments in remote monitoring and virtual wards.

## 2.8 Research and innovation

Cancer care is constantly adapting to new and improved treatments, technologies and care models. This is likely to continue at pace in line with the National Cancer Plan for England's focus on world-class research,<sup>3</sup> and will have benefits for acute and supportive oncology.

2.8.1 Acute and supportive oncology healthcare professionals and services should quickly adopt innovations within science and technology that will enable better patient care and outcomes (eg new treatments, AI).

2.8.2 Acute and supportive oncology healthcare professionals and services should seek opportunities to innovate how they deliver care where it is likely to improve patient outcomes, care and/or experience, and share beneficial innovations at a regional and national level to inform wider practice.

2.8.3 Healthcare professionals working within acute and supportive oncology should, where possible, contribute to research that will further the specialties.<sup>11a</sup>



## Minimum acute and supportive oncology provision required in every health system

While not all acute oncology and supportive oncology needs can be met in every neighbourhood, there is a minimum level of provision that should be delivered by providers.

Service configurations will vary depending on how health systems are structured, yet these should meet the principle that services should be accessible in each geographic region and as close to home as possible.



### Access to highly specialised/national services

- > Equitable access to highly specialised services such as:
  - rare cancer services and MDTs
  - shared standards – training, education, data
- > Access to appropriate clinical trials, no matter where people live

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### Local services

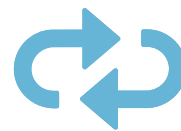
- > Urgent and emergency care
- > Core acute oncology service 7/7
- > Multidisciplinary support



4

### Regional services

- > Regional expert oncology clinical advice and triage
- > Specialist toxicity and complication services
- > Specialist organ-specific expertise
- > Specialist cancer emergency pathways
- > Specialist supportive oncology services



2

### Two-way integration with core community non-cancer-specific services

- > Primary care
- > Palliative care
- > Frailty and long-term condition care
- > Services to support living well with cancer including prehabilitation/rehabilitation, psychology, nutrition
- > Urgent community support

3

# 1

## Core local services (available in all acute hospitals)

Every acute provider caring for people with cancer should provide:



### Urgent and emergency cancer care

- > Integration with local urgent and emergency care pathways, including ambulance services, pre-hospital triage, hospital at home services, and admission avoidance pathways.
- > Access to cancer assessment pathways within existing medical same-day emergency care (SDEC) services or a dedicated cancer SDEC.
- > Acute oncology involvement in emergency department and acute medical/surgical pathways.



### Acute oncology service

- > A core acute oncology team with:
  - job-planned consultant oncologist capacity
  - specialist acute oncology nursing workforce
  - administrative and service coordination support.
- > Access to a 24/7 acute oncology advice line, which may be delivered through a networked regional model. Advice lines must integrate with local UEC services.
- > Electronic systems for rapid identification and review of patients admitted with cancer-related complications.



### Multidisciplinary support

- > Palliative care review of patients referred to acute oncology – consider joint MDT working
- > A defined malignancy of unknown origin (MUO)/cancer of unknown primary (CUP) pathway with access to regional specialist advice.
- > Defined local pathways and relationships to ensure rapid access to:
  - specialist palliative care
  - acute medicine and urgent diagnostics and procedures (ascitic drains, pleural procedures)
  - emergency medicine
  - emergency surgery
  - care of older people/frailty services, including allied health professionals (AHPs)
  - haematology
  - psychological support/psycho-oncology services.



### Governance and assurance

- > A local acute oncology working group reporting to trust cancer governance structures.
- > Oversight of urgent cancer care activity, quality improvement and service development.
- > Monitoring of access to key acute and supportive oncology pathways.



**Standalone cancer centres have a key role.** They can provide substantial clinical expertise, and also training, education and trials capacity. They should ensure that they develop safe pathways to manage as many patients as possible within their own centre. They should also ensure equity of care across the population that they serve, and partner with local acute trusts to networked regional acute oncology expertise.

## 2

## Regional network services

Cancer alliances and regional cancer networks should ensure access to specialist services that are not feasible to provide in every hospital and which benefit from networked expertise.



### Regional clinical advice and triage

- > Regional 24-hour cancer triage and advice services supporting urgent cancer care, SACT toxicity and radiotherapy-related complications.
- > Senior specialist remote triage and advice to support decision making before secondary care transfer.
- > Integration with regional urgent and emergency care pathways.
- > Rapid access for specialist symptom support – via phone, video or hot clinic.



### Specialist toxicity and complication services

- > Regional onco-toxicity expertise for the management of complications associated with immunotherapy and novel anti-cancer treatments.
- > Agreed access to specialist immunosuppressive and supportive therapies for severe toxicities.
- > Networked access to specialist advice for treatment-related complications.



### Specialist organ-specific expertise

Named specialist expertise for complex cancer treatment-related complications in the following specialties:

- > neurology
- > endocrinology
- > respiratory medicine
- > gastroenterology
- > cardiology
- > dermatology
- > acute medicine

with clear mechanisms for urgent consultation and MDT input.



### Specialist cancer emergency pathways

Regional pathways should be established and accessible 7/7 for complex cancer emergencies:

- > metastatic spinal cord compression (MSCC), including access to surgery and radiotherapy
- > superior vena cava obstruction (SVC), including interventional radiology and radiotherapy
- > malignant bowel obstruction
- > upper and lower gastrointestinal stenting
- > central airway obstruction
- > malignant pericardial effusion
- > emergency chemotherapy for life-saving indications
- > neuro-oncology emergencies.



### Specialist supportive oncology services

Access to regional expertise – these services should be accessible from community settings:

- > complex supportive oncology services
- > specialist pain services
- > pleural services and procedures, including ambulatory pleural care
- > late effects services
- > specialist rehabilitation
- > teenage and young adult (TYA) and young adult family support
- > complex psycho-oncology
- > advanced symptom management services.

**3**

## **ACUTE ONCOLOGY – EMERGENCY CANCER CARE**



The most common reason that patients with cancer need acute care is disease progression and poor symptom control. For people with known or suspected cancer, accessing acute care is linked to poorer outcomes and death,<sup>12</sup> with research suggesting that most people with cancer access unplanned care in the year before they die.<sup>13</sup> Triaging and caring for people presenting with escalating or acute cancer needs is therefore a critical moment in their patient journey and requires specialist skills, knowledge and care.

The statements below detail what services should seek to deliver for patients, adding detail to the outline in the tables on pages 16–17. These principles build on published guidance on commissioning of acute oncology services (England 2017)<sup>14</sup> and the national standards for acute oncology (Wales 2016),<sup>15</sup> but recognise that acute oncology services alone cannot provide comprehensive acute cancer care. For more detail on how a model acute oncology service could be structured at a local level, see Appendix 1.

