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Representing and supporting Medical Oncologists in the UK

Medical Oncology and Shape of Training

Tuesday 31st January 2017
Royal College of Physicians, London

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Medical Oncology and Shape of Training

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Professor Johnathan Joffe
Chair of the Association of Cancer Physicians, Macmillan Consultant in Medical Oncology, Calderdale and Huddersfield

Professor David Cunningham
Chair of the Specialty Advisory Committee for Medical Oncology, Royal Marsden Hospital

Professor Peter Selby
President of the Association of Cancer Physicians, Leeds

Professor Helena Earl
Professor of Clinical Cancer Medicine, Cambridge

Medical Oncologists, at all career stages and within all hospitals and institutions, are firmly against becoming "general physicians with an interest " and undertaking unselected GIM take as consultants and during specialist training, because it will be bad for patients and for the discipline

We recognise that we must help to relieve the pressures within GIM and care of the elderly.

We are already doing so through the Acute Oncology Service (AOS) and our Cancer of the Elderly (CE) initiatives will do more. AO is an agreed commissioned service. It is evidenced-based, patient-centred and has sound economics.

AOS can relieve unselected takes of 5-10% of patients and takes them into a better, safer, more specialised system which yields better outcomes and cost savings as it reduces admissions and length of stay. We deliver in this system what we are good at and believe in--excellent specialised cancer care

NHS trusts and commissioners are validating our approach by purchasing AO

AO and GIM Unselected take are mutually exclusive--the skill sets are different and the capacity to do both does not and cannot exist in the UK

We are making good progress in these initiatives and need support and endorsement to make AO and CE work everywhere --and we need to take back to our colleagues a sense that the Colleges and NHS appreciate their very hard work being done in the interests of our patients and the whole NHS

Why Medical Oncologists should not undertake acute GIM:

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Patient Safety

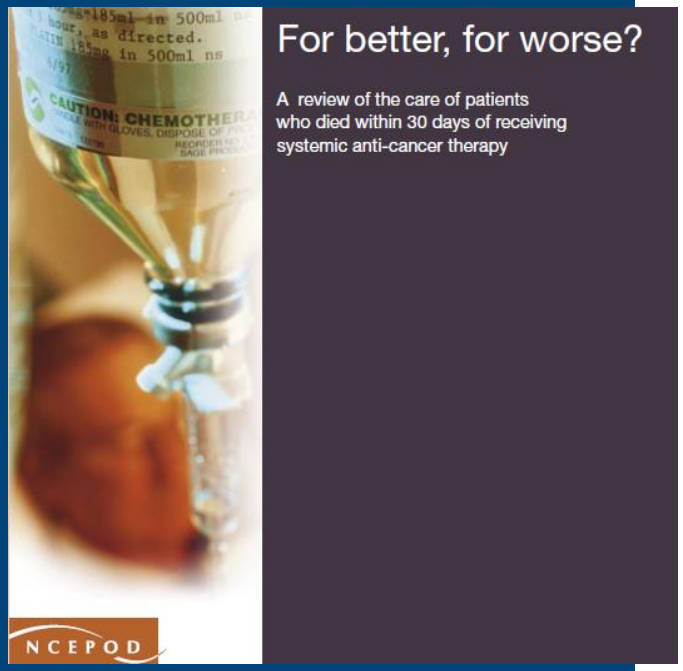
Health economics

Demographics

Specialisation and research

Complexity of cancer therapies

NCEPOD Report 2008: Deaths within 30 days of chemotherapy



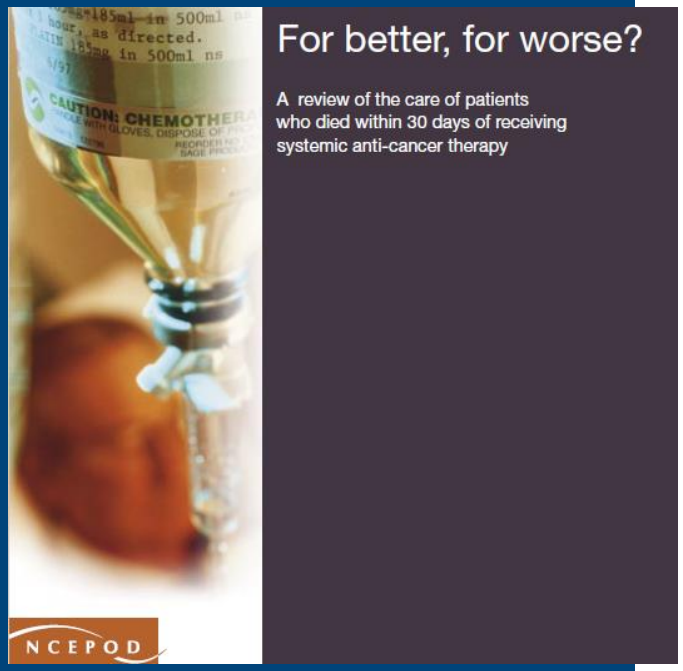
- Only 35% of cases were considered to have received good care

- National Chemotherapy Advisory Group (NCAG) established by Department of Health and National Cancer Director

- NCAG report in response to NCEPOD:
  - Chemotherapy Services in England, Ensuring Quality and Safety 09

Established concept of the Acute Oncology Service

NCEPOD Report 2008: Deaths within 30 days of chemotherapy



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Acute Oncology Service:

- Complications of cancer therapy
- Complications of disease
- Assessment and investigation of new presentations of cancer

These patients comprise 5% – 10% of acute presentations in typical acute hospitals (Audit Data)

Acute Oncology - Manual for Cancer Services 2011

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Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Manual for Cancer Services:

Acute Oncology - Including Metatastic Spinal Cord Compression Measures

Version 1.0

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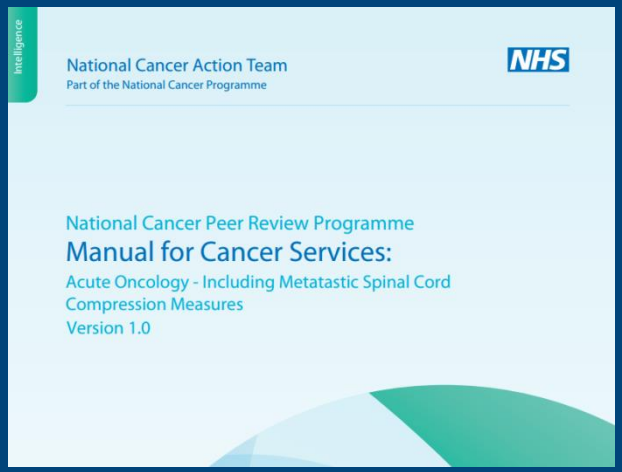
Acute Oncology – Manual for Cancer Services 2011



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There should be DCC PAs, worked in the hospital, in the job plans of consultant oncologists, which fulfil the following specifications:

- the oncologists may be medical, clinical or haemato-oncologists
- there should be a minimum of two oncologists involved
- there should be a minimum of one DCC PA for each of the 5 weekdays
- during the specified PAs, the oncologist should be available for consultations with and/or ward visits to patients presenting with acute oncology problems, admitted during the previous 24 hrs, (or over the weekend, for a Monday PA)

Acute Oncology Services – Commissioning

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Acute Oncology is valued and being commissioned in medical oncology

	No of posts advertised	Mean number of AOS PAs	Range	Mean number Radiotherapy PAs
Medical Oncology	19	**1.32**	0 -3.26	0
Clinical Oncology	20	**0.25**	0 - 1	1.56

PAs for AOS

Audit of Posts advertised in November/December 2016

Workload in non-surgical oncology (NAO)

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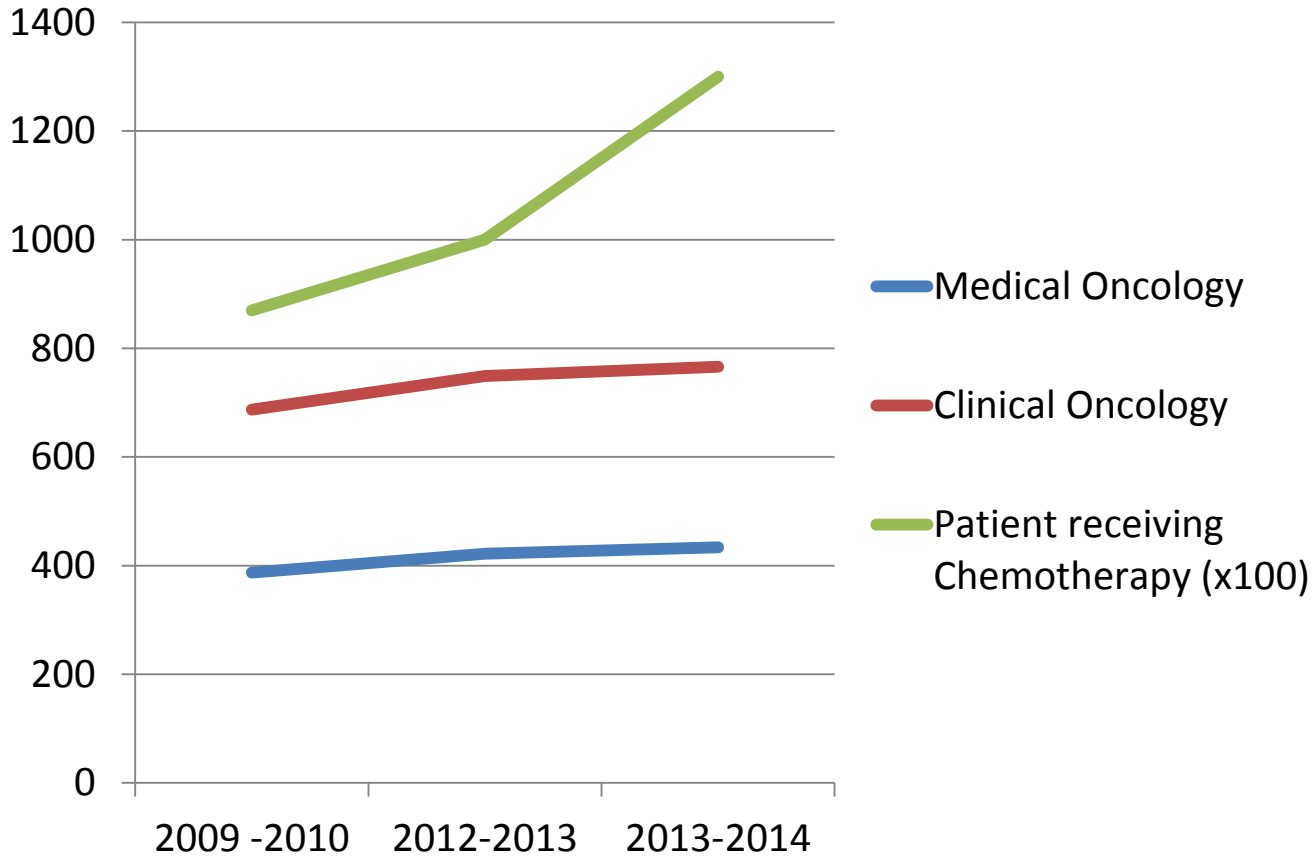

Mean Number of Finished Consultant Episodes (FCE) per consultant in the UK 2015-16[1]	
Medical Oncology	**603**
Clinical Oncology	**457**
General Medicine	**500**

1. Hospital Episode Statistics Dataset, 2015-

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Acute Oncology: Hallmarks of a fully developed AOS

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Acutely presenting cancer patients with cancer or treatment complications (including those with a possible cancer diagnosis) are funneled directly to the AO service without engaging with unselected “take” or consuming GIM capacity.

