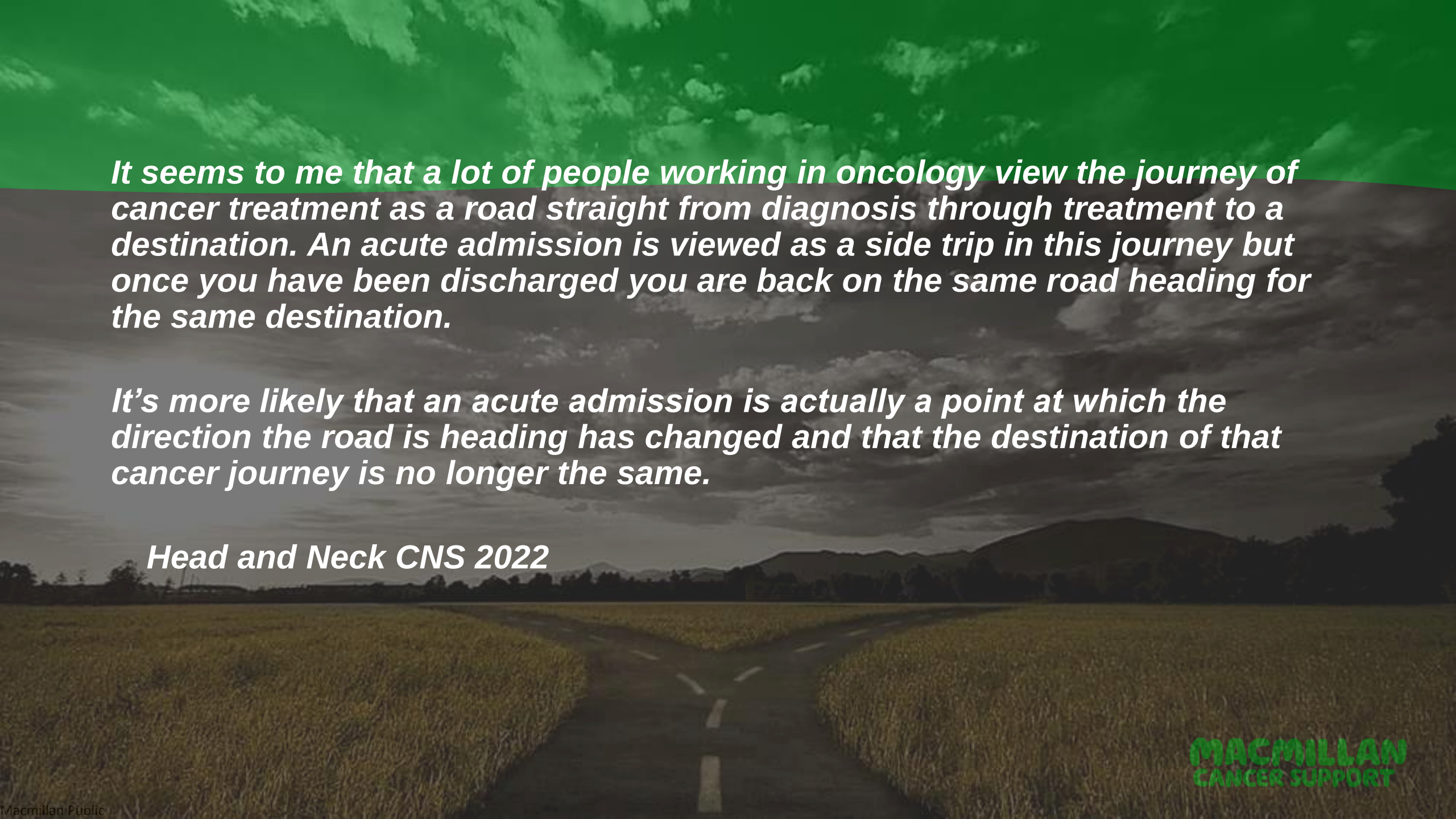
Acute cancer care

Thinking beyond acute oncology

Dr Ashling Lillis
Consultant in Acute Medicine, Whittington Health NHS Trust
National Clinical Advisor, Macmillan cancer support
@AshlingLillis

MACMILLAN CANCER SUPPORT



It seems to me that a lot of people working in oncology view the journey of cancer treatment as a road straight from diagnosis through treatment to a destination. An acute admission is viewed as a side trip in this journey but once you have been discharged you are back on the same road heading for the same destination.