### 3.1 Overarching service principles

Acute oncology provision, at a health-system level, must be available 24 hours a day, 7 days a week, with continuous specialist oversight and a dedicated helpline. While many services are run by nurses and other healthcare professionals, this should include access to consultant expertise 7 days a week.

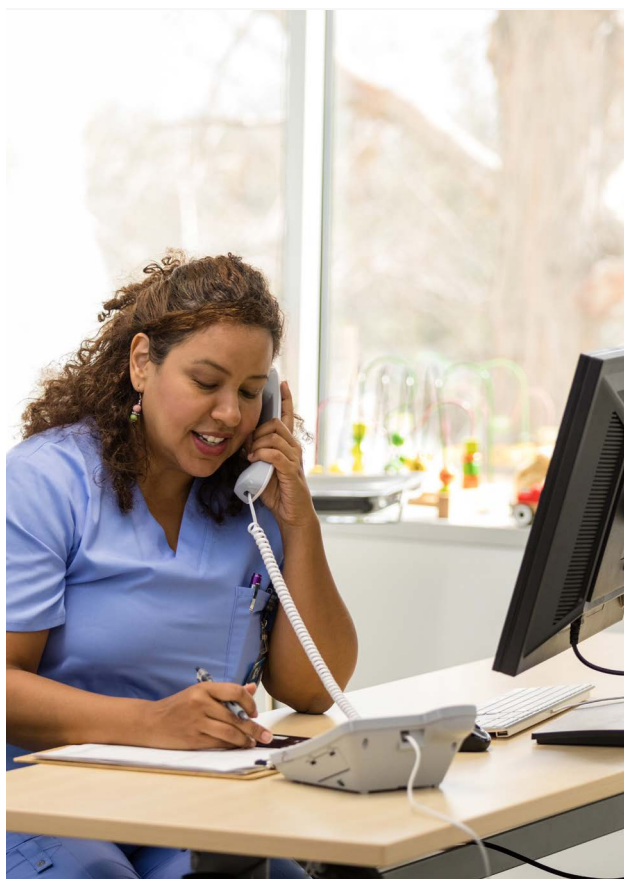
- 3.1.1 Acute oncology should be well understood and integrated with all other relevant NHS services, including NHS 111, primary care and unplanned care, so that there is ‘no wrong front door’ for patients, and an effective two-way flow between services is established.
- 3.1.2 Patients should be effectively triaged and not sent inappropriately to emergency departments where there are alternatives, eg hot clinics that would provide better patient outcomes. This requires capacity and capabilities in the alternatives, and operating hours matching the most common presentation times for emergencies.

- 3.1.3 Patients should be supported to avoid acute admission, through integrated working between acute and supportive oncology that enables monitoring, early intervention and keeping them at home where clinically appropriate.
- 3.1.4 Hospitals with emergency departments should provide face-to-face acute oncology assessment over extended hours, 7 days a week. To ensure equity of service, acute oncology services may require networked capacity across a region. This may include remote senior acute oncology expertise and/or joint working with palliative care services across 7 days.
- 3.1.5 Acute oncology services should include dedicated consultant oncology time for direct care, especially in light of the increasing number of complex onco-toxicity cases and patients with multiple long-term conditions. Consultants should be involved in service oversight in line with recent RCR/UKAOS job planning guidance.<sup>16,17</sup> Consultant oncologist support to the acute oncology team has historically been inconsistent, because acute oncology time has not always been visible in consultant job plans. This has been exacerbated by pressure to shift acute oncology activity into site-specific roles.<sup>18</sup>

### 3.2 Triage

- 3.2.1 There should be clear pathways to guide how patients with known, or suspected, cancer are cared for, wherever they present with acute needs. These should account for how local services are configured and include emergency departments, primary and urgent community response (UCR) teams, including pre-hospital care.
- 3.2.2 UCR teams should have access to acute oncology expertise to ensure that patients with acute cancer needs are not conveyed unnecessarily to secondary care.
- 3.2.3 When patients with known, or suspected, cancer present in person as an emergency, they should be assessed by or with the support of acute oncology (also see 3.9).

- 3.2.4 Hot clinics, comprising acute and supportive oncology healthcare professionals, should be used to proactively identify patients who would benefit from targeted interventions to prevent escalating care needs where possible. These could be delivered in person or virtually.



### 3.3 Triage via an acute oncology helpline

- 3.3.1 Acute oncology helplines should be staffed by healthcare professionals with the skills to assess patients, using the UKONS 24-hour triage toolkit.<sup>19</sup> Teams should direct patients appropriately, with support from a senior clinician with expertise in acute oncology as outlined in 3.3.2, for care and support based on individual patient needs and knowledge of local service provision (eg whether there is an acute oncology SDEC).
- 3.3.2 Acute oncology teams should have access to, and be supported by, a senior decision maker with acute oncology expertise in their health system, who can remotely review cases where needed to ensure that patients are referred to the most appropriate service for their needs.
- 3.3.3 Acute oncology helpline teams should minimise unnecessary hospital attendance and emergency admissions where clinically appropriate, while ensuring that patients with potentially life-threatening presentations, such as neutropenic sepsis, are urgently directed to the most appropriate emergency care.
- 3.3.4 When contacted out of hours, helpline teams should consider whether it is in the patient's best interests to arrange urgent care the following day (eg review in an SDEC or a non-face-to-face assessment) or an immediate referral to the acute oncology service, medical services or, for true emergencies, the emergency department. Helpline teams should be able to refer patients to alternative services without patients having to contact another service for 're-triage'.
- 3.3.5 Patients should be given clear guidance on how to contact their acute oncology helpline, and consideration should be given to those with disabilities or skill/language barriers that may impact their ability to access the service.

## Cancer SDEC – Weston Park Cancer Centre

Weston Park Cancer Centre (WPCC), Sheffield Teaching Hospitals NHS Foundation Trust, developed an oncology SDEC model serving the South Yorkshire and Bassetlaw Cancer Alliance population of 1.8 million people. As the region's sole oncology provider, WPCC delivers treatment across five acute trusts and hosts a 24/7 oncology hotline.

To improve urgent cancer care and reduce avoidable

admissions, WPCC established a dedicated cancer SDEC service linked to a regional acute oncology MDT. The service provides rapid specialist assessment, diagnostics and ambulatory management for patients with treatment toxicities and cancer-related complications.

During 2023, the cancer SDEC reviewed 1,199 patients, with more than 500 seen face to face and the remainder managed

virtually. The admission rate was <1 %, compared with approximately 50 % for patients managed through the traditional oncology assessment and admission pathway. The service has demonstrated that many patients can receive safe specialist care without hospital admission while maintaining access to oncology expertise across a large geographical area.