They are seen promptly (eg twice daily consultant rounds) by cancer specialists (medical and nursing), commonly but not only medical oncologists, and directed to the appropriate in or out patient investigation or care

The inclusion of early specialist expertise (and confidence) ensures prompt and appropriate interventions and has been shown to reduce admissions and length of stay

It also ensures high degrees of patient safety for the high risk cases such as severe neutropaenic sepsis

Patients who do not require long admissions are managed appropriately including referrals (such as the a specific ”cancer of unknown primary” service) or outpatient care such as low risk neutropaenia

Challenges in Acute Oncology Services

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Model of delivery is variable

In most large centres delivery is consultant oncologist-led over 7 days

There is inequity

- Especially in smaller hospitals
- Particularly those with relatively little peripatetic oncology input
- Often nurse-led

Oncology Pilot - Whittington Hospital

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- Whittington Hospital set up a fully comprehensive AOS in July 2009 after completing a 6 month pilot

- With just one full-time Consultant Medical Oncologist on-site Mon- Fri supported by a staff grade in Oncology the model of AOS adopted was one of supporting the Acute medical & surgical take with an electronic referral system triaged by AOT three times daily Mon-Fri, access to updated protocols on managing

Oncology Pilot - Whittington Hospital

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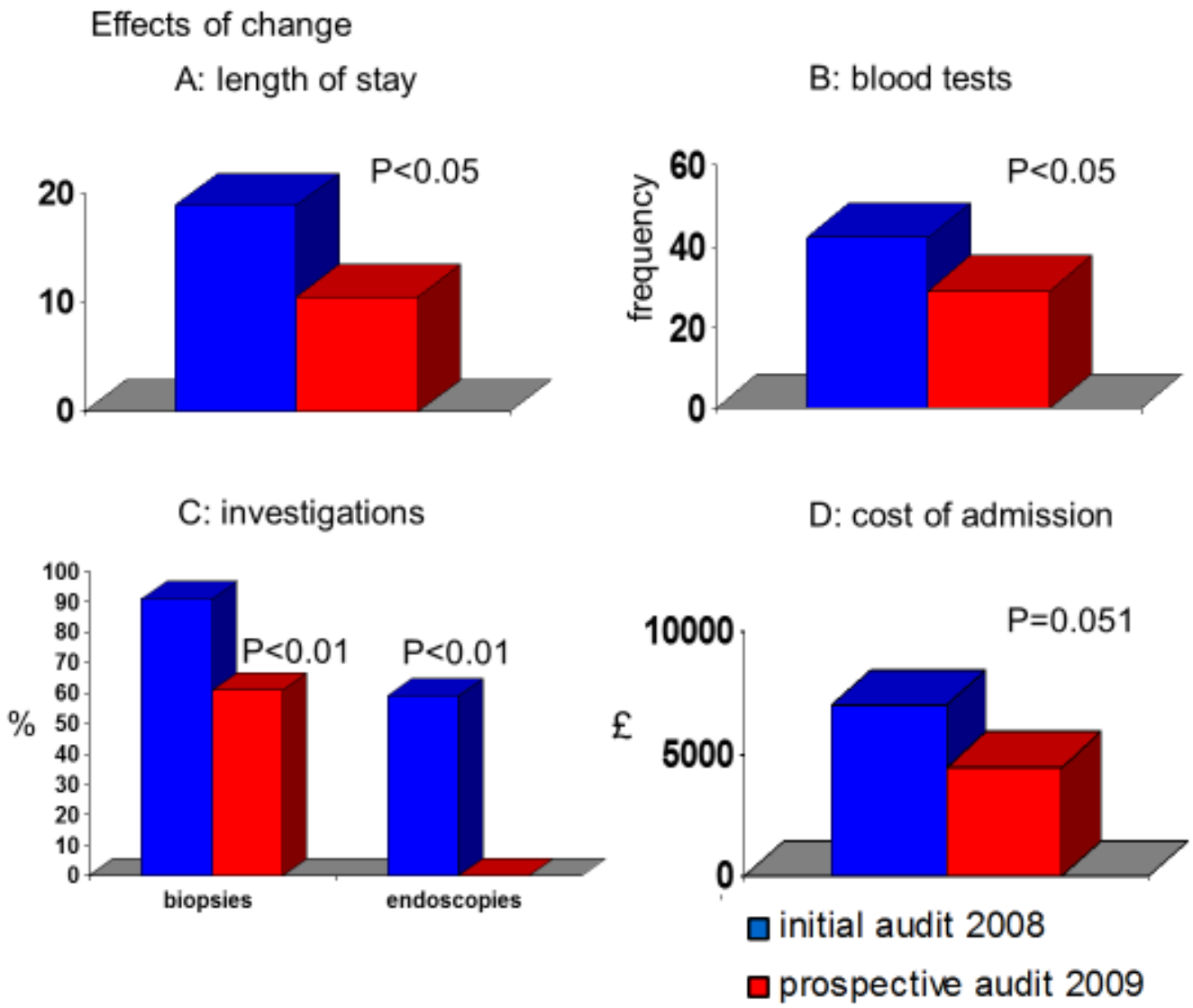

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Oncology Pilot - Whittington Hospital

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LoS in all new cancers n=74

Specialty	Pre-pilot	Post -pilot
Care of the elderly	22.8	20.6
General medicine	13.9	10.2
Respiratory medicine	21.0	15.0
Oncology	23.4	13.2
Total	17.1	12.1

Acute Oncology Services (AOS) save bed days and money

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Clatterbridge Oncology Business case 2009 establishing AOS in local Secondary Care

- Based on 2005 / 2006 activity Data
- Established 5 new Oncology posts between Cancer Centre and DGHs

Hospital	Eligible Acute admissions	Bed days saved	Value
Countess Of Chester	231	693	£173,250
Royal Liverpool and Broad Green	390	1,170	£292,500
Southport and Ormskirk	218	654	£163,500
St Helen's and Knowsley	359	1,077	£269,250
University Hospitals Aintree	414	1,242	£310,500
Warrington & Halton	304	912	£228,000
Wirral University Teaching Hospital	336	1,008	£252,000
TOTALS	2,252	6,756	£1,689,000
Total staff costs 5 oncologists, 7 CNS, 7 0.6WTE Secretaries			£915,497
Saving			£773,503

Population and Cancer Demographics

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Population Predictions

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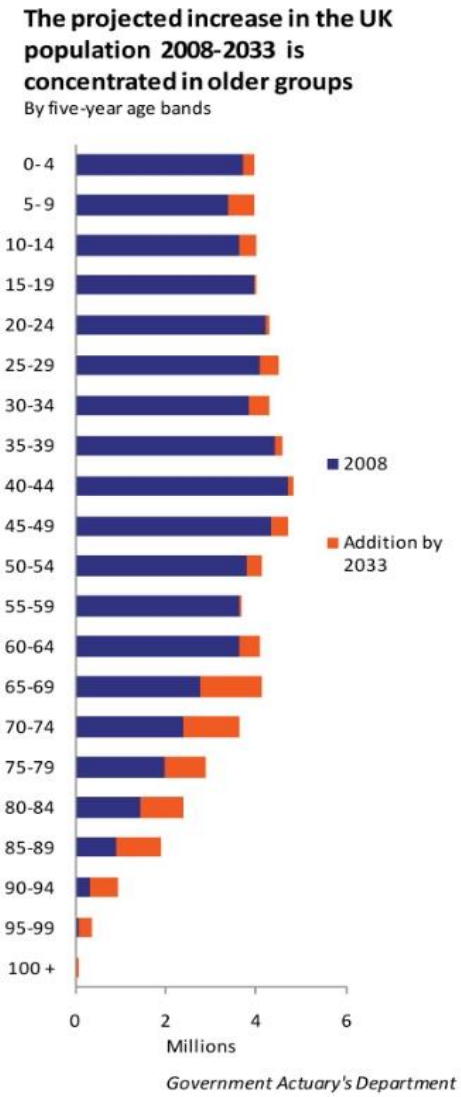

