What is Acute Oncology?

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What is ‘Acute Oncology’?

Outline of Talk

• Concept of Acute Oncology Service (AOS)
• The rationale and need for AOS
• Benefits and Challenges of an AOS
• Peer review
• AOS at the Oxford University Hospitals NHS Trust
• OUH AOS
  • Referrals
  • Current structure
  • How to contact
What is ‘Acute Oncology’?

“Acute Oncology”

“A Unknown primary service”

“Acute Palliative Care”

“Brokering Reimbursement”

“Managing Chemotherapy Side Effects for Dummies”

A Reference for the Rest of Us!
What is ‘Acute Oncology’?

• Ensuring that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need
  • *Early, Appropriate, and Convenient*
  • *At any point in the cancer journey (?)*

• Includes management of patients who present as emergencies due to symptoms caused by the disease process itself, regardless of whether the primary is known, unknown or presumed

• Development of a service for managing unknown primary presentations
Why Bother?

- Cancer Reform Strategy, 2007
- In-patient cancer care is the most expensive care setting
- In-patient cancer care = 52% of all cancer expenditure (£4.4 billion/yr)
- In-patient cancer care: 12% of all inpatient bed stay
- Rising numbers of emergency admissions
- 60% of cancer in-patient stay is from non-elective admissions and largely under physicians in medicine
- Short-comings in management of specific entities: (CUP/MUO, neutropenic sepsis, MSCC)
- Projected increase in in-patient cancer costs expected to rise by 24% over 15 years
In-patient admissions for cancer rose by 25% over past 8 years

- 47% increase in acute admissions
- 9% increase in elective admissions

In 2006-07: 273,000 emergency admissions: 44% initially under care of medicine, 22% surgery, 23% onc/haem

Equivalent to 750 emergency admissions per day in England or in a typical Trust, 5 emergency admissions per day
Chemotherapy Services in England: Ensuring quality and safety

A report from the National Chemotherapy Advisory Group

AUGUST 2009
• Use of chemotherapy has increased 60% over 4 years
• NCEPOD assessed care of patients (solid tumour / haematological) who died within 30 days of receiving systemic anti-cancer treatment (SACT)
• 47,050 treatment cases, 55,710 deaths from any cause
• 1415 cases died within 30 days of SACT

• Results:
  • 35% patients received good care
  • 49% had room for improvement
  • 8% care less than satisfactory
  • 8% Insufficient data to comment

One concern surrounded the admission of acutely unwell oncology patients to hospitals where there are no or limited oncology services
• 18% patients admitted during last 30 days of life not admitted to where their last chemo was given
• 42% patients admitted to general medicine following SACT complication rather than haem / onc
• 16% admitted with neutropenic sepsis with the following areas highlighted as concerns:

  • **Organisational**: no neutropenic policy in A+Es, clinicians unaware of neutropenic sepsis policy, inappropriate place of care for a patients with serious complication of SACT, difficulties as visiting oncologist only once a week
  • **Clinical aspects**: failure by juniors to make diagnosis, lack of assessment by senior staff, lack of awareness that pts may not have a fever with neutropenic sepsis, delay in prescribing and admin of antibiotics
  • **Patients factors**: patient information sheets need to stress importance of sepsis, patients not following protocols to obtain advice
NCAG Report highlights improvements to be made in 3 key areas;

- Elective chemo services

- Development of Acute Oncology Service: provision of emergency care for patients with complications from their cancer or cancer treatment ...bringing together staff from A+E, general medicine, haematology, clinical and medical oncology, palliative care, oncology and palliative care nursing and pharmacy’

- The leadership, information governance, monitoring and commissioning of chemotherapy services
Acute Oncology - benefits

- Early oncology input into management of toxicity and cancer-related complications
- Early management of re-admissions
- Early oncology input into the care of pts admitted with a previously unknown but likely diagnosis of malignancy
- Reducing unnecessary investigations: worthwhile pursuit of diagnosis versus not
- Savings: reducing in-patient stay, possible admission avoidance, unnecessary investigations
- Teaching and research opportunities

...Ultimate benefit is improved patient care (safety, quality, LoS)........
Acute Oncology setting...where?