### 3.4 Same-day emergency care (SDEC)

SDEC has a vital role in providing urgent care for people with cancer, while avoiding emergency admissions where clinically appropriate and in the patient's best interests.

- 3.4.1 Health systems should include SDEC provision to meet the needs of patients with cancer, while reducing unnecessary hospital admissions where possible. This could be a dedicated cancer SDEC or ensuring that acute oncology support is available in local SDEC services, including surgical, older people's care or acute medicine. Any acute oncology SDEC or support should be available through the normal operating hours of SDEC services in that system.
- 3.4.2 Cancer SDECs should provide coordinated access to assessment, diagnostics and treatments, and be staffed by healthcare professionals with skills to deliver time-sensitive care and deal with complex cancer cases.
- 3.4.3 Acute oncology services should be integrated into urgent community care developments, for example virtual ward services.<sup>20</sup>

### 3.5 Acute oncology admission

- 3.5.1 Acute oncology services should receive a timely notification when an oncology patient is admitted. Consideration is needed of shared access to treatment information, noting that many patients receive cancer treatment on a different site from where emergency care is provided.
- 3.5.2 When an acute admission to hospital is required, urgent and acute oncology services should identify and meet initial patient needs as quickly as possible. This should be in line with the standards in the Model Acute Pathway.<sup>11</sup>
- 3.5.3 Acute oncology team members should have recorded conversations with patients on contingency planning, prognosis and future care plans, which are shared with tumour-specific teams and community services that will support patients closer to home.
- 3.5.4 To create equity and consistency at a system level, virtual acute oncology MDT meetings should be provided to local services. In this way, regional clinicians with acute oncology expertise could support with reviewing complex cases and decision making and enable interdisciplinary collaboration and learning.

## The Sussex Acute Oncology virtual multidisciplinary team

The Sussex Acute Oncology virtual MDT provides daily consultant-led specialist input to clinical teams across all Sussex hospitals, ensuring equitable access to expert acute oncology advice regardless of a patient's location. The service supports rapid decision making for patients presenting with cancer-related complications, treatment toxicities and complex supportive care needs.

Through daily virtual discussions, acute oncology consultants work collaboratively with local clinical teams to provide timely recommendations on investigation, management and treatment escalation or de-escalation. This model provides consultant oncologist support for acute oncology nursing colleagues working across a large geographical patch. A key strength of the model is its close integration with specialist palliative care services.

This integrated approach has improved access to specialist expertise, strengthened collaboration between organisations, reduced variation in care and helped to ensure that patients receive the right treatment, in the right place, at the right time.

**'Having their specialist experience was so reassuring when I was going through a complex time following treatment. The team knew exactly what to do.'**

Patient who received support from an acute oncology service after immunotherapy for kidney cancer diagnosis

**'Your team makes an enormous difference not only to the patients you see, but also to those you don't – through education, through visibility, and simply through familiarity with how you work – meaning that clinicians think more readily of palliative care inputs than they would if you didn't exist.'**

Acute medical consultant referring to the specialist palliative care team presence on the AMU

### 3.6 Treatment side effects and toxicity

While cancer treatments are becoming more effective, they are also increasing in complexity and side effects. Unlike chemotherapy, immunotherapy toxicity can present at any point and may result in long-term conditions that require ongoing monitoring. It is crucial that acute oncology services can respond to urgent patient care needs covering both traditional and newer treatments, including immunotherapies such as checkpoint inhibitor immunotherapies.<sup>21</sup> Between 30–50% of patients receiving checkpoint inhibitors will develop significant immunotoxicity.<sup>22</sup> In modern cancer care, onco-toxicity services are therefore vital to support patients experiencing toxicities.

- 3.6.1 Health systems should provide access to onco-toxicity services to all patients with cancer. These services should focus on early intervention and toxicity reduction, to enable patients to continue receiving potentially life-saving therapies.
- 3.6.2 Acute oncology services should have rapid access to advice and support from other specialties, to enable them to deal quickly with the complexity and unpredictability of side effects from some newer treatments.
- 3.6.3 Services should be able to readily access medication for refractory immunotoxicity, including targeted immunosuppressive therapies.
- 3.6.4 Given that recognising novel side effects of treatments can be challenging for generalists, acute oncology services should take opportunities to educate other specialties that provide care for patients with cancer.
- 3.6.5 There should be pathways for acute oncology and other colleagues across primary and secondary care to access regional expertise for complex onco-toxicities. This expertise should include MDT input for complex toxicities and late-effect considerations, as acute presentations may occur years after cancer treatment has finished.

### 3.7 Risk of death and palliative care in acute oncology admissions

Given that patients who have had an acute oncology admission are at a higher risk of deterioration and death,<sup>12,13</sup> it is important that acute and palliative care services work together closely and proactively to meet patient needs and support a two-way patient flow between the services. It is also vital that healthcare professionals working in these services have honest conversations with patients, families and carers about poor prognosis where relevant, to help prevent the otherwise significant risk of futile interventions at the end of life and patients dying without dignity.<sup>23</sup>

- 3.7.1 Acute and supportive oncology care should be underpinned by timely, compassionate and effective communication with patients, their families and carers about prognosis, death and future care planning. This should include recognition of uncertainty around recovery and prognosis where appropriate.<sup>24</sup>

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**'... if the team had not stepped in and been the professional, knowledgeable and compassionate team member he clearly is, I really do not want to think what could have happened. The team was able to identify that my Dad was presenting serious symptoms which needed further investigation and was able to support with pain management and be the conduit between my Dad and the acute medical team.'**

**Family member supported by specialist palliative care team during an unplanned cancer admission**

- 3.7.2 Healthcare professionals in acute and supportive oncology services should receive training and guidance on the communication skills needed to deliver 3.7.1, so that staff are supported and there is equity in patient experience.
- 3.7.3 There should be appropriate information sharing and coordinated working across care settings to ensure that patients receive the right care at the right time.
- 3.7.4 Palliative care, geriatric medicine and acute oncology services should be closely networked, and establish a way of working to identify and meet the needs of patients under acute oncology services – an example of this could be a weekly MDT meeting.
- 3.7.5 Acute oncology services should have 24/7 access to palliative care for advice and support. They should work together in real time to identify those patients at highest risk of deterioration and death and act accordingly, eg have care planning conversations with those at highest risk, and their families and carers, to meet patient wants and needs.

## 3.8 Acute episode follow-up

Effective follow-up care after unplanned care can be key in preventing further acute episodes where possible.