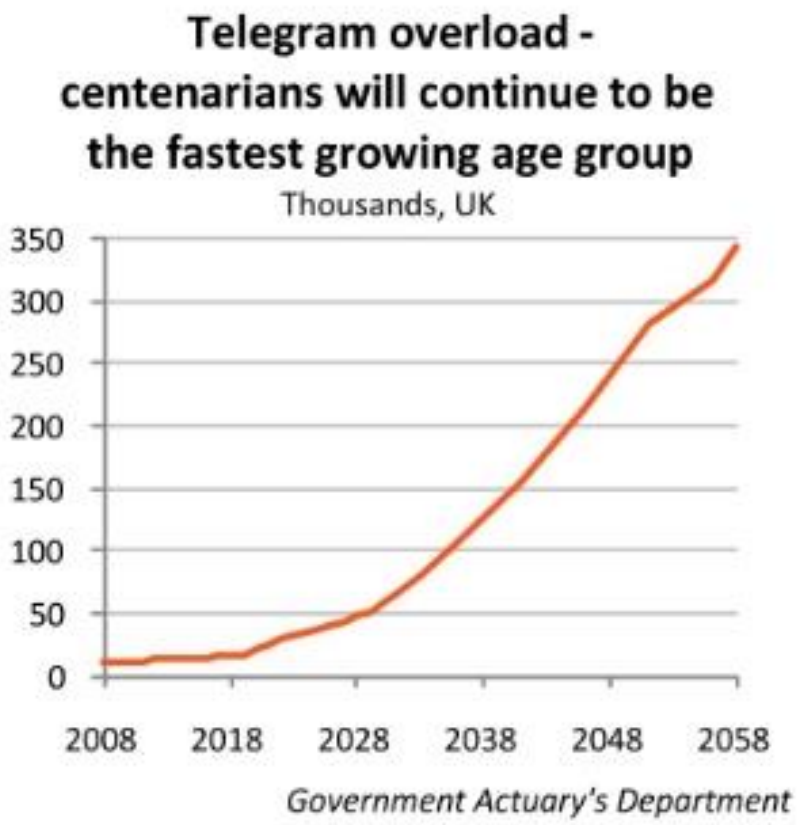

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Population Predictions

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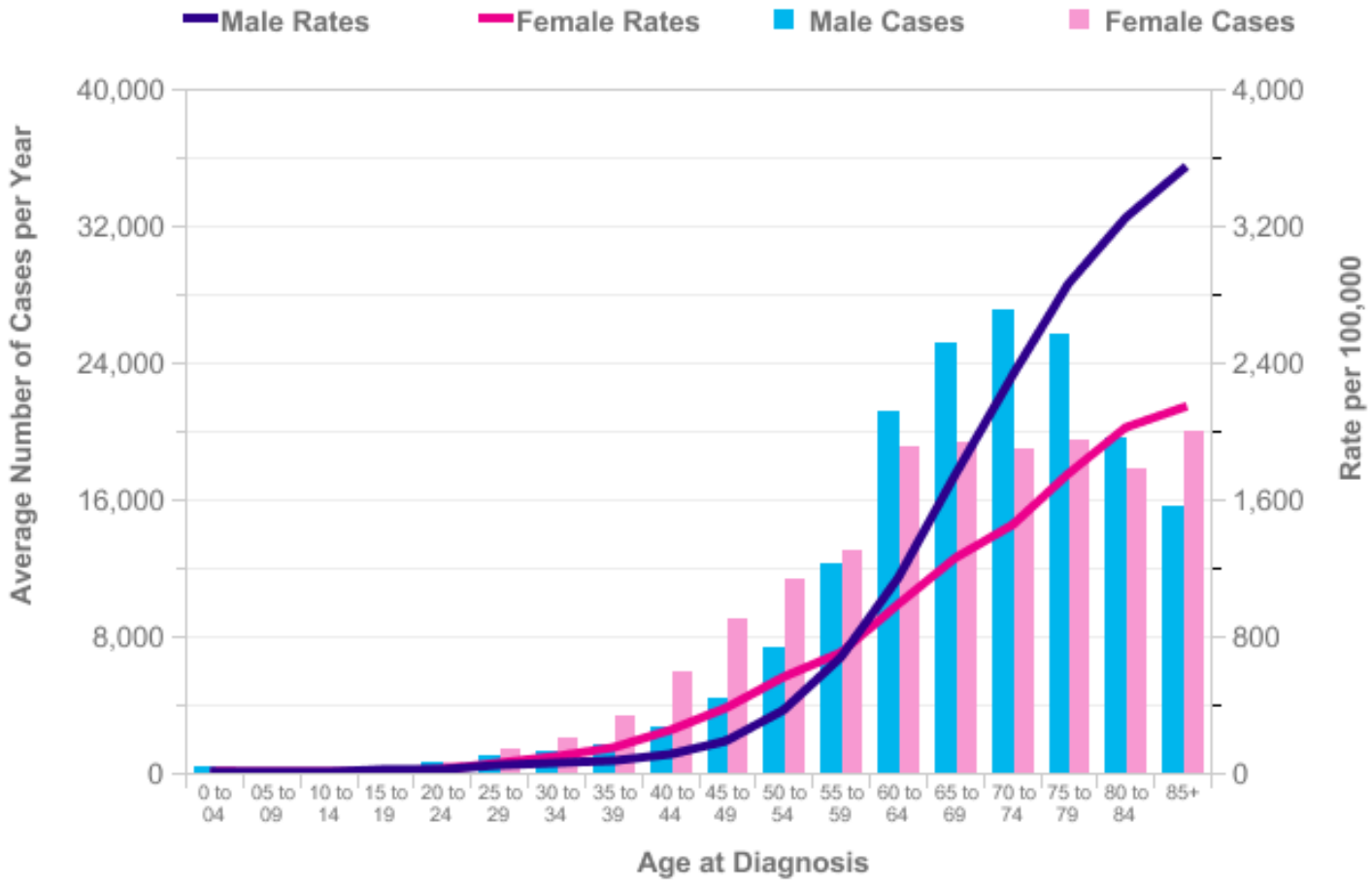
Average Number of New Cases of Cancer per Year and Age-Specific Incidence Rates, UK, 2009-2011 (CRUK 2014)



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Population Predictions

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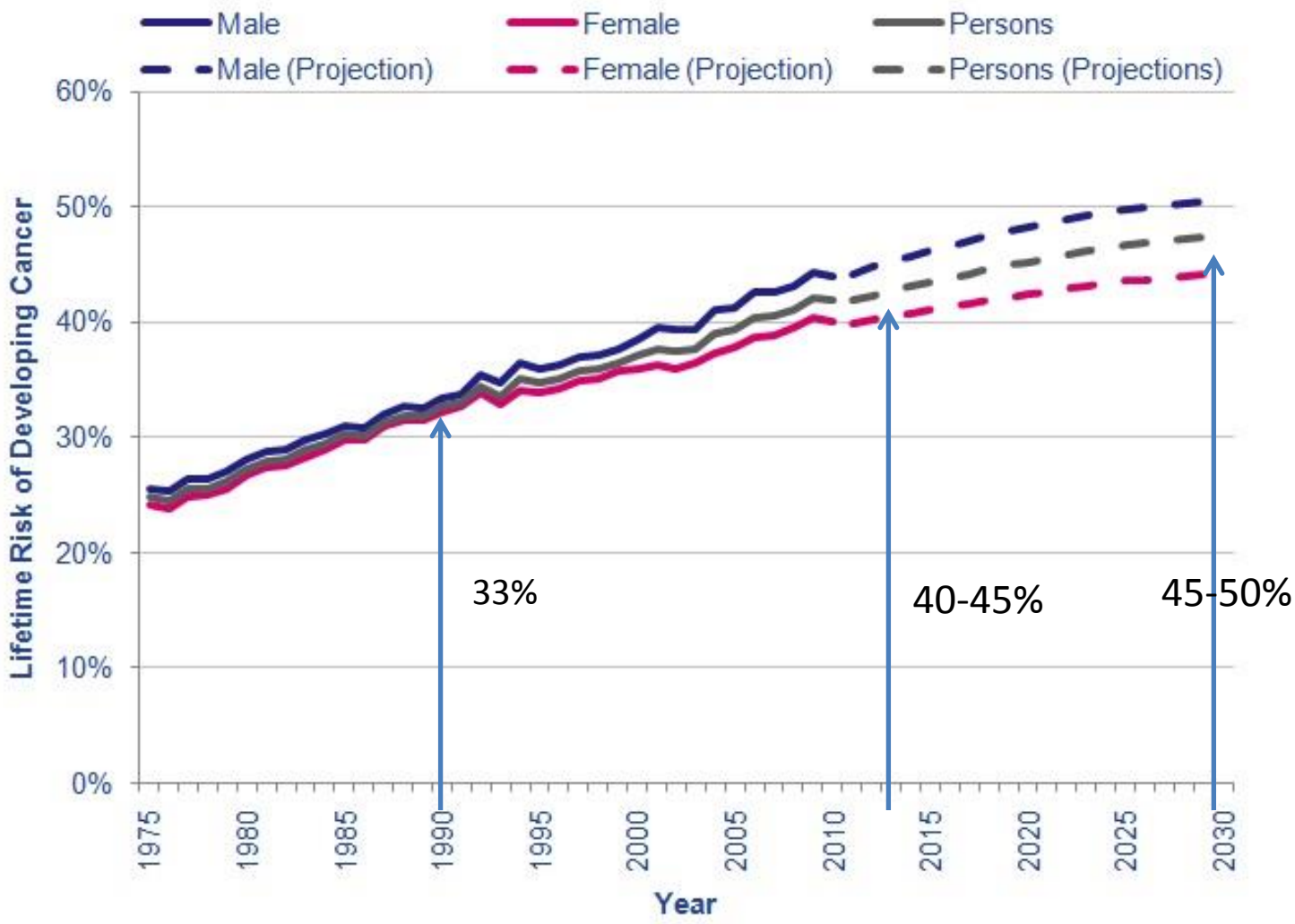
Lifetime Risk of Being Diagnosed with Cancer, UK, 1975-2030 (CRUK 2014)



