Chemotherapy services in England: Ensuring quality and safety
The NCAG report
Should medical oncology change?

Professor Peter Clark
Chairman
National Chemotherapy Implementation Group
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- NCAG report: elective chemotherapy
- NCAG report: emergency care and acute oncology
- NCAG report: cross-cutting issues
- Models of service and integration
- Role of medical oncology
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- NCAG report: elective chemotherapy
- NCAG report: emergency care and acute oncology
- NCAG report: cross-cutting issues
- Models of service and integration
- Role of medical oncology
Issues in chemotherapy

- Greater benefits of treatment
- More modalities, more multidisciplinary care
- Older patients, more comorbidities
- Consistently rising activity, nearly all day case
- Capacity problems and access issues
- Waiting times
- Chemotherapy environment – variable quality
- Treatment nearer to home
- Increasing and different toxicity
- Increasing admissions to DGHs with toxicity
Issues in systemic therapy

- Inpatient care
- IOG reforms
- Cancer Reform Strategy, Next Stage Review
- Poor data
- New roles eg nurses, pharmacists
- Governance
- Commissioning
- Independent sector
- Variation in practice
- NHS funding over next years
- Election year
- Role of medical oncologists
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- NCAG report: elective chemotherapy
- NCAG report: emergency care and acute oncology
- NCAG report: cross-cutting issues
- Models of service and integration
- Role of medical oncology
NCEPOD audit: For Better Or Worse 2008

- 47000 pats treated June/July 2006
- 1000 (2%) died within 30 days
- 63% questionnaires returned
- 52% case notes returned
- Lowest rate of response of any NCEPOD audit
- 21 % PS 3 or 4, 50% previously treated, 37% significant comorbidities
- Poor recording of consent and toxicity
NCEPOD: re-admissions

- 85% re-admitted, 15% to different hospital
- 51% under care of haem/oncologist
- 49% under care of acute physicians
- Advice before admission: telephone triage 19%, GP 30%, A & E 43%, OPD 8%
- 17% with G 3 or 4 toxicity delayed >24 hrs
- 83 admissions with n’penic sepsis: delays in admission, lack of policies in A & E and DGHs, failure to make diagnosis, lack of assessment by senior staff, delays in prescribing & admin of antibiotics
NCEPOD verdict on care

- 35% received good care
- 49% had room for improvement, mainly in clinical care 38%, 6% in organisational care, 5% in both
- 8% rec’d less than satisfactory care
- 8% had insufficient data
- In 27% (NB 115/429) treatment caused or hastened death
- NB remember the other 46000 patients
NCEPOD report 2008: lessons

• Need to get the basics right in chemotherapy pathway
• Selection of patients
• Recording of performance status
• Consent
• Prescribing, checking by pharmacy
• Recording of toxicity
• Management of toxicity
• Leadership, governance, audit
Chemotherapy services: quality and safety

• Issues in chemotherapy today
• Concerns re safety and quality in ST
• Inpatient stay and acute oncology
• NCAG report: elective chemotherapy
• NCAG report: emergency care and acute oncology
• NCAG report: cross-cutting issues
• Models of service and integration
• Role of medical oncology
Acute oncology and inpatient stay:
Cancer Reform Strategy

- IP cancer care is the most expensive care setting
- IP cancer care = 52% of all cancer expenditure (£4.4b/yr)
- IP cancer care = 12% of all IP bed stay
- IP admissions for cancer rose by 25% over past 8 years, most relating to emergency episodes
- 60% of cancer IP stay = non-elective admissions, largely by physicians in medicine
- IP cancer costs will rise by 25% in 15 years, due to increased cancer incidence esp in elderly
Acute oncology and inpatient stay

- 273,000 emergency admissions with diagnosis of cancer in 2006/7, up by 30% from 1997/8
- 44% initially under care of medicine, 22% under surgery, 23% under onc/haem
- Equivalent to 750 emergency admissions per day across England
- Typical Trust: 5 emergency admissions with cancer per day (2 under medicine, 1 under surgery, 1 under onc/haem and 1 ‘other’)
Acute oncology and cancer inpatient stay