- 3.8.1 A patient's named lead should be informed if they have an episode of unplanned care related to cancer or its treatment, and they should see them face to face after discharge to update their needs assessments and anticipatory crisis care plan before any planned SACT or radiotherapy.
- 3.8.2 Pathways should be in place to de-escalate care from acute to supportive services and there should be recognition by the patient's cancer and wider healthcare team of the mortality risk of their admission, triggering a care planning conversation as appropriate.
- 3.8.3 Patients should be provided with effective and comprehensive follow-up care. This could include relevant health and lifestyle information and advice to enable them to be active partners in managing their continued recovery. This has been piloted effectively with cancer support workers for inpatients at North Bristol NHS Trust acute oncology service, linking out into community-based assessment, services and third sector providers.

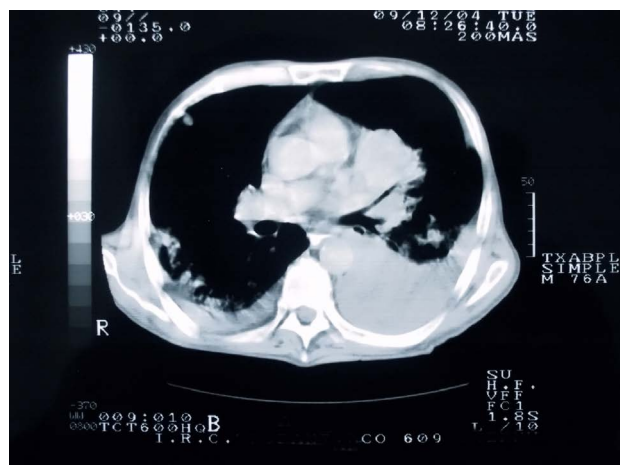


### 3.9 Acute and supportive oncology services' role in emergency diagnosis

Approximately 17 % of cancer diagnoses in England are linked to an emergency admission,<sup>25</sup> which has been a positive trend downwards; however, rates remain high for some tumours, eg brain, pancreatic and gastric cancer. Acute presentations are typically higher in patients with multiple comorbidities, including mental health, and in those living with deprivation. Patients who receive a diagnosis through an emergency route have high unmet needs, high unplanned care use and often do not have a site-specific team to manage early diagnostics and symptom management.

Early oncology input has been proven to speed up the diagnostic pathway and reduce inappropriate invasive diagnostic procedures for patients on MUO/CUP pathways, and there is an opportunity to improve outcomes where emergency diagnosis is common but treatable (eg ovarian cancer).

- 3.9.1 When patients with suspected cancer present as an emergency, they should be assessed by, or with, acute oncology so that the service can support decision making from presentation.
- 3.9.2 Acute oncology services should be the key case manager for people diagnosed with cancer in an emergency, helping to assess suitability for treatment, coordinating care, and working closely with palliative care when active treatment is not appropriate.
- 3.9.3 Acute oncology services should not wait until a biopsy-confirmed tissue diagnosis is made before involvement.
- 3.9.4 Patients who can be safely discharged from the acute care setting should be provided with clear follow-up support, including a named key acute oncology contact.



# 4

## **SUPPORTIVE ONCOLOGY – ITS ROLE AT CANCER DIAGNOSIS**



Keeping people at home and as well as possible through cancer and its treatments requires acute and supportive oncology services that are proactive in preventing, anticipating and addressing patient needs. At diagnosis, it is important to undertake baseline assessments and create care plans, including for those diagnosed with advanced disease, to inform patient care.

It is also important to support patients to be active partners in their care, where appropriate, to optimise their health ahead of treatment through providing information and tailored advice, alongside setting realistic goals.

## 4.1 Baseline assessments to inform care

Baseline assessments inform patient care and support, including upstream intervention and prevention, and can identify social, practical and other barriers that contribute to poor care outcomes.

For older patients, comprehensive geriatric assessment is key, as research highlights that they can support optimal treatment and care planning, for example, in predicting which patients may be at greater risk of chemotherapy toxicity.<sup>26</sup> Furthermore, onco-geriatric services, such as the Geriatric Oncology Liaison Development (GOLD) team at St Thomas' Hospital, have shown reduced toxicity and use of unplanned care, yet less intensive interventions – such as training oncologists in basic geriatric management and reducing polypharmacy – can benefit older patients.

- 4.1.1 Where the baseline needs assessment (outlined in 2.1.1) indicates mental health needs – for example, anxiety, low mood or distress affecting a patient's readiness to engage with prehabilitation – patients should be referred to psycho-oncology, in line with the four-level model of psychological care.<sup>27</sup>

- 4.1.2 Patients aged 65 and over, and those with multiple long-term conditions, should undergo frailty screening using the Clinical Frailty Scale (CFS). Those with CFS scores of 4–6 should undergo comprehensive geriatric assessment to inform their care plan. Services could use the Joint Collegiate Council for Oncology (JCCO) guidance to support this,<sup>28</sup> and timelines for completing frailty assessments should align as appropriate with the Model Acute Pathway.<sup>11</sup>

## 4.2 Psychological care during cancer

Cancer and its treatment can create significant distress, uncertainty and practical complexity for patients and their families and carers at every stage of the pathway, so psychological care is essential. There are multiple points in the cancer pathway that require healthcare professionals to respond compassionately and safely to trauma, deterioration, difficult decision making and fear of recurrence.

- 4.2.1 Embedding psychologically informed care alongside physical and medical care enables earlier identification of distress, better communication, improved treatment engagement and quality of life, and timely access to specialist psycho-oncology for those with more complex or persistent needs.
- 4.2.2 Professionals working in acute and supportive oncology services should have access to both psychological support for teams and training in trauma-informed communication and psychological support.
- 4.2.3 The competencies and training for psychological practitioners working in developing acute and supportive oncology services should be met.<sup>29</sup>

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**‘Prehabilitation helps you pick, edit and contribute to your cancer story – so you have your own ownership and don’t just feel you are being “done to” ... Now I have a feeling of control over my body ... I don’t want [the diagnosis] to define me.’**

Patient who accessed a cancer-specific prehabilitation programme

### 4.3 Healthy living and prehabilitation

Effective prehabilitation has been shown to support patients to better tolerate cancer treatments.<sup>30</sup> Exercise is a component of this, and there is growing evidence suggesting that it impacts cancer survival rates<sup>31</sup> and that patient motivation to engage in physical activity increases when they understand its benefits.<sup>32</sup>

- 4.3.1 Patients should be supported to understand the benefits of prehabilitation and healthy living behaviours ahead of, during and following treatment. They should be offered advice and support, tailored to their needs, on areas including (but not limited to) exercise, nutrition, mental health and managing comorbidities. Patients should be signposted and referred as appropriate.
- 4.3.2 Patients should have access to ongoing advice and support regarding prehabilitation, should they have concerns or a change of circumstances.
- 4.3.3 Patients should be linked into relevant local public health services such as vaccination programmes and social prescribing.
- 4.3.4 Tobacco dependency treatment should be offered to every person with cancer who smokes, on an opt-out basis. Continued smoking after a cancer diagnosis is associated with reduced survival, increased treatment toxicity, higher rates of surgical and wound complications, and greater risk of recurrence and second primary cancers, across almost all tumour sites.<sup>33</sup>
- 4.3.5 In line with the neighbourhood health ambitions set out in the 10 Year Health Plan for England,<sup>4</sup> health systems should consider delivering prehabilitation services in the community where clinically possible and appropriate.