It's more likely that an acute admission is actually a point at which the direction the road is heading has changed and that the destination of that cancer journey is no longer the same.

Head and Neck CNS 2022

MACMILLAN CANCER SUPPORT

Acute cancer care

personalised care and advance care planning for people living with cancer at a key time of transition

MACMILLAN CANCER SUPPORT

Acute oncology: the oncology based services that manage and treatment of patients who present acutely with cancer treatment side-effects or as emergencies with complications from a known or new cancer diagnosis (cancer CNS and oncologists)

Acute Cancer Care : The wider concept of all care provided for people with cancer who become acutely unwell. The wider group of professionals providing acute cancer includes primary care, oncology, emergency care (**ED**), acute medicine and palliative care

MACMILLAN CANCER SUPPORT

Acute oncology – it's a messy business

Are AO services set up to meet the needs of the patients they see?

- Type 1 - diagnosis of cancer as an emergency

Eg Lung, brain tumours, GI. More likely to have advanced disease and less likely to have anticancer treatment

- Type 2 - complications of anti-cancer treatment

Neutropenic sepsis, complications of novel treatments, chemo issues.

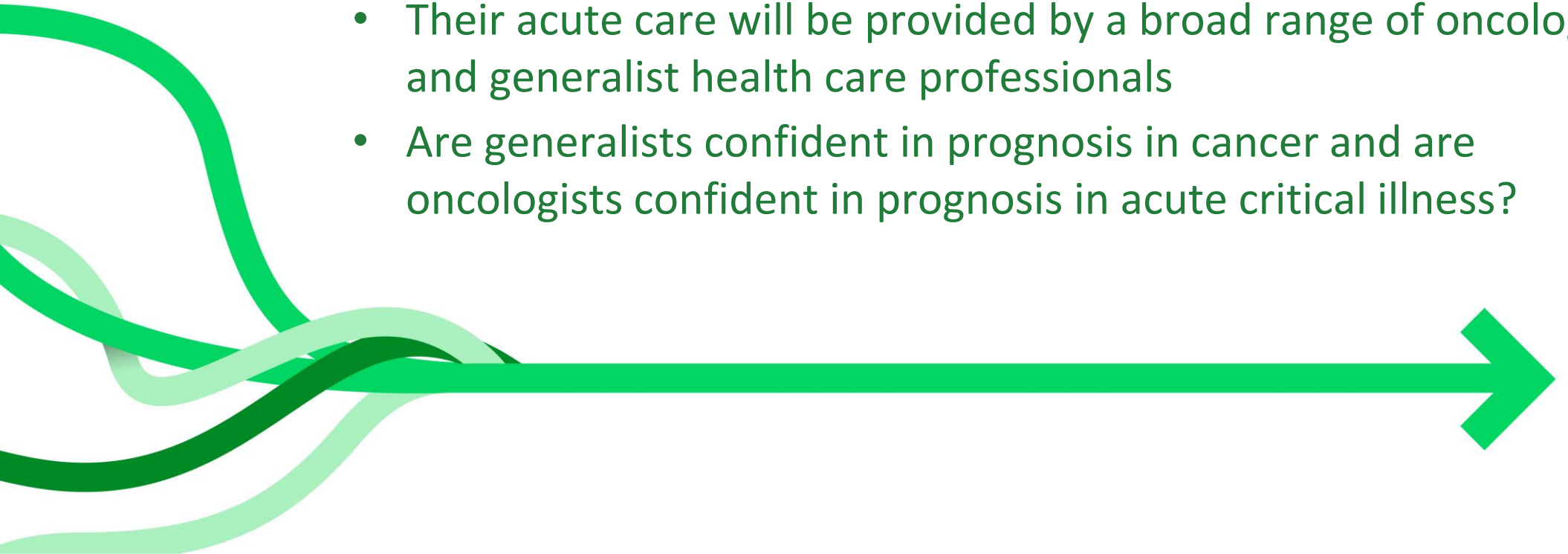
- Type 3 - progression of disease or cancer as a bystander

Nearly 50% of acute cancer admissions, increasing with the age/frailty & co-morbidities of cancer populations

MACMILLAN CANCER SUPPORT

Acute Cancer Care – the Scale of the Challenge

- People with cancer are living longer, have more co-morbidities and receiving more treatments for longer.
- Complexity is now the norm for people with cancer and acute illness will happen in their cancer journey
- Their acute care will be provided by a broad range of oncology and generalist health care professionals
- Are generalists confident in prognosis in cancer and are oncologists confident in prognosis in acute critical illness?