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Population Predictions

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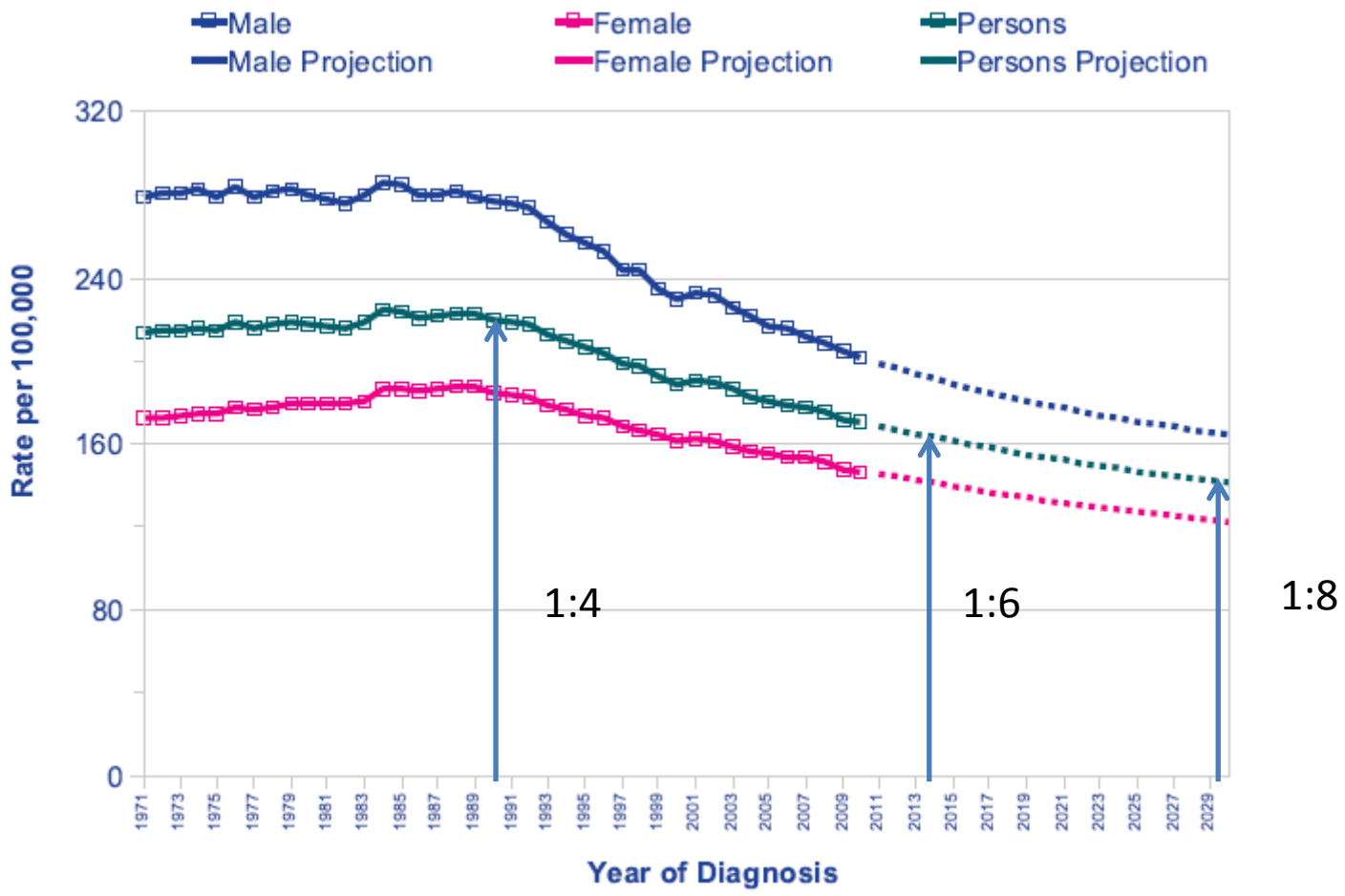
European Age-Standardised Mortality Rates (all cancers), UK, 1971-2030 (CRUK 2014)



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Effect of Demographics

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10 Million over 65 today will be 15.5 Million in 20 Years

Cancers are most frequent in older people

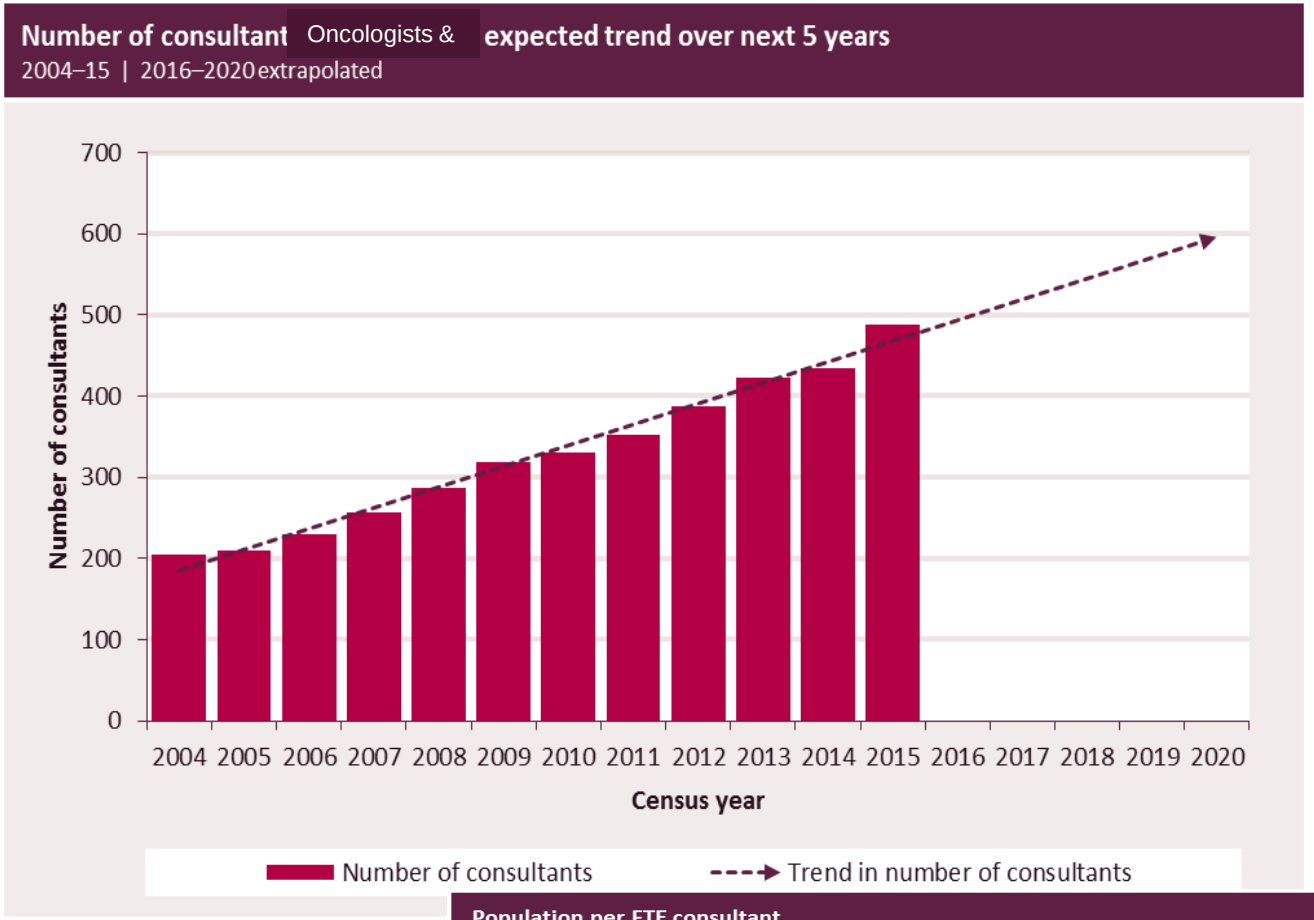
Common cancers are becoming long-term conditions, managed with complex disease-modifying therapies

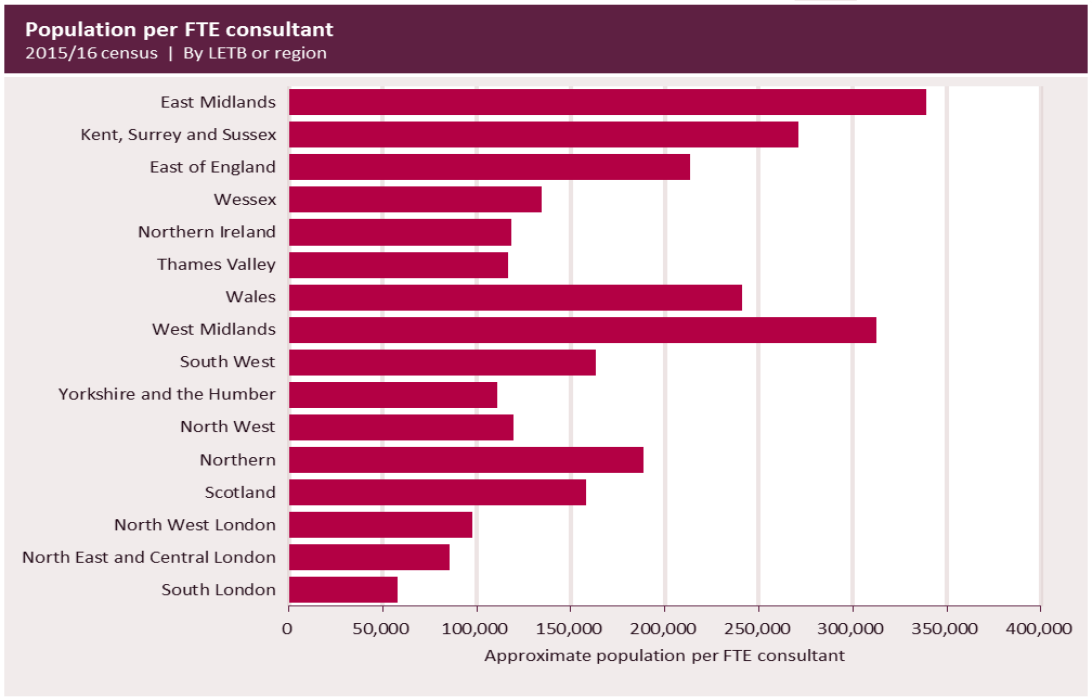
People increasingly live with and beyond cancer

Cancer survivorship is bringing new acute and long-term problems

The Oncological workload is increasing in volume and complexity

Consultant Medical Oncologists:





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Consultant Medical Oncologists:

