ONC-SOP-005: Palliative care integrated with active cancer treatment

Standard operating procedure (SOP) · ONC-SOP-005 · Version 0.1 · Draft for local review

Supports: 51.6

At a glance

- Patients with a serious cancer diagnosis are referred to palliative care early, alongside active treatment, not only when treatment has stopped.
- Symptoms and wellbeing are screened with a validated tool at every treatment cycle.
- Each patient has a shared care plan agreed between oncology and palliative care, reviewed at set intervals and at any change.
- Referral, review and decisions are recorded in the notes the same day.
- Escalate at once if: a patient has uncontrolled symptoms, a new serious complication, or a request for end-of-life care.

1. Purpose

To make sure palliative care expertise is part of the cancer pathway from the point of serious diagnosis, so that symptoms are controlled, goals are understood and treatment decisions are made with the patient, while active treatment continues (51.6).

2. Scope

Item	Coverage
Applies to	Oncology, haematology and palliative care staff, and any clinician who diagnoses or treats cancer
Patients	Adults with a cancer diagnosis that is advanced, metastatic, recurrent or likely to shorten life, and any patient with a high symptom burden, at any point of treatment
Locations	Oncology outpatient clinics, day units, inpatient wards and community services linked to the facility

3. Definitions

Term	Meaning in this SOP
Palliative care	Care that improves quality of life for patients and families facing a serious illness, by preventing and relieving suffering, treating symptoms and supporting decisions. It can be given alongside treatment that aims to cure or control the cancer
Trigger for referral	A defined event listed in Section 9.1 that requires a palliative care referral
Shared care plan	A written plan of symptom management, goals and next steps agreed by oncology and palliative care, and shared with the patient and the primary care team
Validated tool	A symptom screening questionnaire with a known reliability, such as the Edmonton Symptom Assessment System (ESAS) or the Integrated Palliative care Outcome Scale (IPOS)

4. Background

Patients with serious cancer have high symptom burden, and many have needs that are not identified until late in the illness. Early integration of palliative care is associated with better symptom control, better quality of life and clearer understanding of prognosis. It does not mean that active treatment has stopped.

Introducing palliative care only at the end of treatment often means that patients and families have not had the chance to talk about their goals, or to get support with symptoms, when they most needed it.

5. Responsibilities

Role	Responsibility
Treating oncologist	Identifies triggers for referral, makes the referral, and agrees the shared care plan with the patient and palliative care
Oncology nurse specialist	Carries out symptom screening at each cycle and escalates concerns, and supports the patient between visits
Palliative care physician or nurse	Assesses symptoms and needs, leads the goals conversation with the patient, and agrees the plan with oncology
Unit or service manager	Keeps the referral pathway working and audits timeliness and completeness
Medical director	Approves this SOP and receives audit results

6. Materials and equipment

- Validated symptom screening tool (ESAS or IPOS), in the local language, in paper or electronic form.
- Palliative care referral form and access to the palliative care service's contact list.
- Goals of care and advance wishes form (ONC-FRM-004).
- Shared care plan template, kept in the electronic record.
- Written information for patients and families about palliative care and how it fits with treatment.

7. Safety

Palliative care referral is not a sign that treatment has failed, and must never be presented to a patient as a decision that treatment is ending. The language used must explain both aims of care: continuing treatment and controlling symptoms.

> If a patient or family asks about prognosis, answer honestly, check what they want to know, and record the conversation. Do not give a precise time frame unless the clinician is confident of it.

8. Before you start

1. Confirm the cancer diagnosis, stage and current treatment plan in the record.
2. Check the most recent symptom screen and any open safeguarding or social needs.
3. Check that the patient understands their diagnosis and has been offered a chance to ask questions.

9. Procedure

9.1 Triggers for palliative care referral

1. Diagnosis of advanced, metastatic or incurable cancer, at the time of diagnosis or at relapse.
2. Symptom score above the local threshold on the validated tool, or any symptom not controlled within one week.
3. Two or more unplanned admissions or emergency visits in three months.
4. A significant change in performance status or a decline in the patient's ability to care for themselves.

