Introduction to Acute Oncology Study Day

- **0900 Welcome and Introduction:** Dr Matt Winter / Sister Clare Warnock

- **0910 What is Acute Oncology?**
  Dr Matt Winter – Consultant Medical Oncologist

- **0940 Acute Oncology presentations caused by disease**
  Dr Kash Purohit – Consultant Clinical Oncologist

- **1020 Complications / Adverse effects of radiotherapy**
  Dr Simon Pledge – Consultant Clinical Oncologist

- **1050 Coffee**

- **1110 Malignant spinal cord compression**
  Dr Bernie Foran – Consultant in Clinical Oncology

- **1200 Complications of systemic treatments of cancer**
  Dr Caroline Wilson – Specialist Registrar, Oncologist

- **1250 Lunch**

- **1320 Cancer Unknown Primary**
  Helen Rickards – Unknown Primary / Acute Oncology CNS

- **1400 Acute Oncology – patient assessment and triage**
  Sister Clare Warnock – Practice Development Sister

- **1430-1550 Interactive case based scenarios and management discussion**
  3 x 20 minutes, coffee at 15:30, group as per colour allocation on programme
  **Facilitator:** Dr Matt Winter
  **Facilitator:** Sister Clare Warnock / Helen Rickards CNS
  **Facilitator:** Jan Siddall (Palliative Care CNS)
  Shortness of breath
  Neutropenic Sepsis
  Nausea and Vomiting

- **1550 - 1600 Evaluation and Close**
What is Acute Oncology?

Dr Matt Winter
Consultant in Medical Oncology, Weston Park Hospital
STHFT Lead for Acute Oncology

1st October 2014
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 Northern General Hospital
• Sheffield Teaching Hospitals AOS
  – Referrals
  – Current structure
  – How to contact
What is ‘Acute Oncology’?

“Acute Oncology
“Unknown primary service
“Acute care of patients
“Acute care of oncological care
“Brokering chemotherapy side effects
“Acute Oncology
Managers of Chemotherapy Side Effects for Dummies
A Reference for the Rest of Us!

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REVIEWED REVISED EDITION

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Editors: Dummies

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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
NCEPOD, November 2008

• 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
National Chemotherapy Advisory Group, 2009

• 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
  - AOS may be self-funding but needs pump-priming
- 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 geographically linked to General Hospital
  – e.g. Beatson, Leeds Bexley wing, Rosemere, QEHB.
  – Weston Park Hospital, Sheffield...not so geographically linked.....
    ...a short walk from RHH.........but
    the NGH, with the sole adult A+E and unselected acute medical take, is across the other side of the city. Minimal oncology presence

• General Hospitals with/without A&E
  – Almost everywhere else
AO Peer Review Measures 2011

- 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
Hospital Groupings

• **Group 1**
  Any hospitals with **one** or **both** of
  an A&E department and acute medical beds which are open to direct emergency admissions. This can be with or without specialist oncology beds or OP chemotherapy.
  Most acute hospitals, e.g, a general teaching hospital, a DGH with haematooncology beds, hospitals with some acute services where A&E and other acute services have split between hospitals in a multi-hospital city.

  **Group 1 hospital in STHFT is NGH (‘Northern Campus’)**

• **Group 2**
  Hospitals with specialist oncology beds and OP chemotherapy but **without either** an A&E department or acute medical beds used as in group 1.
  Specialist stand – alone ‘cancer’ hospitals or specialist oncology units within hospitals with other specialties but without an A&E or any other acute medical admissions.