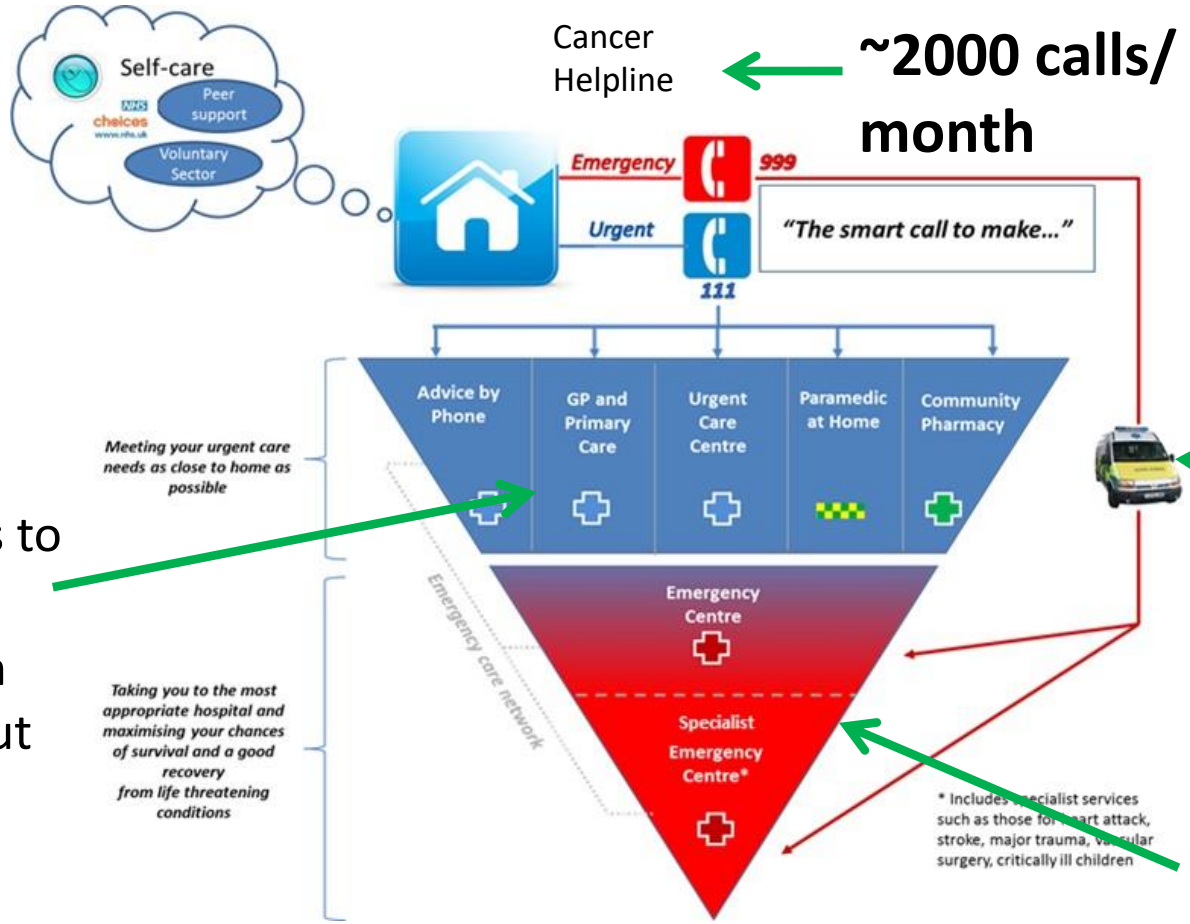


MACMILLAN CANCER SUPPORT

What do we know about people living with cancer who have to access acute care?