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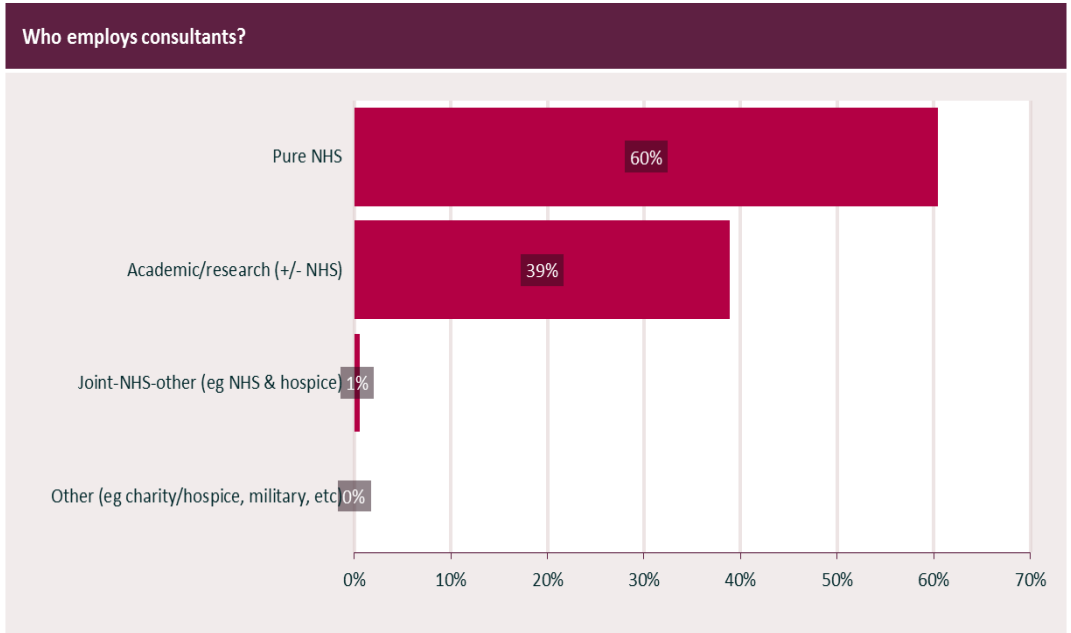
41% of appointments were unsuccessful (2015) - 67% because there was no suitable applicant



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Specialisation

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Increasing complexity of science and therapeutic options and rate of evolution of knowledge

Consultants can specialise in no more than 2 (exceptionally 3) cancer sites

Our general practice is in acute oncology

Acute oncology skills are specific to cancer and are not the same as acute GIM

All consultants work / lead in 2 – 3 MDTs

All consultants undertake clinical trials and many (including NHS appointees) lead clinical trials

Consultant Job Plans

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Outpatients

Inpatient supervision

Systemic Anticancer Therapies

Acute Oncology Services

7-day working and On call commitments

Multi-disciplinary Team Meetings

Clinical trials

(Academic sessions)

Supporting Professional Activities

Leadership of cancer clinical trials by specialty

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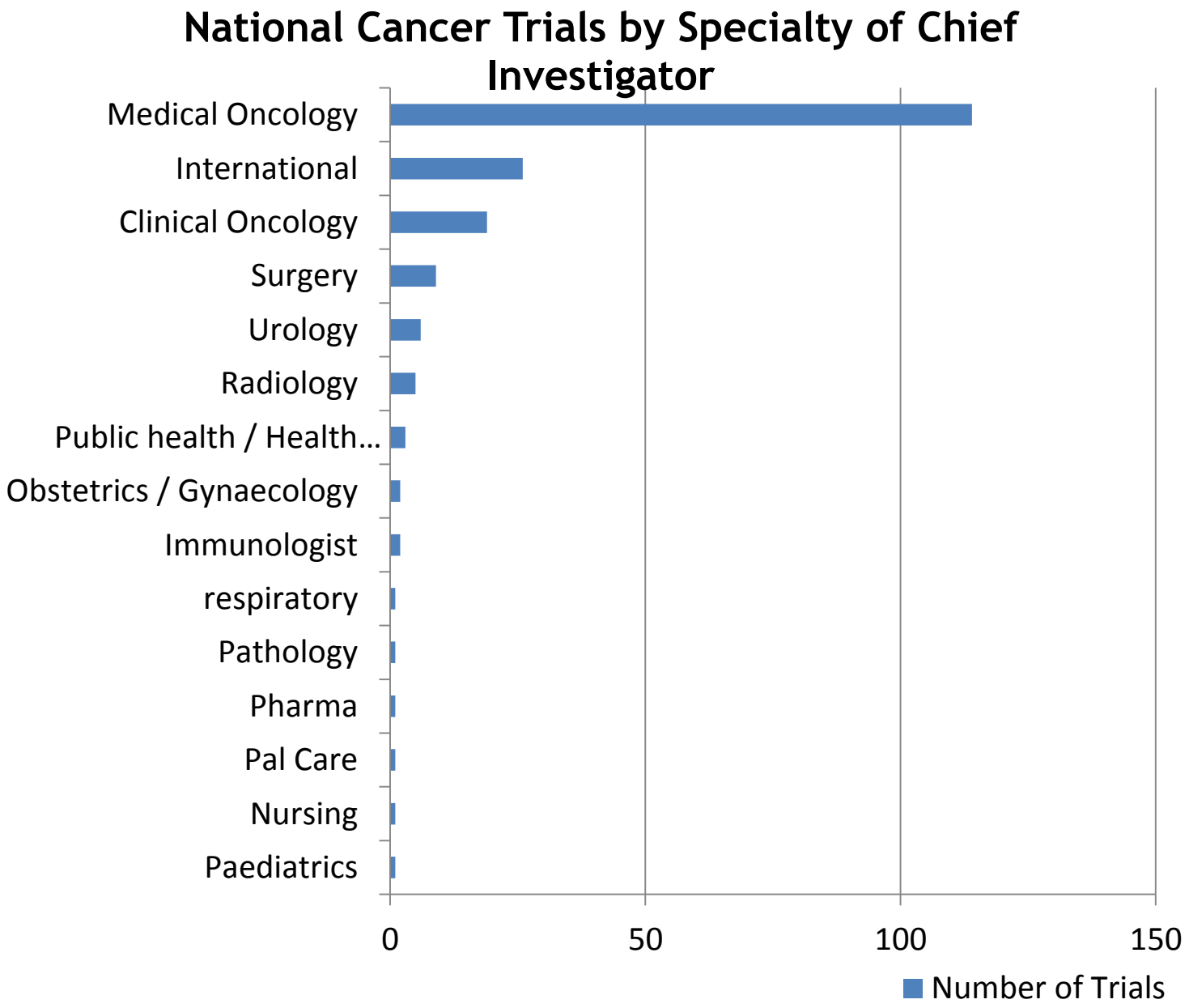

Audit of Chief Investigators in cancer trials of systemic treatments, 2016, Clinicaltrials.gov

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Number of oncologists and cases of cancer

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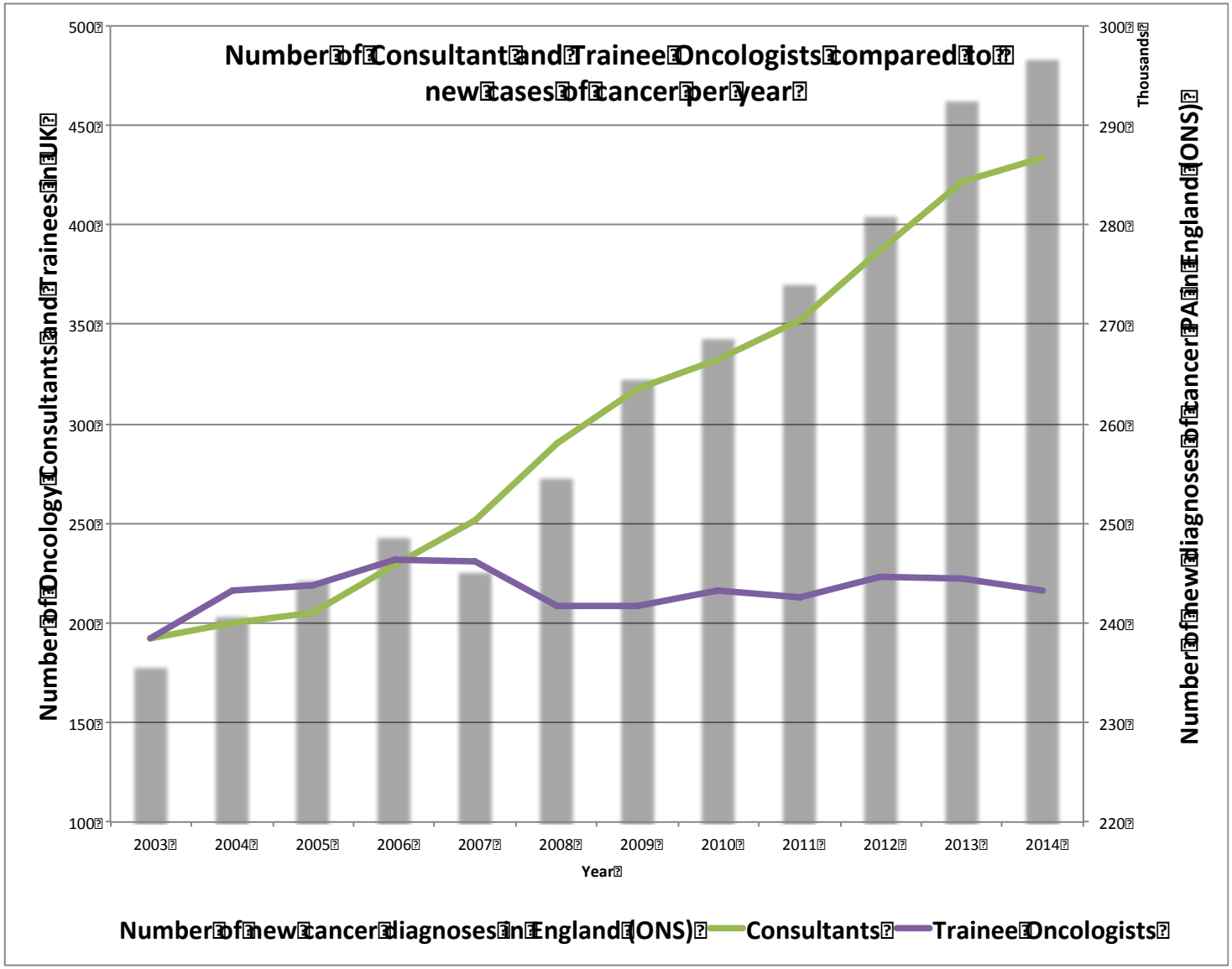

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What are our trainees doing?