### 4.4 Anticipatory crisis care planning

There is often a failure to include pre-emptive planning for anticipated acute illness and deterioration at the start of a cancer journey, especially when starting SACT. Planning in case of acute illness is a fundamental activity that supports patient-centred care and can enable early intervention when complications are encountered, such as neutropenic sepsis<sup>35</sup> or toxicity from checkpoint inhibitors.<sup>36</sup>

- 4.4.1 Treating oncology teams should work with patients to ensure that they understand the signs and symptoms that they should look out for which may imply a complication of their cancer or treatment, and what to do in response. This should be supplemented with digital and physical information as appropriate.
- 4.4.2 Treating oncology teams and supportive oncology services should work with patients to develop an anticipatory crisis care plan, covering medical, personal and religious wishes as relevant to them. This should be updated at the patient’s request and reviewed at key stages of their pathway, for example, during or following an acute oncology admission. This should include information regarding prognosis, resuscitation decisions and advice on appropriate escalation of care in the event of critical illness.



## Community outreach supportive oncology – Right By You Wessex

Right By You Wessex is a community outreach supportive oncology service that delivers personalised cancer care for people with complex clinical, psychological and social needs.

Led by experienced cancer clinical nurse specialists, the service provides proactive care planning, symptom management and coordinated support for patients and their families, particularly those living with frailty, multimorbidity and/or severe mental illness, or experiencing health inequalities, where the ‘usual’ pathway is not set up to meet their needs.

The Right By You team provides navigation and bridging to cancer services, primary care, community teams, social care and the voluntary sector, enabling patients to receive holistic support closer to home.

The service also supports home-based management of symptoms and treatment of side effects, helping patients to maintain their quality of life and continue treatment where appropriate.

Independent evaluation of Right By You Wessex demonstrated improved patient experience, enhanced

integrated working across services, and reductions in healthcare utilisation, including emergency department attendances and hospital admissions. The evaluation found that for every £1 invested, the service generated up to £4 in health service savings.<sup>34</sup>

The Right By You model demonstrates the value of proactive, personalised supportive oncology services in improving outcomes, reducing inequalities and supporting care closer to home.

## 4.5 Palliative care

Palliative care is too often introduced late in the cancer pathway, leading to missed opportunities for early symptom management, advance care planning and holistic support, such as access to non-means-tested financial support.

- 4.5.1 Referral to palliative care should be based on patient need rather than prognosis alone, and may occur at any stage of the cancer pathway, including alongside active anti-cancer treatment.
- 4.5.2 Clinical teams should work with patients to establish personalised goals of care that reflect their wishes, needs and priorities, including avoiding unnecessary hospital admissions where appropriate.



**5**

## **SUPPORTIVE ONCOLOGY – ITS ROLE DURING CANCER TREATMENT**



To prevent unplanned and emergency care where possible during treatment, supportive oncology services need to be proactive in monitoring patients for any complications from their treatment or any progression of their disease that would benefit from early intervention. Where clinical issues are identified, collaboration between acute and supportive services, along with other specialties where needed, is vital to rapidly deliver appropriate care.

## 5.1 Healthy living support

- 5.1.1 Patients should continue to be given tailored prehabilitation advice and support, as outlined in 4.3, to support their health and wellbeing through treatment. This may be updated from their initial advice and support to account for the impact of their treatment.
- 5.1.2 Tobacco dependency treatment should be offered to every person with cancer who smokes, on an opt-out basis (see 4.3.4).



## 5.2 Patient monitoring and responding to emerging concerns

Patient monitoring is key in enabling early intervention to prevent upstream issues and to keep patients at home where possible and clinically appropriate.

- 5.2.1 Patients' electronic patient records (EPRs) should include that they are receiving cancer treatment and what this comprises, so that it is accessible wherever they may present.
- 5.2.2 Healthcare professionals should proactively monitor patients for treatment side effects and toxicities that may require medical intervention, taking advantage of digital tools and technology that enable this to be done remotely where clinically appropriate. Interventions here could include phone calls and PROMs, and clear thresholds should be in place to trigger further investigation of symptoms.
- 5.2.3 Patients living with multiple conditions and deprivation are likely to be least well served by the current system. Systems should focus on ensuring proactive support for those with greatest need and identify what to look out for, which may indicate a complication of their cancer or treatment and when and how to seek help.
- 5.2.4 Healthcare professionals monitoring patients should be able to swiftly access senior advice and request a patient review, guided by clear escalation thresholds.
- 5.2.5 Pathways should be in place to enable supportive oncology services to access timely advice and support from other specialties as needed.
- 5.2.6 There should be clear escalation thresholds in place to enable patient referrals into acute oncology, with the advice and support of acute oncology teams.

## 5.3 Specialist supportive oncology services

Specialist supportive oncology services in cancer centres have been shown to improve symptom burden and reduce secondary care use, including hospital attendance/admission as well as reduced length of stay, when proactive and multidisciplinary.<sup>37</sup> These services provide multiprofessional care to patients in a preventative manner. While these services are developing, it is vital that they are accessible for those with the greatest need and do not exacerbate existing unwarranted variation and inequity.

- 5.3.1 Supportive oncology service design should be informed by local need and resource, and align with the neighbourhood shift outlined in the government's 10 Year Health Plan for England<sup>4</sup> and the National Cancer Plan for England.<sup>3</sup>
- 5.3.2 Systems should work towards providing accessible supportive oncology services for people with the most complex needs who are undergoing cancer treatment, living with incurable cancer or living with the consequences of cancer treatment. This builds on enhanced supportive care (ESC) services for people with treatable but incurable cancer, who have complex needs stemming from their cancer or treatment.
- 5.3.3 Health systems without an ESC or supportive oncology service should look to incorporate best practice and principles from existing models, eg ensuring that the wraparound services in ESCs, such as cardio-oncology, psycho-oncology and endocrine late effects, are commissioned.



## The Christie NHS Foundation Trust – Supportive Oncology Directorate

The Christie Supportive Oncology Directorate is the first in the UK to bring together all supportive services in one place.

Launched in 2024, its goal is to fully integrate multidisciplinary supportive care into both planned and emergency pathways, as well as outpatient care and follow-up.