MACMILLAN CANCER SUPPORT

Cancer patients and unplanned care



6% of referrals to ED/direct admission from primary care out of hours

>10% of paramedic activity

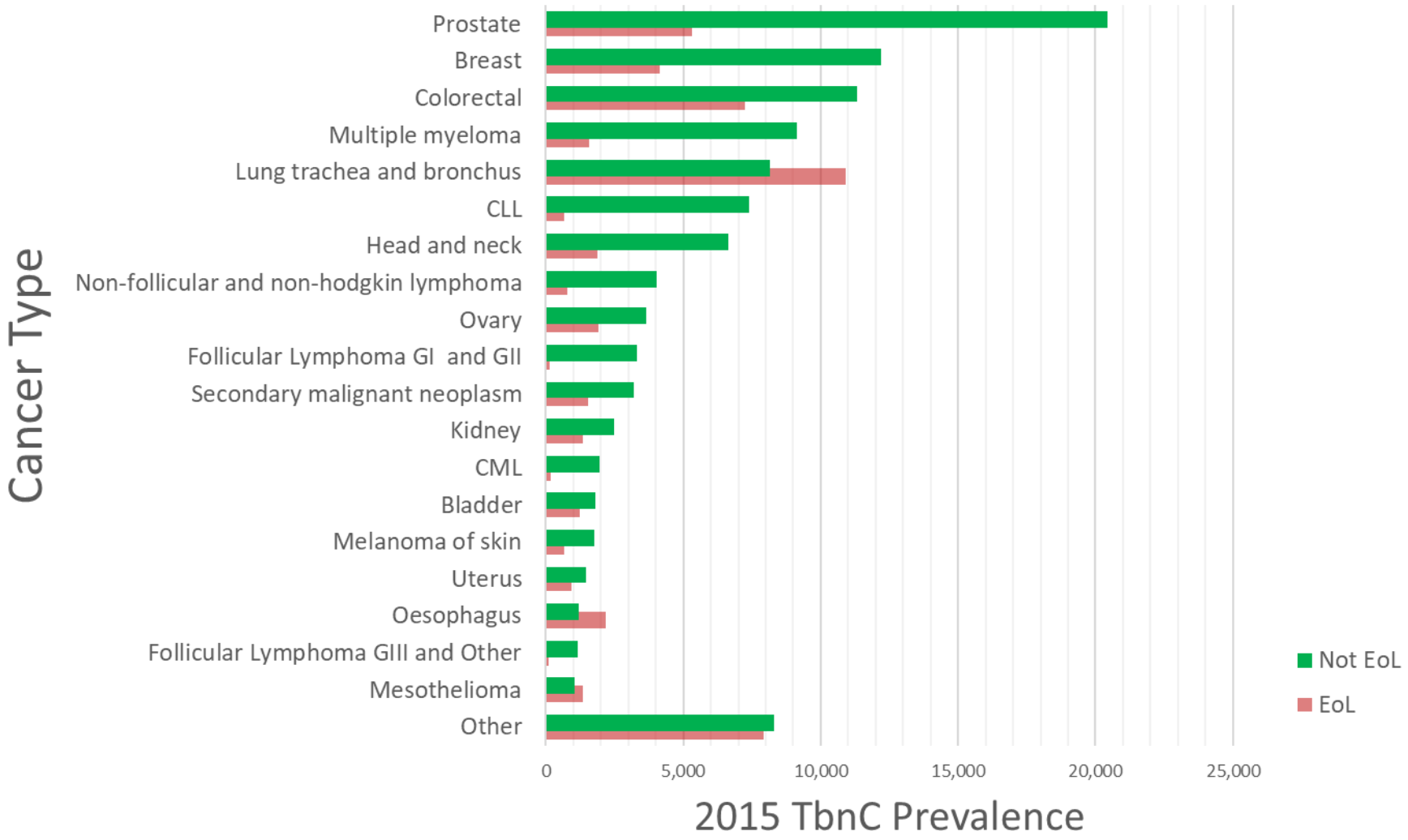
60% conveyance Rate to hospital

5% of ED attendances

15% of ED admissions

