Urgent Care and Cancer
What’s New in Acute Oncology?

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What is AO and what is the Problem?

Dislocated Care
- Lack of Oncology input
- Reliance on General Medicine
- Lack of information
- Poor communication
- Patient Safety – Neutropenic sepsis
- Poor patient experience
Emergency Presentation of Cancer

1 in 5 cancer patients present Via Emergency routes
Associated with advanced stage and poor 1 year Survival

Emergency Presentation
- Brain 62%
- Lung 35%
- Pancreas 50%
- Unknown Primary 57%
The AO Service and Achievements

**Workforce**

173 AO Services established

**Medical:**

- >95% Oncology led
- 13% Consultant job plans (RCR) include AO role

**Nursing:**

- 221 WTE AO nursing (2016)

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"Towards saving a million bed days: reducing length of stay through an acute oncology model of care for inpatients diagnosed as having cancer"

By Judy King, Celia Ingham-Cline, Cathy Parker, Richard Jennings, and Pauline Leonard

"The impact of a new acute oncology service in acute hospitals: experience from the Clatterbridge Cancer Centre and Merseyside and Cheshire Cancer Network"

By Hil Neville-Webbe, JE Cares, H Wong, J Andrews, T Poulter, R Smith, and E Marshall

"Reduced LOS 3day per AO episode"

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"Acute care toolkit 7: Acute oncology on the acute medical unit October 2013"

"Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients"

"Diagnostic and management of metastatic malignant disease of unknown primary origin"
BUT.....The Increasing Burden of Urgent Cancer Care

- Older people living with cancer is set to treble by 2040
- Increasing SACT Delivery And Complexity
- Merseyside AO admissions trebled since 2009-2017
- 9.2 million Bed Days For Cancer EOL Care

ACHIEVING WORLD-CLASS CANCER OUTCOMES
A STRATEGY FOR ENGLAND
2015-2020

- 2.5 million people living with cancer in UK rising to 4.0 million by 2030
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NHS INTEROPERABILITY 2018
DATA-ShARING EFFORTS, OBSTACLES, AND PROGRESS IN ENGLAND
AO: Where next?
Joined Up Urgent Cancer Care

• Cancer Help lines that support both professionals and patients and are linked to NHS III

• Ambulatory Capacity linked to paramedics, Urgent treatment Centres and Hospital ambulatory strategy

• Greater AO ‘in reach’ into ED and AMU

• Cancer specific emergency pathways?
AO Moving Forward: Admission avoidance

AO Type I (10%)
New Cancers

AO Type II (40%)
Treatment Complication

AO Type III (50%)
Cancers/CMB Complication

How do we reduce emergency presentation?

Systemic Anti-Cancer therapy (SACT)
Side effects

Integrated Care
Better Conversations

Clinical Advice to Cancer
Alliances for the
Commissioning of Acute
Oncology Services
Reducing Late Presentation: Improving Diagnostic Pathways for Patients with Vague Symptoms (April 2017)

www.cruk.org/ace-resources

Non-Specific symptoms linked with increasing age, comorbidity and poor patient & professional experience

9 VS Pilot sites evaluated pathways including coordinated triage, rapid access diagnostics and ‘hot clinic’.

- Improved experience, timely diagnosis, reduced ED presentation, conversion rates 6.5-47%

4 ‘Wave 2’ Multi-disciplinary Diagnostic Centres (MDCs) ongoing
- 1034 referrals (Nov 17) with 8% conversion rate
Neutropenic sepsis

BUT

NICE REVIEW 2018

• Risk stratification (MASCC/CISNE) not routinely used*
• Time to iv antibiotics drives the pathway
• NS is not well aligned with UK Sepsis Developments
• ‘Recent Chemo’ is a RED Flag to initiate SEPSIS 6
• Lack of standards for isolation, step down and discharge policies
• Variable GCSF policies

*Ambulatory Care outpatient care in Low risk Neutropenic Fever
The Changing Landscape of Cancer Drug Therapy
(Systemic Anti Cancer Therapy)

Greatest thing since sliced bread

I am so very excited to be sitting here writing about my favorite cancer topic: immunotherapy. This is a post that I have wanted to write for some time, but I just didn’t have the right context for the childhood cancer community. But the context is finally

Figure 1. Growth of the cancer immunotherapy space based on publications. [Select Biosciences]
High quality communication is associated with better serious illness care (Mack JCO 2010, Detering BMJ 2010, Zhang Annals 2009)

- Earlier supportive & palliative care
- Improved quality of life
- Influence decisions on EOL SACT
- Fewer hospital admission

**NHS E CQUINS**

- Enhanced Supportive care
- SACT decision making
Can We reduce hospital Admission?

Predictive modelling of Cancer Emergency admission risk in Liverpool CCG

North Mersey Integrated Community Reablement and Assessment Service (ICRAS)

Cancer Help Line

Community specialist Palliative Care

Community matron and DN services

Community respiratory services

Primary Care

Community geriatrics services

Community Therapy services
Partnership Working with Acute Medicine

- AO needs to align with A&E delivery Boards and Acute Medicine strategy
- AO needs to be more multi-professional and system-wide
- AO needs Acute Medicine Leadership and skills
- Is Acute Medicine is best placed to deliver Cancer-specific urgent care Pathways?

When ‘i’ is replaced By ‘we

Even
‘illness’
Becomes
‘Wellness’

Malcolm X
THANK YOU!