The directorate focuses on:

- > ensuring that all patients have equal access to services that improve their experience and quality of life during and after treatment

- > reducing waiting times and improving access to clinical expertise

- > increasing the input of senior medical staff and allied health professionals in hotline services, ward and outpatient provision

- > reducing emergency hospital admissions and shortening hospital stays through these efforts.

This model provides comprehensive, 7-day support through an integrated approach aligned with acute oncology. Services include attending ward rounds, close links with the hotline for

advice and guidance, daily drop-in ESC clinics, and a weekly supportive oncology MDT for discussion of complex cases.

By supporting ‘front door’ services at The Christie, the directorate helps patients to avoid hospital admissions when their GP or other secondary care options are only accessible through A&E.

A 3-year pilot estimated that almost 600 emergency admissions were avoided as a result of supportive oncology – equivalent to a £1.4m saving, or £460,000 a year.<sup>38</sup>

**‘The service supported me a lot with my neuropathy problems while supporting my recovery before any long-term support was available. This meant that I had access to support that aided my recovery in a timely and efficient manner.’**

Patient who received care from The Christie supportive oncology service during cancer treatment

## **SUPPORTIVE ONCOLOGY – ITS ROLE IN POST-TREATMENT CANCER CARE**



Increasing numbers of people are living with and beyond cancer, yet many experience persistent physical, psychological, social and/or financial consequences of cancer and its treatment without access to consistent, coordinated expertise and support. While many of the services required to help people live well after cancer are delivered outside specialist cancer care, there is limited integration and signposting to community-based support, making comprehensive end-of-treatment care planning essential. The third sector also plays a vital role in supporting people affected by cancer, with organisations such as Maggie's providing holistic psychological, practical and emotional support that complements NHS services, yet access to and integration with these resources remains variable. In addition, complex consequences of cancer treatment remain a significant and growing source of ill health, requiring equitable access to specialised services and a system-wide commissioning approach to supportive oncology care.

## 6.1 Neighbourhood care lead

- 6.1.1 As covered in 2.2, the National Cancer Plan for England commits to every patient having a community care lead by the second half of the plan.<sup>3</sup> These healthcare professionals should have the skills to support people who have had a cancer diagnosis in the community, including those in remission and those living with cancer as a chronic condition. The focus of these roles should be to support equitable access and signposting to supportive oncology services, as set out in this statement.
- 6.1.2 Neighbourhood care leads should be well networked into NHS and social care services, as well as those provided by charities and other community organisations, so that they can signpost patients as needed. They should be proactive, with a focus on prevention and upstream intervention where possible.

## 6.2 Patient monitoring and supported self-management

- 6.2.1 Where patients require monitoring for recurrence or progression, this should be done remotely where possible and as appropriate for their circumstances.
- 6.2.2 Where clinically appropriate, patients should be given information to enable them to self-manage the effects of cancer and its

treatment. Relevant referrals should be made to support them with self-management where this is appropriate, including advice regarding symptoms of common side effects, signs of recurrence, healthy lifestyle advice and rehabilitation provision.

## 6.3 End-of-treatment summary

- 6.3.1 As committed to in the National Cancer Plan for England, patients should receive a co-produced end-of-treatment summary for every definitive treatment.<sup>3</sup> This should include, but not be limited to, an overview of their treatment; any current support needs they may have from cancer or its treatment, including supported self-management; healthy living and rehabilitation advice; signs and symptoms to look out for that may indicate late effects of treatment, cancer recurrence or disease progression; and how to respond if these occur, including a rapid route back to oncology services if needed.
- 6.3.2 As neighbourhood models of care develop, treatment summaries should evolve to include this provision.

## 6.4 Ongoing side effects of cancer and cancer treatments

- 6.4.1 Patients should be supported to manage any ongoing effects of cancer or its treatments to enable them to live as well as possible. This should include access to late-effects services, and tailored rehabilitation advice and support on topics including, but not limited to, physical activity, nutrition and mental health.
- 6.4.2 These services should be in the community where possible, in line with ambitions for neighbourhood health.<sup>4</sup>
- 6.4.3 Where patients present with psychological late effects – such as persistent anxiety, depression or trauma-related symptoms following treatment – they should have access to psycho-oncology where specialist (level 3–4) input is indicated.
- 6.4.4 Primary care and other community-based healthcare professionals should be trained and equipped to readily spot the signs of late effects and recurrence, and to refer patients as needed. This should be underpinned with clear pathways.

## **SUPPORTIVE ONCOLOGY – ITS ROLE IN THE CARE OF PATIENTS WITH PROGRESSIVE AND INCURABLE CANCER**



As increasing numbers of people live with incurable and progressive cancer, access to coordinated supportive and palliative care remains variable, resulting in unmet physical, psychological and practical needs. A lack of timely, honest conversations about prognosis is a significant barrier to personalised care planning, effective supportive care, and helping people to live as well as possible with cancer.

## 7.1 Supporting patients to live well with incurable cancer

- 7.1.1 Patients with incurable cancer should be educated on how to spot signs of acute illness and what to do if these arise.
- 7.1.2 Patients with incurable cancer should be provided with information on living well and be signposted to resources and programmes as relevant, including psycho-oncology. These should be accessible in the community.
- 7.1.3 All patients with incurable cancer should have a 'what matters to me' conversation with their named lead, which should be shared in their personalised care plan. The Thinking Ahead Programme hosted by NHS Harrogate and District Cancer Services delivers patient education for people living with incurable cancer, supporting them to live well with cancer, but also to plan for acute illness and the end of life.<sup>39</sup> This could be replicated to enable personalised care planning at a greater scale.
- 7.1.4 An advance care plan should be prepared for future acute illness, including discussion of resuscitation decisions and appropriate escalation of care. This should be tailored for non-cancer professionals who patients may meet.

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**'With several problems after cancer treatment, the service has helped me return to work and be self-sufficient in my day-to-day living.'**

Patient who accessed specialist care from a supportive oncology service

- 7.1.5 Breathlessness is one of the most common and distressing symptoms experienced by people with advanced cancer, frequently leading to emergency attendance and admission, and causing significant distress for families and carers. Health systems should ensure access to integrated breathlessness support, delivered by respiratory, palliative care and allied health teams, combining non-pharmacological and pharmacological management, carer support and chronic cough management, with services commissioned as part of the supportive oncology offer and delivered where possible in community and neighbourhood settings.

## 7.2 Palliative care and end of life

- 7.2.1 Given the service overlaps, acute and supportive oncology should be aligned with palliative care in both secondary and community settings, and the Modern Service Framework for Palliative and End of Life Care should be implemented.<sup>40</sup>
- 7.2.2 Healthcare professionals in acute oncology should have the confidence and skills to recognise likely deterioration, to create advance care plans with patients, and to take a generalist palliative care approach to those patients with a high risk of dying and unmet palliative care needs.