  **Group 2 hospitals in STHFT are WPH and RHH (‘Central Campus’)**
Challenges to AO development

• Scepticism within and without the profession
• Lack of resources in financially very difficult times
• Over-expectation about what is deliverable
• Oncologists getting involved at the diagnostic end
  – Change of culture

• In Sheffield…..development of compliant acute oncology service is challenging due to the way that acute services are delivered
Northern General Hospital, Sheffield

- Currently 1354 beds
- Covers population of 550,000
- Admits almost all acutely unwell patients in Sheffield via the sole adult A&E dept and unselected medical take
- Prior to the pilot, oncology input at the NGH limited to 1 outpatient clinic and 2 MDTs per week

Pilot started Sept 10
1st 6 months: single Consultant oncology weekly Tues pm session
2nd 6 months: in addition to above SpR 2 days / week
Service advertised to all NGH consultants via email, MAU visits, orthopaedic wards sisters
NGH pilot Patients seen

• 136 patients seen Sept 2010-Aug 2011
• Notes available for 122, although some information was available for some of the missing patients
• 84 known patients with cancer, 3 patients had > 1 primary
• 38 newly diagnosed
Patients with existing cancer diagnosis, n=84

Existing patients – number on active treatment
Newly Diagnosed patients
n=38 – Referral source

Newly Diagnosed patients
n=38 – presentation
Newly diagnosed patients – cancer diagnosis

- Lung
- Renal
- Upper GI
- Breast
- Breast
- Prostate
- Glioma
- Ovary
- Bladder
- Suspicious but not diagnostic biopsy

Newly diagnosed patients – ultimate treatment following AOS input

- BSC / PC
- Pall RT
- Surgery/systemic treatment
- Unknown
- No definite cancer
Overall outcomes

127 patients

Discharged: 81
- Alive: 41
- OP death: 40

Median time from AOS to OP death is 48 days

Not Discharged: 46
- Alive: 43
- IP death: 3

Median time to IP death is 14 days
Timelines

AOS service 0.5 days per week

- 11.5 days (n=48)
- 13 days (n=35)

AOS service 2.5 days per week

- 5 days (n=79)
- 8 days (n=46)

Mann Whitney U test

P=0.029
P=0.643
No. of pts new referrals at NGH
However we can go further........

AO team review

Decision to discharge

Admission

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

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

Discharge

- Information giving
- Community support
- Discharge planning
- Liaison with allied professions
- Communicate with GP and community nursing teams

Slide courtesy of Dr Richard Griffiths
STHFT Acute Oncology - who do we want to know about?

- 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 STHFT AOS

• Central Campus
  – Dedicated AO consultant on-call each day Mon-Fri 9am to 1pm at WPH available for ward referrals fulfilling the above referral criteria
  – Referrals should be discussed with the Acute Oncology consultant via 07949 021449 and if appropriate the patient will be reviewed the same day or the following day, depending on the time of referral

• Northern Campus (NGH)
  – For advice and referrals, our Acute Oncology CNS team based at the NGH Monday - Friday 9am – 5pm can be contacted on mobile numbers 07500 765584 or 07500 766581.
  – Currently at the NGH there is specialist Consultant Oncologist input twice a week, on a Monday pm (Dr DeCatris) and a Thursday am (Dr Winter). Please complete the Acute Oncology Referral Form and fax to Dr Winter’s secretary
Contacting the AOS

• If the patient is known to an oncologist, it is often more appropriate to contact the patient’s own treating team

• However if you need to discuss a patient with an oncologist, there is also a WPH acute oncology consultant available every day Mon-Fri 9am to 5pm via the following:
  • direct phone line – 07949021449 or
  • long range pager 07623895100 or
  • via the automated portal ext 69690 then ‘Acute Oncology’

• This service is for use by Consultant or Specialist Registrar grade or Nurse Specialist.
Acute Oncology Intranet site

Accessed through
> Main STH intranet page
> Clinical Directorates and Specialities
> Acute Oncology

Oncology Services

Acute Oncology Service

The Acute Oncology Service is divided into the service delivered on the Northern General site, the Royal Hallamshire site and Weston Park Hospital site (Central campus).

The Trust wide Acute Oncology Service supports the following non-elective oncology patients admitted to the Trust:

1. A 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.

2. 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).

Please note:

If you need to discuss a patient with an oncologist, there is also a WPH acute oncology consultant available every day Mon-Fri 9am to 5pm via the following:
- direct phone line – 07949021449, or
- long range pager 07623895100, or
- via the automated portal ext 59890 then 'Acute Oncology'.

This service is for use by Consultant or Specialist Registrar grade or Nurse Specialist.

After hours, oncology advice can be initially sought via the oncology SpR on call via switchboard.