- Increasing systemic therapy leads to increasing toxicity & need for admission
- Treating older with more comorbidities leads to more toxicity & admissions
- DGHs bear brunt of ‘acute oncology’ – toxicity of treatments delivered in DGH and elsewhere (NB IOGs), ill patients with diagnosed cancer (NB IOGs), ill patients with undiagnosed cancer
- DGHs remain foundations of haematology but not generally of oncology
- DGHs are usual base for palliative care
- DGHs bear brunt of dislocation of care
Acute oncology and ways of reducing inpatient stay

- For complications of treatment
- Early oncology input into the care of known cancer patients admitted with cancer-related complications
- Early oncology input into the care of patients admitted with a diagnosis of likely malignancy
- NB Management of neutropenic fever for low risk patients changing
Reducing IP stay by early input into undiagnosed cancer patients

- Particularly with patients presenting with disseminated disease from primary tumours which are not immediately obvious
- Prolonged IP stay, especially in medicine
- Delayed referral to oncology and palliative care team
- Many investigations
- Worthwhile pursuit of diagnosis vs not
- Poor quality of care for patient and carers
St Helen’s & Knowsley

• New pathway for inpatients admitted with likely diagnosis of cancer: acute oncology team
• Reduced length of stay: 22 days to 9 days
• Reduced time to referral to site-specific or palliative care team
• Reduced investigations
• Increased collaboration with acute medicine, radiology, pathology
• Universal assessment as to better care
• Substantially increased referrals
Acute oncology team

- Early management of toxicity
- Early management of re-admissions
- Early management of UKP cancers
- Acute oncology alongside acute medicine and surgery as well as palliative care, haematology
- Investment at hospitals with A & E departments (mainly DGHs)
- Better care
- Savings especially in bed stays
- Medical workforce is potentially there over next few years
Chemotherapy services: quality and safety

• Issues in chemotherapy today
• Concerns re safety and quality in ST
• Inpatient stay and acute oncology
• NCAG report
• NCAG report: elective chemotherapy
• NCAG report: emergency care and acute oncology
• NCAG report: cross-cutting issues
• Models of service
• Role of medical oncology
National Chemotherapy Advisory Group Report

- Focus entirely on safety and quality
- Need to improve elective chemotherapy (based on care pathway model)
- Improve acute oncology services
- Establish acute oncology teams
- Leadership, clinical governance and audit, workforce, training, data collection & IT, peer review measures, commissioning
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- **NCAG report: elective chemotherapy**
- **NCAG report: emergency care and acute oncology**
- **NCAG report: cross-cutting issues**
- Models of service
- Role of medical oncology
Elective chemotherapy

- The chemotherapy pathway
- Assessment decision to treat, consent
- Prescribing and dispensing
- Delivery and treatment environment
- Information, education, support, advice
- Treatment record, prescribing subsequent cycles, end of treatment record, subsequent care plan
- Audit
Chemotherapy services: quality and safety

• Issues in chemotherapy today
• Concerns re safety and quality in ST
• Inpatient stay and acute oncology
• NCAG report: elective chemotherapy
• NCAG report: emergency care and acute oncology
• NCAG report: cross-cutting issues
Acute oncology service: all hospitals with A&E departments

- Faster and better care of patients with complications (early recognition, better treatment, early discharge)
- Faster and better care of patients with complications of cancer (early recognition, better treatment, early discharge, rapid triage to appropriate team)
- Appropriate treatment of patients presenting with unknown primary cancers (targeted investigations, triage of patients into appropriate team)
- Close multidisciplinary integration between AOS and haematology, A&E, acute medicine, acute surgery, radiology, pathology and palliative care
- Overlap and integration with site-specialist oncology
Acute oncology service: illustrative model for level 2 service

- 2 oncologists working opposite each other, providing 5-day service but also having chemotherapy practice for common cancer at unit, many practising at both unit and centre
- 0.5 wte between them for AOS
- 2 specialist cancer/chemotherapy nurses (1 wte) working opposite each other but also having other related roles (managerial, haematology, chemotherapy, palliative care, spinal cord compression, site-specific duties)
- AOS office and part-time secretary
- IT systems which flag known cancer or chemotherapy patients when in A&E or on wards
- 24hr telephone advice (shared with other units/centre)
- AOS leads policies and procedures covering its activities
- No oncology beds
The acute oncology service