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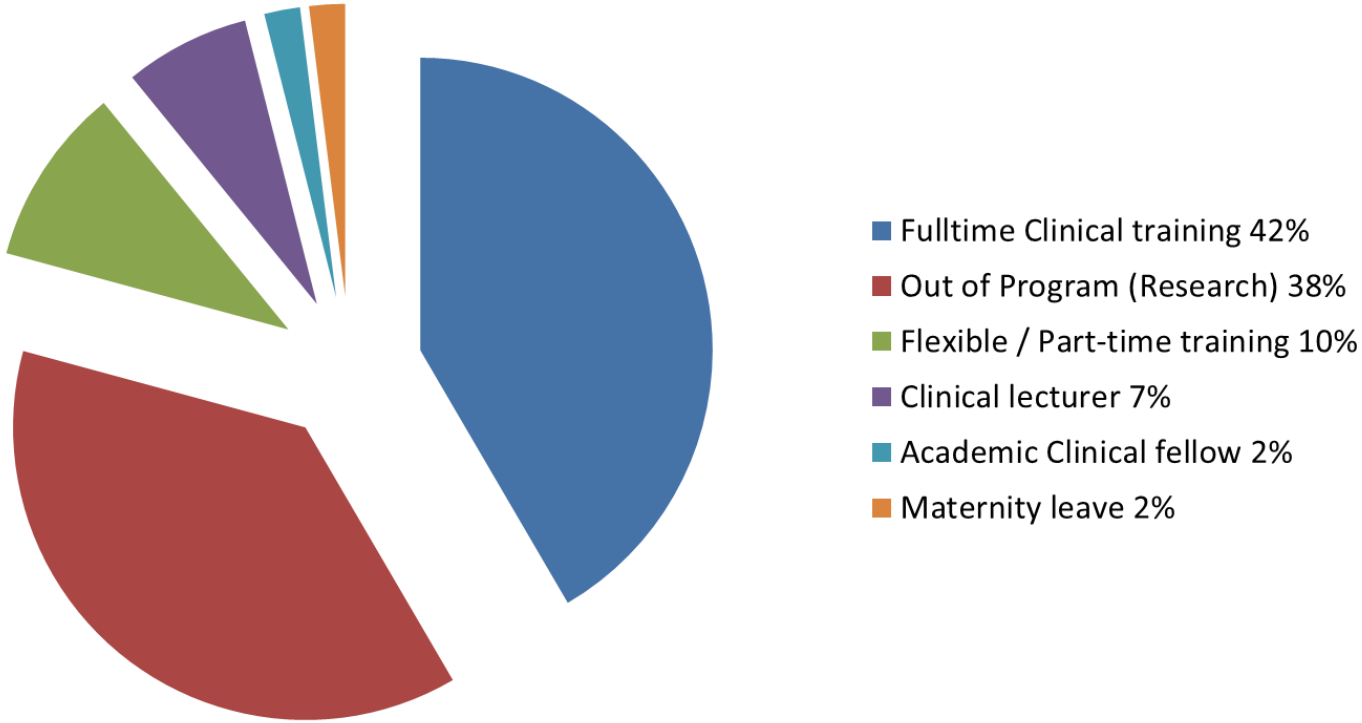

Less than 150 (WTE) trainees are in clinical positions

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Training Curriculum

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All trainees undertake a compulsory taught course in 1st / 2nd year of training

Many lead to an MSc

Typically half a day per week

Covers

- Basic sciences
- Translational science
- Pharmacology and drug development
- Clinical Skills

Strategic Development of the Specialty

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'Improving services and outcomes for cancer patients' – ACP 2016:

- Onco-geriatrics
- Onco-genetics
- Onco-immunology
- Onco-psychology
- Survivorship
- New integrative ways of working

All additional pressures on our training curriculum

Conclusions

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The skills of AO have to be learned and sustained in AO and are not the same as those of a GIM consultant. AO now has a central place in our curriculum.

We welcome the third “medical registrar” year of training which exactly and adequately sets up our trainees for their AO and specialist oncology training and practice.

AO and unselected take are mutually exclusive . There is inadequate capacity at all levels, the skill sets are different and having both skill sets is an unnecessary and undeliverable expectation.

Conclusions

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Medical oncologists provide an increasing proportion of systemic anticancer therapies and cancer drug development

We cannot meet the current demand and must expand to provide for the future

There is no capacity in the workforce for Acute GIM and no rationale for us to provide this

We do not have the training numbers to meet the current and foreseeable workforce needs

Going back to being a generalist with 'an interest in oncology'?

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- Increase avoidable cancer deaths by:
  Reducing the quality of specialised cancer care
  Reducing the availability of Acute Oncology
- Cost more for acute cancer and GIM services
- Unacceptable to cancer patients and the public
- Be unattractive to NHS trusts and commissioners who place cancer patient outcomes as a priority
- Reduce the attractiveness of medical oncology as a discipline
- Reduce research and innovation in oncology
- Threaten cancer research in the UK

Acute Oncology

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Allow medical oncologists to concentrate acute activity on the Acute Oncology Service

Allow medical Oncology to expand to meet the demands on our service

Allow us to work to develop Acute Oncology Services in all hospitals to the same standard that exists in current services with comprehensive oncology support

Allow us to ensure safety for cancer patients and do our “10%” for the Acute GIM take

Medical Oncologists, at all career stages and within all hospitals and institutions, are firmly against becoming "general physicians with an interest " and undertaking unselected GIM take as consultants and during specialist training, because it will be bad for patients and for the discipline

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AO and GIM Unselected take are mutually exclusive--the skill sets are different and the capacity to do both does not and cannot exist in the UK

We have a very good way forward in these initiatives and need support and endorsement to make AO and CE work everywhere --and we need to take back to our colleagues a sense that the Colleges and NHS appreciate their very hard work being done in the interests of our patients and the whole NHS

Medical Oncology and Shape of Training

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President of the Association of Cancer Physicians, Leeds

Professor Helena Earl,
Professor of Clinical Cancer Medicine, Cambridge

Supported by members of the association of cancer physicians and specialty advisory committee for Medical Oncology. Including Dr Ernie Marshall (National lead for acute oncology services), Dr Pauline Leonard (Acute Oncology Lead, Whittington Hospital) with support of medical oncology trainees.

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Additional Slides

Models of Care
Trainee numbers and survey
Rotation Gaps
What is Medical Oncology?
Increasing demand

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Models of Acute Oncology Care - Urgent and Emergency Care

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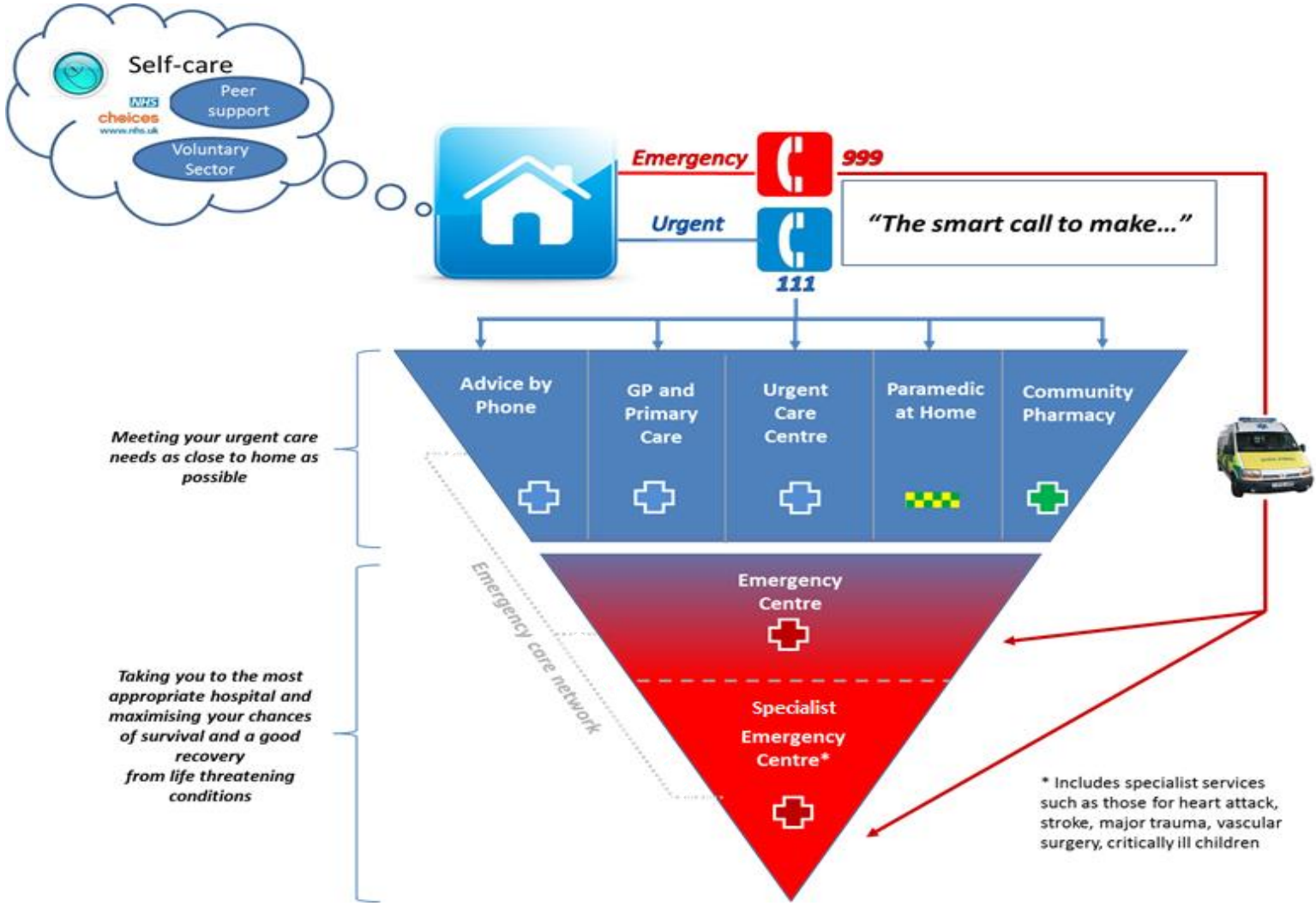