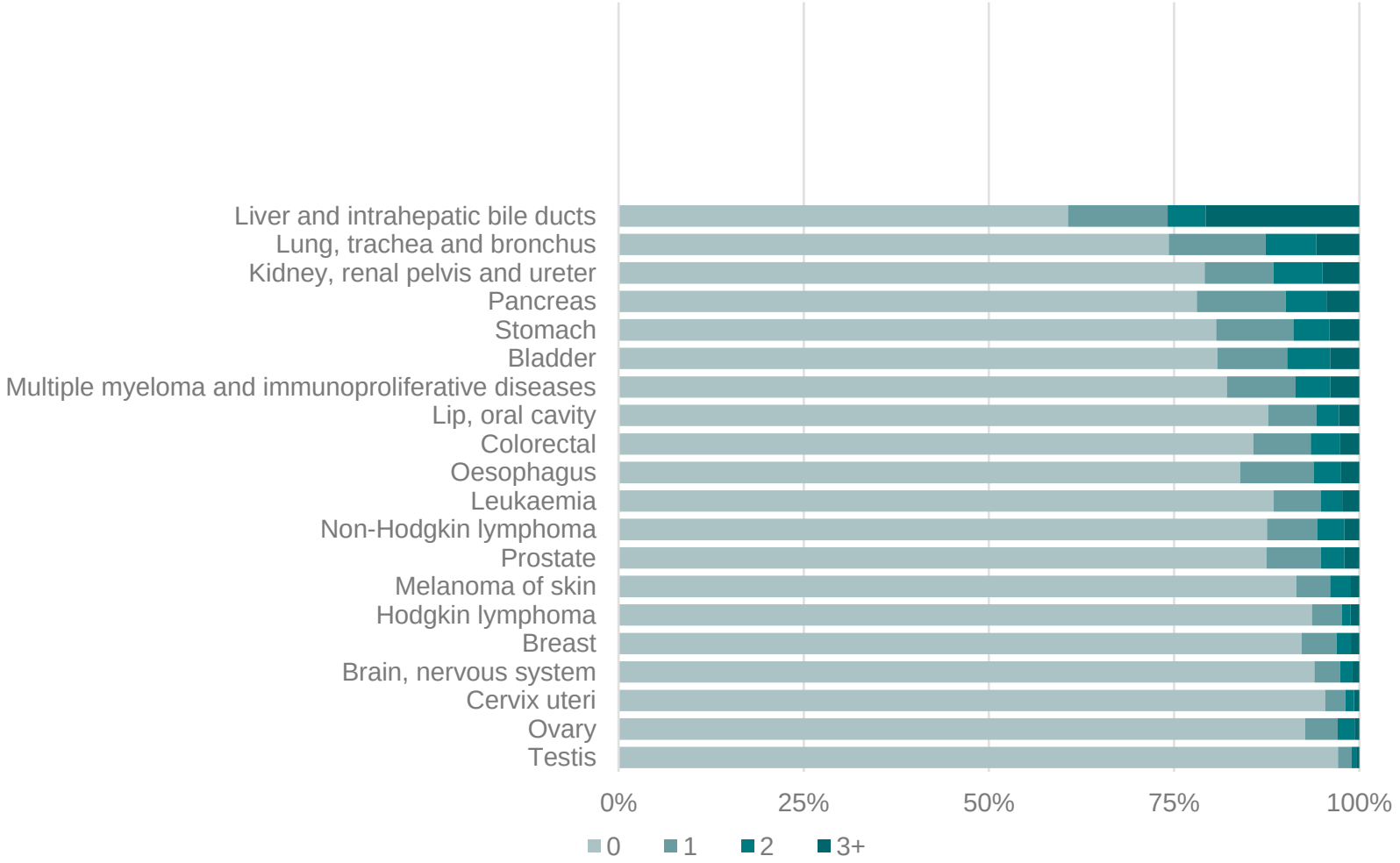
80% admission rate

In 2017 the estimated treatable but not curable cancer population was 110,000. This is likely to be >200,000 by 2030



MACMILLAN CANCER SUPPORT

Co-morbidity in people living with cancer in London (2018)