- Different models to suit local resources and needs
- Issues in oncology expertise and availability, training, acute oncology competencies
- Issues re AOS and site-specific oncology
- Issues in oncology nurse expertise and availability, acute oncology competencies
- Integration with haematology
- Treat and transfer arrangements if no AOS
- IT issues
- Regular audits of emergency admissions with cancer
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- NCAG report: elective chemotherapy
- NCAG report: emergency care and acute oncology
- NCAG report: cross-cutting issues
- Models of service
- Role of medical oncology
NCAG report: cross cutting issues

• Leadership and audit
• Clinical governance and peer review
• Workforce and training
• Data and IT
• Commissioning
Leadership

• Elective chemotherapy service
• Acute oncology service
• Roles in policies, capacity planning, clinical governance, workforce and training, patient information and support, financial management, treatment facilities, IT, audits of safety and quality in elective chemotherapy service and acute oncology service
• Integration at clinical end: oncology, haematology, oncology nursing, pharmacy
Clinical governance and peer review

- All chemotherapy services to reassess themselves urgently against current peer review measures and take account of NCAG recommendations
- Peer Review measures to be updated
- Further self-assessment and followed by peer review
- Regular audits eg febrile neutropenia
Workforce and training

- NCAT and cancer networks to develop collection of workforce numbers for chemotherapy nurses and oncology pharmacists
- New competences to be developed – especially in acute oncology
- New training programmes to be developed
- New roles (e.g., consultant nurses/pharmacists and chemotherapy support workers) to be encouraged
Data and IT

• Core chemotherapy dataset to be defined
• Collection of this will then be mandatory (Cancer Reform Strategy commitment)
• E-prescribing to be introduced as quickly as possible
• Networks to examine ways of those hospitals involved in cancer services sharing appropriate information to allow out of hours decisions in acute oncology to be made wholly in the interests of patients eg should this patient be referred to ITU
Commissioning

• Flexibility, capacity, safety, efficiency, integration
• DGH investment offers best safeguard for future rise in activity and complexity at least for the common 3 cancers and opportunities for shared care with IOGs
• DGH investment offers best safeguard for current and future management of toxicity for treatment administered at any hospital
• DGH investment offers greatest opportunities for impacting on inpatient stay for cancer
• DGH investment offers greatest integration of oncology into DGH (as in haematology) and with haematology
• Sharing of patient information between hospitals involved in any patient’s care
• Robust commissioning required: patient-centred esp when FTs compete to detriment of service to patient
Chemotherapy services: quality and safety

- Issues in chemotherapy today
- Concerns re safety and quality in ST
- Inpatient stay and acute oncology
- NCAG report: elective chemotherapy
- NCAG report: emergency care and acute oncology
- NCAG report: cross-cutting issues
- Models of service
- Role of medical oncology
Models of chemotherapy service

- Cancer centre
- Cancer unit (DGH)
- Other NHS sites – specialist hospitals, cold hospitals, community hospitals, polyclinics
- GP surgeries
- Other ‘community’ sites
- Chemo bus
- Home
Models of service

• Quality, safety, flexibility, efficiency
• Centralise IP/complex therapy
• Devolve simpler treatments
• Nurse-led chemo unlocks rigidity in chemotherapy system
• Investment in 5-day chemo units
• Investment & integration of service in DGHs: the best option for satisfying competing needs
• Work with haematology
• Break the mould of oncologist as the visitor
• Oncology cover for leave
• Network chemo service: not CC vs CU
Chemotherapy services: quality and safety

• Issues in chemotherapy today
• Concerns re safety and quality in ST
• Inpatient stay and acute oncology
• NCAG report: elective chemotherapy
• NCAG report: emergency care and acute oncology
• NCAG report: cross-cutting issues
• Models of service
• Role of medical oncology
Role of medical oncology

• Academic medical oncology
• NHS medical oncology
• Site-specific medical oncology – centres
• Site-specific medical oncology – DGHs
• Acute oncology – centres
• Acute oncology – DGHs
• Integration of roles
• Leadership
Quality and safety in chemotherapy services

• There are very real concerns about the quality and safety of some chemotherapy services

• The NCAG Report addresses these concerns as well as offering a clear framework for service improvement

• The NCAG report requires urgent action from providers and commissioners as well as Royal Colleges
Challenges in systemic therapy

- Safety and quality in ST: working together
- Acute oncology: working together
- Inpatient care: working together
- Time for investment in acute oncology services (but overall cost savings)
- Capacity, flexibility, efficiency and quality
- Leadership
- Integration across a network
- Opportunities for medical oncology