The Keogh Urgent Care Review, 2013

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Models of Acute Oncology Care - Urgent and Emergency Care

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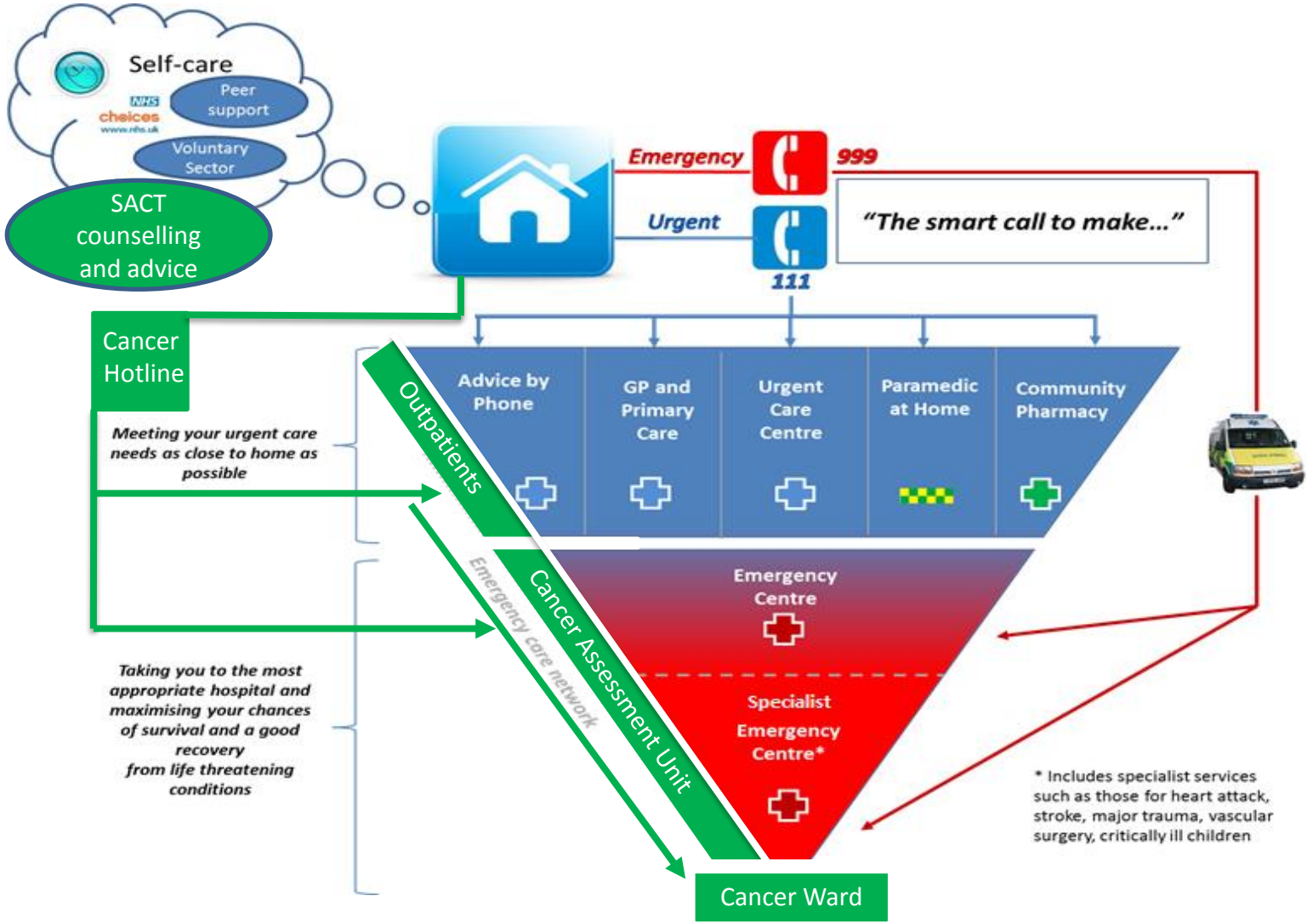

The Keogh Urgent Care Review, 2013

Oncology Patients are triaged directly to oncology teams for assessment and management

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Models of Acute Oncology Care - Future Hospital Programme

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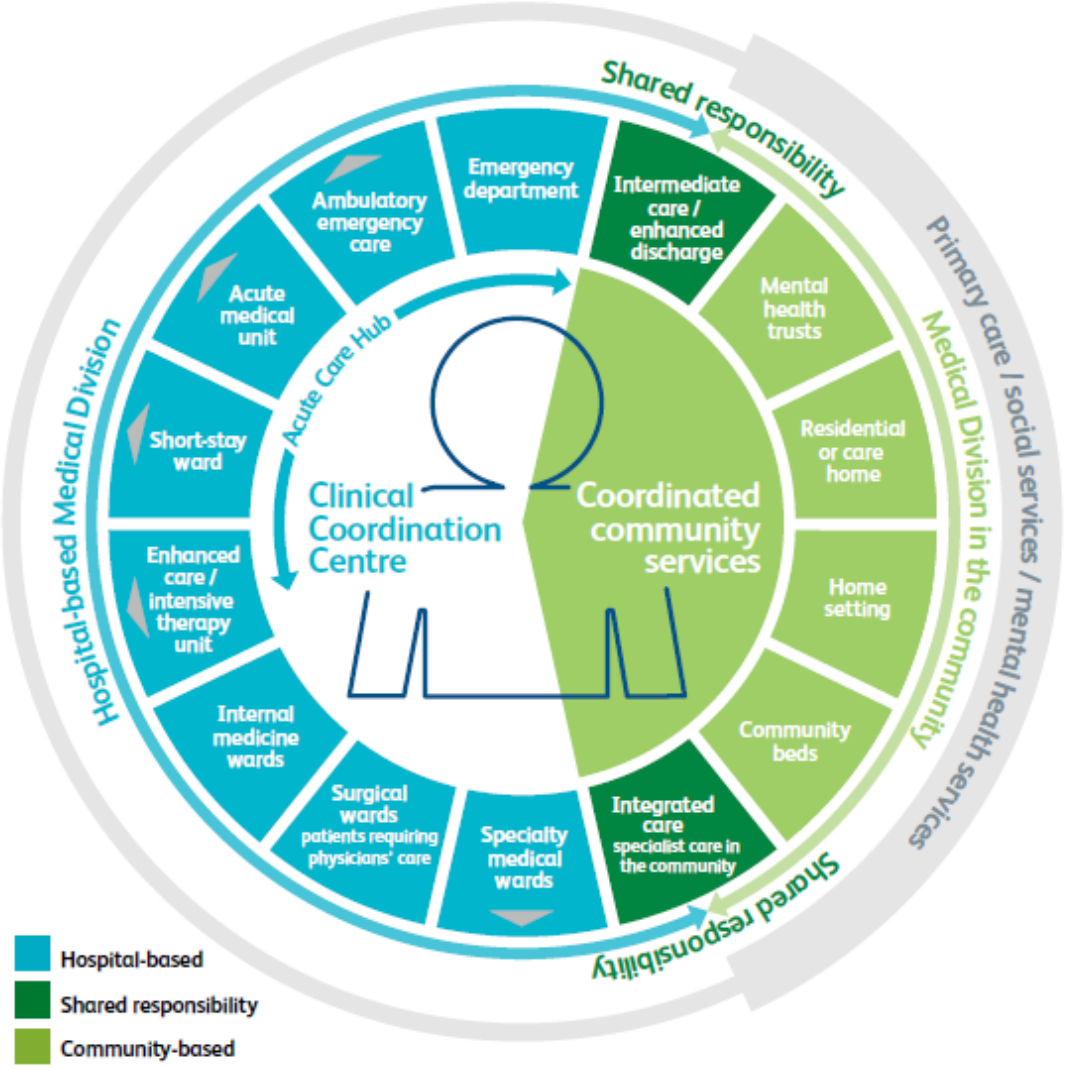

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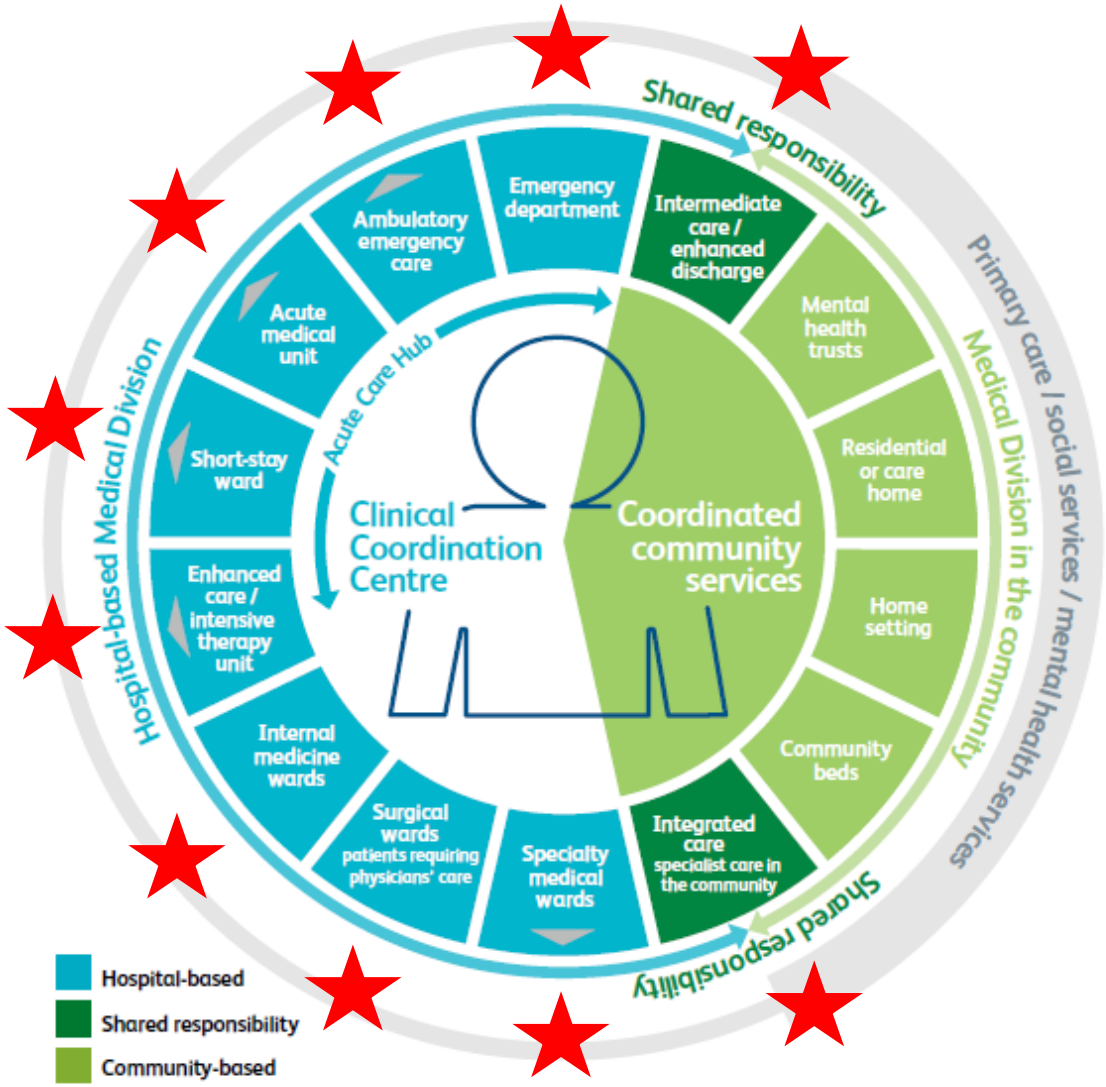

Acute Oncology allows early access to specialist advice and review

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Medical Oncology Training – What are our 255 trainees doing?