[Last updated: Tuesday July 24, 2012] (STH)
Oncology Services

Listing of Acute Oncology related policies, guidelines and protocols:

- WPH Arthralgia/Myalgia (Acute Oncology)
- WPH Bleeding and/or Bruising (Acute Oncology)
- WPH Chemotherapy Induced Diarrhoea (Acute Oncology)
- WPH Chemotherapy Induced Mucositis (Acute Oncology)
- WPH Chemotherapy Induced Nausea and Vomiting (Acute Oncology)
- WPH Chest Pain (Acute Oncology)
- WPH Constipation (Acute Oncology)
- WPH CVAD Infection (Acute Oncology)
- WPH CVAD Thrombosis Pathway (Acute Oncology)
- WPH Dyspnoea [Shortness of Breath] (Acute Oncology)
- WPH Extravasation (Acute Oncology)
- WPH Fatigue (Acute Oncology)
- WPH Hypercalcemia of Malignancy (Acute Oncology)
- WPH Hypomagnesaemia – Management of… at WPH (Acute Oncology)
- WPH Intracranial Space Occupying Lesions (Acute Oncology)
- WPH Lymphangitis Carcinomatosis (Acute Oncology)
- WPH Malignant Abdominal Ascites – Management of (Acute Oncology)
- WPH Malignant Pericardial Effusion Active Pathway Protocol (Acute Oncology)
- WPH Malignant Pleural Effusion – Management of (Acute Oncology)
- WPH Neutropenic Sepsis Pathway (Acute Oncology)
- WPH Palmer Plantar Erythrodynaeesthesia [PPE] (Acute Oncology)
- WPH Radiation Induced Pneumonitis (Acute Oncology)
- WPH Radiotherapy Induced Acute Skin Reaction (Acute Oncology)
- WPH Radiotherapy Induced Cerebral Oedema (Acute Oncology)
- WPH Radiotherapy Induced Diarrhoea and Proctitis (Acute Oncology)
- WPH Radiotherapy Induced Mucositis (Acute Oncology)
- WPH Radiotherapy Induced Nausea (Acute Oncology)
- WPH Radiotherapy Induced Oesophagitis (Acute Oncology)
- WPH Skin Rash (Acute Oncology)
- WPH Superior Vena Cava Obstruction Active Pathway Protocol (Acute Oncology)

Additional, related Guidelines, etc., NOT owned by Acute Oncology:

- STH Anaphylactic Reaction – Initial Treatment
- STH Anaphylactic Reaction (Anaphylaxis Algorithm)
Acute Oncology Flagging System
Further resources

North Trent Cancer Network
Acute Oncology Induction

click next to begin
Hospital Acute Oncology Services

The North Trent Cancer network Acute Oncology service runs from 8 hospitals, click on the relevant tab from the image below for more information on the Acute Oncology Service provided by the hospital.
Acute Oncology Nurses

The nurse is available Monday to Friday 9am to 5pm across both Doncaster and Bassetlaw sites (telephone advice is offered to Mexborough).

Contact via mobile:
Doncaster - 07789741129
Bassetlaw - 07789746164

The Acute Oncology nurse will also receive an alert for every cancer patient admitted to the hospital.

One of the responsibilities of the nurse is to attend and assess patients with cancer related problems and assist to coordinate a management plan.
How to refer to the AOS STHFT

To find out how to contact either of the hospitals, click on the appropriate button located below each of the hospitals signage.

Sheffield Teaching Hospitals
NHS Foundation Trust

Welcome to the
Northern General Hospital

Sheffield Teaching Hospitals
NHS Foundation Trust

Welcome to the
Royal Hallamshire Hospital

Referrals from Northern General Hospital

Referrals from Hallamshire Hospital/Central Campus
Assessment

Welcome to the end of module Acute Oncology eLearning assessment. The assessment consists of 7 questions, each question is based on the content covered in the module. You must answer each question before being able to proceed to the subsequent question.

You must achieve a minimum score of 90% to pass the assessment.

Please enter your full name below, this will appear on your certificate of completion:

[Input field]

[Submit button]
Thanks

Any questions?