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**'When I started having problems with mobility in 2015, it was suggested that this was just one of those things caused by chemotherapy and not much help was available. To find this support all these years later has helped me stop looking for miracle cures, but given me a lot more hope for the future.'**

Patient who accessed specialist care from a supportive oncology service

# CONCLUSION

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**Many acute and supportive oncology services currently deliver care to a high standard and have developed innovative solutions in line with local need and geography.**

Equally, emergency department attendance is the default access to care for many people living with cancer when they become acutely unwell. The aim of this statement is not to provide a blueprint that every cancer centre, alliance, health board or integrated care board must follow.

It provides a framework which, if enacted, should ensure that people living with cancer across England receive an equitable standard of care 7 days a week, and utilises a regional and digital approach where possible to reduce duplication, aid resilience and improve equity. Many of those who contributed represent the wider UK; we hope that the learning is equally useful across the four UK nations.



# HOW WAS THE CLINICAL CONSENSUS STATEMENT DEVELOPED?

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The development of consensus statement was jointly led by Dr Hilary Williams (clinical vice president of the RCP and medical oncology consultant) and Dr Ashling Lillis (national clinical advisor at Macmillan Cancer Support and acute medicine consultant), with project support provided by Macmillan Cancer Support. The content of the consensus statement was developed by the Acute and Supportive Oncology Collaborative (ASOC), a clinically led, multidisciplinary group established in January 2026.

To ensure that the consensus statement is comprehensive and reflects the diverse workforce involved in cancer care across settings, expertise was sought from a broad range of organisations involved in the care of people living with cancer. This included:

- > Royal College of Physicians (RCP)
- > Macmillan Cancer Support
- > Royal College of Radiologists (RCR)
- > UK Oncology Nursing Society (UKONS)
- > UK Acute Oncology Society (UKAOS)
- > UK Association of Supportive Care in Cancer (UKASCC)
- > Association for Palliative Medicine (APM)
- > Royal College of Emergency Medicine (RCEM)
- > British Geriatrics Society (BGS)
- > British Oncology Pharmacy Association (BOPA)

- > British Thoracic Society (BTS)
- > Society for Acute Medicine (SAM)
- > Association of Clinical Psychologists UK (ACP-UK) Psycho-Oncology, Cancer and Palliative Care (PSYCAP) Group
- > Royal College of Surgeons of England (RCSEng)
- > UK Society for Medical Oncology (UKSMO)
- > The Immuno-Oncology Clinical Network (IOCN)

Alongside the ASOC, the consensus statement was informed by:

- > published clinical evidence and national guidance
- > existing acute oncology, enhanced supportive care and supportive oncology service models
- > experience of clinicians working across cancer, acute, community and palliative care services
- > relevant England national policy programmes, including the National Cancer Plan for England, the NHS 10 Year Health Plan for England, urgent and emergency care transformation programmes, neighbourhood health developments, onco-frailty initiatives, MDT reform and modern service frameworks as they develop.

The process was conducted in four stages across multiple stakeholders, as outlined in Appendix 3.

## Formally endorsing organisations

The organisations listed below have formally endorsed this consensus statement following consideration through their internal governance processes.

- > Royal College of Physicians (RCP)
- > Macmillan Cancer Support
- > Royal College of Radiologists (RCR)
- > UK Oncology Nursing Society (UKONS)
- > UK Acute Oncology Society (UKAOS)
- > UK Association of Supportive Care in Cancer (UKASCC)
- > Association for Palliative Medicine (APM)
- > Royal College of Emergency Medicine (RCEM)
- > British Geriatrics Society (BGS)
- > Society for Acute Medicine (SAM)
- > Association of Clinical Psychologists UK (ACP-UK) Psycho-Oncology, Cancer and Palliative Care (PSYCAP) Group
- > Royal College of Surgeons of England (RCSEng)
- > UK Society for Medical Oncology (UKSMO)
- > The Immuno-Oncology Clinical Network (IOCN)



**Royal College  
of Physicians**



**The Royal  
College of  
Radiologists**

**UKONS**  
Oncology Nursing Society



**UKAOS**  
UK Acute Oncology Society



**UKASCC**



**Association for  
Palliative Medicine**  
Of Great Britain and Ireland



**British Geriatrics Society**  
Improving healthcare  
for older people



**Royal College of  
Emergency Medicine**



**Royal College  
of Surgeons  
of England**

**UKSMO** UK Society  
for Medical  
Oncology



**IOCN**

The Immuno-Oncology Clinical Network

**ACP** UK  
ASSOCIATION OF CLINICAL PSYCHOLOGISTS

**MACMILLAN  
CANCER SUPPORT**

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## Glossary

|       |                                             |
|-------|---------------------------------------------|
| AHP   | allied health professional                  |
| AMU   | acute medical unit                          |
| ASOC  | Acute and Supportive Oncology Collaborative |
| CA    | cancer alliance                             |
| CNS   | cancer nurse specialist                     |
| COSD  | Cancer Outcomes and Services Data Set       |
| CPD   | continuing professional development         |
| CUP   | cancer of unknown primary                   |
| EPR   | electronic patient record                   |
| ESC   | enhanced supportive care                    |
| ESO   | enhanced supportive oncology                |
| DGH   | district general hospital                   |
| MDT   | multidisciplinary team                      |
| MSCC  | metastatic spinal cord compression          |
| MUO   | malignancy of unknown origin                |
| PCSP  | personalised care and support plan          |
| PHM   | population health management                |
| PREMs | patient-reported experience measures        |
| PROMs | patient-reported outcome measures           |
| SACT  | systemic anti-cancer therapy                |
| SDEC  | same-day emergency care                     |
| SVCO  | superior vena cava obstruction              |
| tAPC  | trainee advanced clinical practitioner      |
| TYA   | teenage and young adult                     |
| UEC   | urgent and emergency care                   |
| UCR   | urgent community response                   |