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HST workforce | By specialty and gender			
Region	Female	Male	Total
Metabolic medicine	1	1	2
Allergy	7	3	10
Medical ophthalmology	4	7	11
Nuclear medicine	7	4	11
Audiovestibular medicine	12	6	18
Stroke medicine	11	15	26
General internal medicine	10	16	26
Clinical neurophysiology	10	18	28
Immunology	13	16	29
Sport and exercise medicine	11	26	37
Clinical pharmacology and therapeutics	14	25	39
Paediatric cardiology	23	26	49
Rehabilitation medicine	35	37	72
Clinical genetics	66	9	75
Genitourinary medicine and HIV/AIDS	105	12	117
Pharmaceutical medicine	58	69	127
Dermatology	163	52	215
Palliative medicine	177	41	218
Medical oncology	176	79	255
Rheumatology	172	88	260
Infectious disease and tropical medicine	159	115	274
Neurology	146	167	313
Acute internal medicine	141	195	336
Renal medicine	185	179	364
Endocrinology and diabetes mellitus	217	220	437
Haematology	322	172	494
Gastroenterology and hepatology	261	381	642
Respiratory medicine	350	321	671
Geriatric medicine	467	253	720
Cardiology	195	551	746
Grand Total	**3,518**	**3,104**	**6,622**

With 135 WTE trainees in clinical positions medical oncology constitutes 2% of physicianly trainees

Less than 150 (WTE) trainees are in clinical positions

89% of trainees have or intend to take an OOPE

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Survey of Medical Oncology Trainees

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42% of trainees would **not have chosen medical oncology** had it included general internal medicine

31% of trainees would consider **leaving the specialty** if they had to contribute to general unselected take

71% of trainees think that **dual accreditation** would be **detrimental** to their training

81% support acute oncology as medical oncologists contribution to general internal medicine

88% of trainees do not support acute unselected take ST4+ in medical oncology

* Survey of Medical Oncology Trainees through the Association of Cancer Physicians, 2015/6

Trainee Survey 2016

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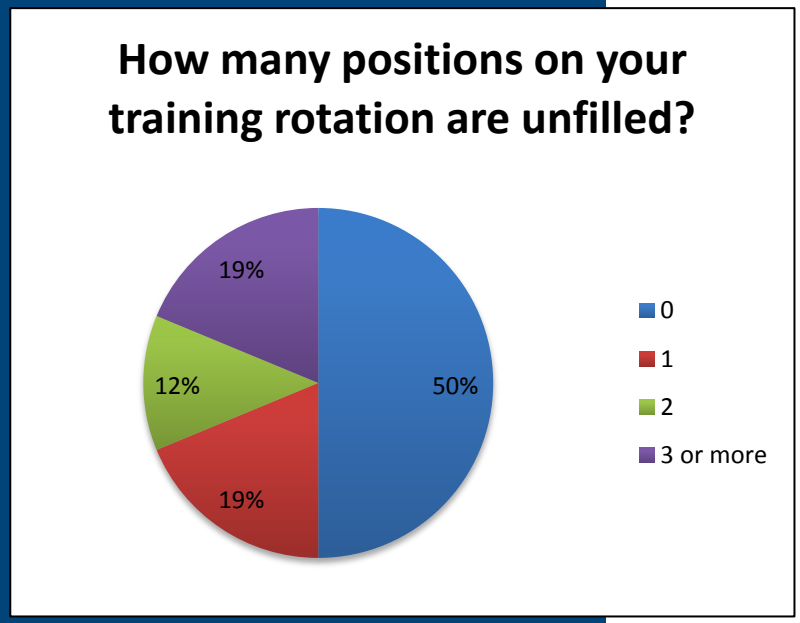

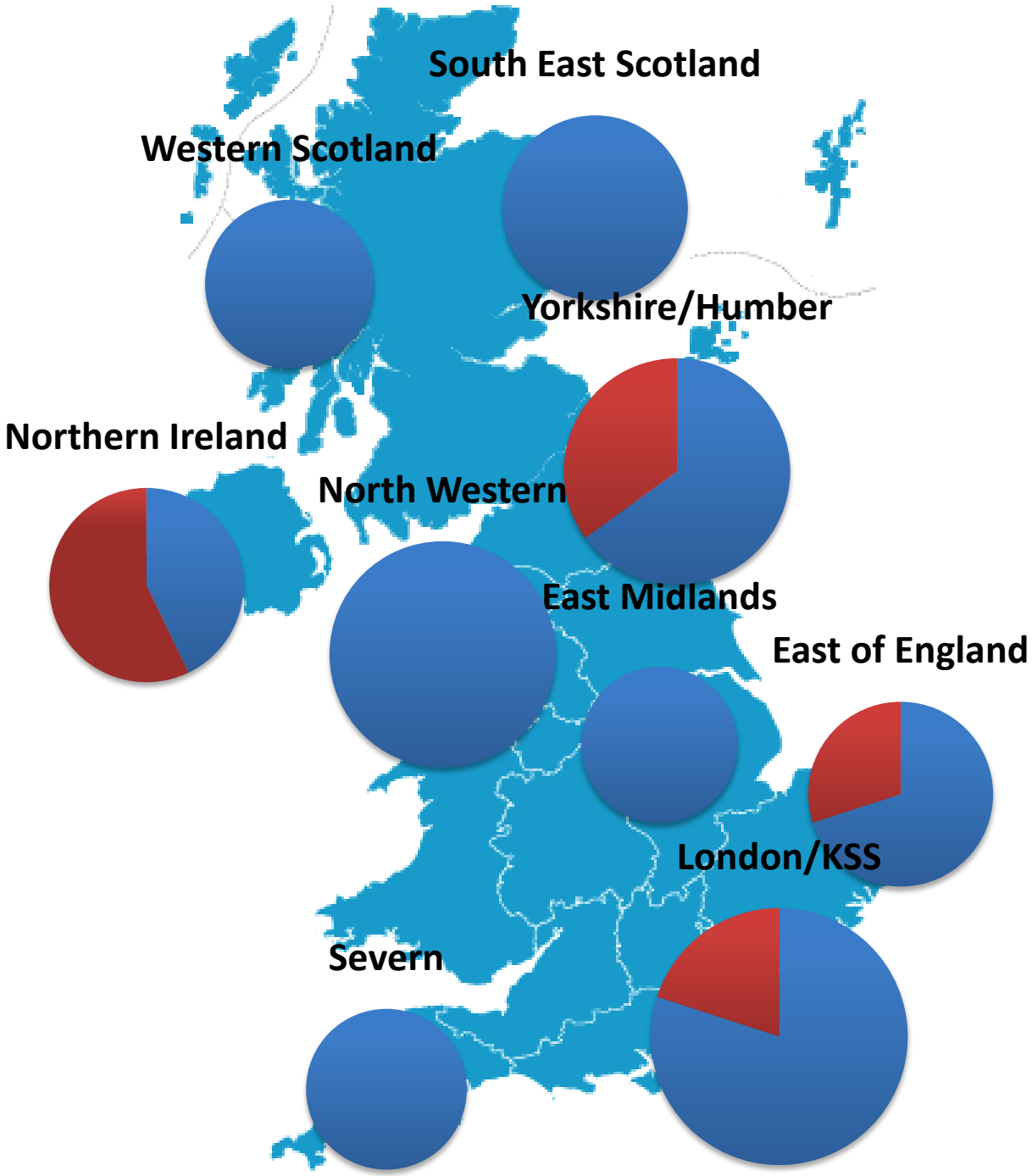

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Medical Oncology

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Academic-based medical specialty specialising in development, testing and administration of systemic anti-cancer therapies (SACT)

One of the ***fastest growing specialties*** in the UK

The **major contributors** in the UK to **planning**, **leading** and undertaking cancer clinical and translational trials

Lead specialty in the development of the National (England) Acute Oncology Service (AOS)

Non-surgical Oncology currently subject to HEE / Cancer transformation Board / CRUK studies on manpower requirements. Expected to demonstrate strategic need for growth.

Medical Oncology – Increasing Demand & Activity

acp Association of Cancer Physicians

Medical Oncologists care for **4.7% of all admissions**[1]

Medical Oncologists saw an **11.8% increase in activity** in the last year (2015 – 2016) compared with 5.4% in General Medicine [1]

Over 130 000 patients received chemotherapy in 2013/14 and there has been a 166% increase in use of the cancer drugs fund[2]

Cancer accounts for **11.[illegible]** [illegible] hospital[1]

Medical Oncologists account for **3.3% of Physicianly consultants**

Mean Number of Finished Consultant Episodes per consultant in the UK 2015-16[1]	
Medical Oncology	603
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General Medicine	500

1. Hospital Episode Statistics Dataset, 2015-16
2. National Audit Office Report 2015