- Standalone Cancer Centre
  - e.g. RMH, The Christie, Clatterbridge

- Cancer Centre within general hospital

- General Hospitals with/without A&E

- And then there’s the JR – Cancer Centre within same Trust but geographically distant. Distance not accurately measured but possibly several hundred miles (!).
AO Peer Review Measures 2015

- Acute Oncology measures specific to
  - Hospitals with A+E and / or Acute general medical take rotas
  - Specialist Cancer Hospitals / Units without above

- Development of an Acute Oncology Team and Service
- Acute Oncology Service : medical and nursing
  - Should provide a 5 day per week service
  - All patients should be seen within 24hrs
  - Acute oncology training for the assessment service

- Agreed selection of acute oncology services in specialist hospitals
- Induction training for A+E / Acute Medicine staff etc including communicating to us that an oncology patient has been seen
- 24 hours access to specialist oncology / haematology advice
- Acute Oncology Treatment protocols e.g. one hour to antibiotic
- Patient flagging
- Fast track out patient slots
- Malignant Spinal Cord Compression service
- Audit, education and training
Challenges to AO development

• Scepticism within and without the medical and nursing professions
• Lack of resources in financially very difficult times
• Over-expectation about what is deliverable – this is a huge problem
• Oncologists getting involved at the diagnostic end
• Change of culture

• In Oxford…..development of acute oncology service is challenging due to the way that acute medical services are delivered
In last twelve months – saw 491 patients. Approximately 75% patients saw ANP only.

327 patients were known to oncology, and 164 received new cancer diagnoses.

363 patients received same day reviews.

Ongoing patient feedback questionnaire – 100% positive comments.

Medical staff feedback – 100% found service very useful.

Future: Expand service and continue to develop links with local and national services.
However we can go further........

AO team review

- Decision to discharge

- Inpatient Care Pathways
- Access to diagnostics
- MDT
- Liaison with palliative care

Admission

- Decision support in acute care
- Flagging systems
- Hospital profile of AO/CUP team
- Ease of referral

Discharge

- Information giving
- Community support

- Discharge planning
- Liaison with allied professions
- Communicate with GP and community nursing teams

Slide courtesy of Dr Richard Griffiths
• Known cancer patient admitted as an emergency that might be related to their cancer diagnosis itself
e.g. brain metastases, hypercalcaemia, spinal cord compression

OR as a direct result of the side effects of treatment, either radiotherapy or chemotherapy e.g. neutropenic sepsis

• An in-patient not known to have cancer and not under the care of an MDT, being investigated for an acute problem who is

EITHER suspected of having a malignancy, and for whom advice is being sought on appropriate investigations

OR found to have a new malignancy
(e.g. patient presenting with pathological fracture, ‘stroke’ patient found to have cerebral metastases, or suspected relapsed disease after a previous diagnosis of early cancer etc)
Current structure of OUH AOS

- **JR**
  - One full time ANP Mon- Fri, one part time ANP Mon, Tues, Thurs am.
    - Dedicated AO consultant ward round three times a week available for ward referrals fulfilling the above referral criteria
    - Referrals should be discussed with the Acute Oncology ANP via bleep 4378 and if appropriate the patient will be reviewed the same day or the following day, depending on the time of referral

- **Horton**
  - One part time ANP and one part time SNP covering 5 days a week between them
    - For advice and referrals, Monday - Friday 9am – 5pm  bleep via HGH switchboard.
    - Specialist Consultant Oncologist input twice a week, on a Monday pm and Wednesday am.
• Mon- Fri 0900- 1700 – bleep 4378 via OUH switchboard, or leave a voicemail 01865 235037.
• Oncology consultant on call is always available 24 / 7 - contact via switchboard.
• Registrar on call bleep 5054 24 / 7 via switchboard.
• Look at the OUH intranet A-Z of sites – Cancer – oncological emergencies.

Contacting the AOS
Thankyou – any questions?