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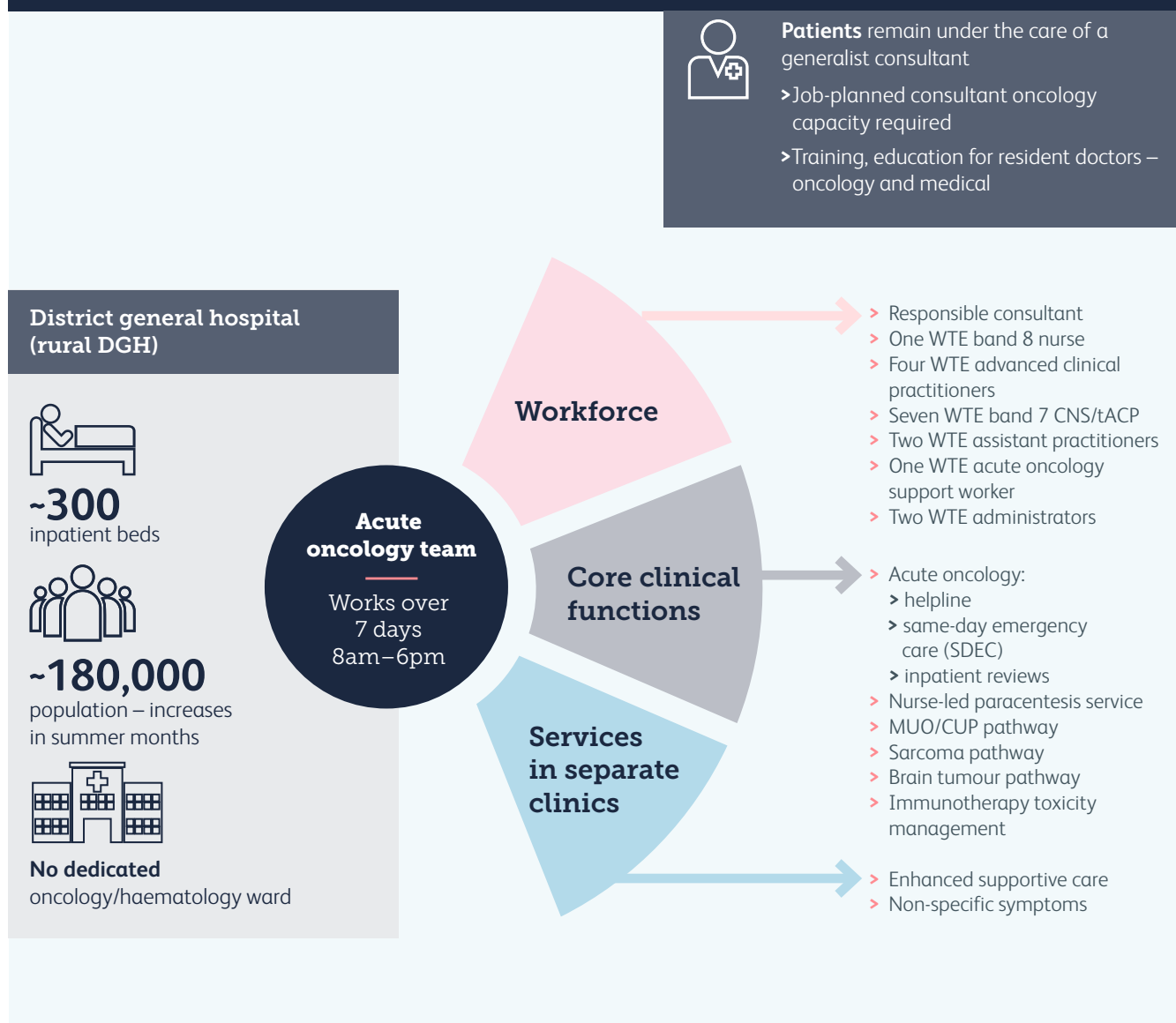
# APPENDIX 1

## Model acute oncology service, acute district general hospital (DGH)

The model below shows how an acute oncology service in a DGH acute trust (non-cancer centre) could support the delivery of the ideal unplanned acute cancer pathway across 7 days.

It requires regional expertise and support for complex presentations, but is based on current successful acute oncology service models that should be the foundation of holistic supportive oncology care. It is acknowledged that many acute oncology services have a much smaller workforce.

### ACUTE ONCOLOGY SERVICE MODEL



# APPENDIX 2

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## **Local acute/supportive oncology governance**

Local governance of acute oncology services in UK acute providers has been via standalone acute oncology working groups that report to local trust cancer boards. This process does not support integration with local UEC or oncology services. There should be a move towards acute provider oversight of urgent cancer care that includes key unplanned care, acute and supportive oncology stakeholders. This should align to local UEC transformation and support local visibility with regard to trust-wide unplanned cancer care performance and assurance. This should, in turn, feed into regional health system (cancer alliance/ integrated care system in England) assurance processes for both acute/supportive oncology and UEC.

## **Regional acute and supportive oncology governance**

Cancer alliances (CAs) in England should provide strategic, system-wide leadership to drive continuous improvement and reduce unwarranted variation in acute and supportive aspects of cancer care. CAs should undertake regular mapping and assessment of acute and supportive oncology services across their geography to identify gaps in provision, inequalities in access, and opportunities to optimise service delivery. CAs also have a role to play, working closely with providers, commissioners and system partners, in leading and coordinating related improvement efforts across acute and supportive oncology services. CAs should have clear assurance through acute oncology pathway boards that collate performance from providers, with clinical leadership and appropriate data and digital support.

CAs should have agreed service specifications that describe what patients and families can expect from acute and supportive oncology services, available to all patients regardless of geography and based on this guidance:

- > how services are delivered across DGHs, cancer centres and community services
- > clear referral criteria and escalation pathways
- > responsibilities of different providers within networked models of care
- > specialist advice should be proactively delivered on a regional basis to allow equity of care and should utilise digital technology.

CAs and integrated care systems should ensure that acute and supportive oncology are explicitly included within cancer programme governance arrangements and integrated with UEC, neighbourhood health and palliative care programmes.<sup>11</sup>

Across the UK, equivalent organisations and governance arrangements within the devolved nations should be responsible for providing assurance that these principles are implemented consistently and equitably.

# APPENDIX 3

The development process of the clinical consensus statement consisted of four stages.

1

STAGE

JANUARY 2026



## SCOPING AND STAKEHOLDER ENGAGEMENT

An initial meeting between Professor Peter Johnson (national clinical director for cancer, NHS England), the Royal College of Physicians (RCP) and Macmillan Cancer Support established the scope and objectives for the project. The Acute and Supportive Oncology Collaborative (ASOC) was subsequently formed from relevant professional groups and specialist societies.

2

STAGE

FEBRUARY–APRIL 2026



## DRAFT DEVELOPMENT

The ASOC established topic-specific clinical writing groups, which developed draft recommendations based on expert clinical experience, existing service models, published evidence and relevant national policy. In April 2026 an additional writer, funded by the RCP, joined the programme to support drafting and synthesis of content.

3

STAGE

JUNE–AUGUST 2026



## STAKEHOLDER REVIEW

The first full draft was circulated to ASOC members and stakeholder organisations for review, before feedback was collated and reviewed by the ASOC leadership team.

4

STAGE

SEPTEMBER 2026



## FINAL REVIEW AND ENDORSEMENT

The final draft was approved by RCP Council, with endorsement and co-badging provided by participating organisations.





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