5. A request by the patient or family for palliative care or for help with decisions.
6. Any decision to change treatment intent, for example from curative to disease control, or from active to supportive treatment.

9.2 Referral and first assessment

1. Make the referral in writing, with the trigger recorded, within two working days of identifying it.
2. The palliative care team contacts the patient within five working days, or sooner if the symptoms are severe.
3. The first assessment covers symptoms, psychological, social and spiritual needs, understanding of the illness, the patient's goals and the family's needs.

9.3 Shared care plan

1. Agree a shared care plan with the patient, using ONC-FRM-004 for the goals conversation.
2. Record the plan in the electronic record, with the symptom management, the review date and the named contacts.
3. Share the plan with the patient, family and primary care team, with the patient's agreement.
4. Review the plan at least every three months, after each significant change in treatment or symptoms, and at discharge.

9.4 Symptom screening during treatment

1. Carry out the validated symptom screen at each treatment cycle, or at least every four weeks for patients on maintenance treatment.
2. Act on any score above threshold the same day, following ONC-SOP-009.
3. Record the score and the action taken.

10. Decision points

Situation	Action
Patient declines referral	Explain the purpose of palliative care again, record the decision and the reason, and offer to revisit at each visit
Symptoms not controlled within 48 hours of an agreed plan	Review the plan with the palliative care team the same day
Patient decides to stop active treatment	Refer to palliative care at once, and follow the end-of-life policy
Patient or family asks for a second opinion on goals	Arrange a multidisciplinary discussion within one week

11. Special situations

- Patients who do not speak the unit's language: use a professional interpreter for the goals conversation.
- Patients with cognitive impairment: involve the person they have chosen as a decision-maker and record the capacity assessment.
- Children and young people: follow the paediatric oncology palliative care pathway.

12. Escalation

- Uncontrolled pain or other severe symptom: same-day review by the on-call palliative care team.
- Disagreement between oncology and palliative care about the plan: refer to the multidisciplinary tumour board (ONC-POL-001).
- Concern about safety at home: follow the facility's safeguarding and social work route.

13. Monitoring

The service manager audits all patients with a trigger each quarter for referral timeliness, screening completion and plan review. Results go to the oncology governance meeting.

Measure	Target
Patients with a trigger who are referred within two working days	100 percent
Symptom screens completed at each treatment cycle	At least 90 percent
Shared care plans reviewed on time	100 percent
Patients with advanced disease who had a goals conversation recorded	100 percent

14. Records

- Referral form with the trigger.
- Symptom screen results and actions.
- Shared care plan.
- Goals of care record (ONC-FRM-004).
- Review and discharge records.

15. Training

All oncology staff complete palliative care communication training at induction and every two years. Oncologists and oncology nurses complete a half-day course on symptom screening and referral triggers every year.

16. Related documents

Code	Document
ONC-SOP-009	Pain and symptom assessment and control
ONC-FRM-004	Patient goals, values and wishes record
ONC-POL-001	Multidisciplinary tumour board
HSP-SOP-001	Family and carer support and information
HSP-SOP-005	Bereavement follow-up

17. Evidence

This SOP is based on the reference sources listed below and on the requirement of criterion 51.6 of the ASF standards. The referral triggers and screening thresholds must be checked

against the tool and the palliative care service in use at each review.

E-learning for this document

- No course linked yet. Request a palliative care in oncology course from the academy (see the Standard 51 request list).

References

1. NICE. NG31: End of life care for adults. 2016.
2. European Society for Medical Oncology (ESMO). Guidance on palliative and supportive care in oncology. Current edition (check the title against the ESMO site before publication).
3. Bruera E, Kuehn N, Miller MJ, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. Journal of Palliative Care. 1991.
4. Facility palliative care referral pathway (to be inserted by the unit at adoption).

Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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