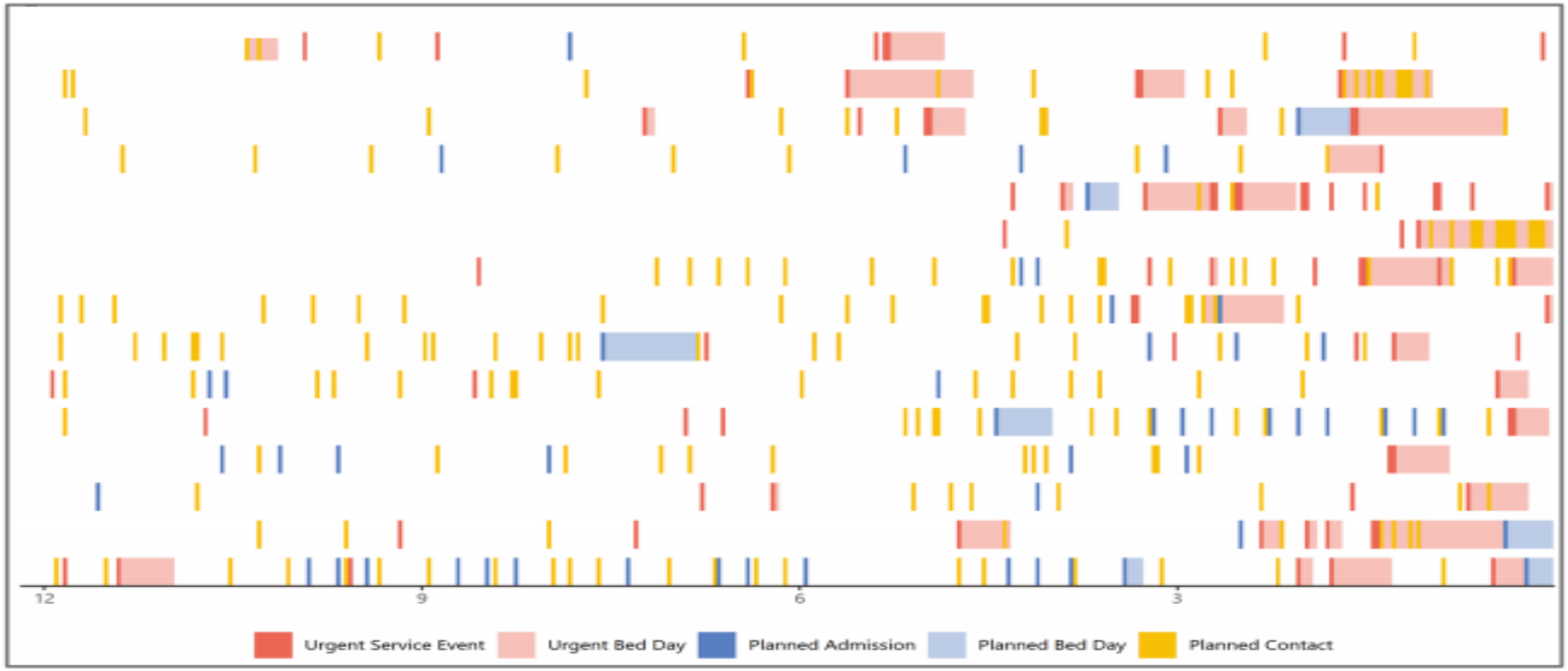


Charlson Group	Description	Charlson Score
1	Acute Myocardial Infarction	1
2	Congestive Heart Failure	1
3	Peripheral Vascular Disease	1
4	Cerebral Vascular Accident	1
5	Dementia	1
6	Pulmonary Disease	1
7	Connective Tissue Disorder	1
8	Peptic Ulcer	1
9	Diabetes	1
10	Diabetes Complications	2
11	Paraplegia	2
12	Renal Disease	2
13	Cancer	2
14	Metastatic Cancer	N/A
15	Liver Disease	1
17	Severe Liver Disease	3
16	HIV	6

5.4.2 Planned care features highly for those dying of cancer

Analysis of the sample of those dying from cancer (Figure 16) suggests frequent planned contacts and planned admissions. This group is also more likely to have a planned stay in hospital and experience more planned bed days than other cause of death groups. Urgent events and associated urgent bed stays are more likely to occur in the last six months of life.

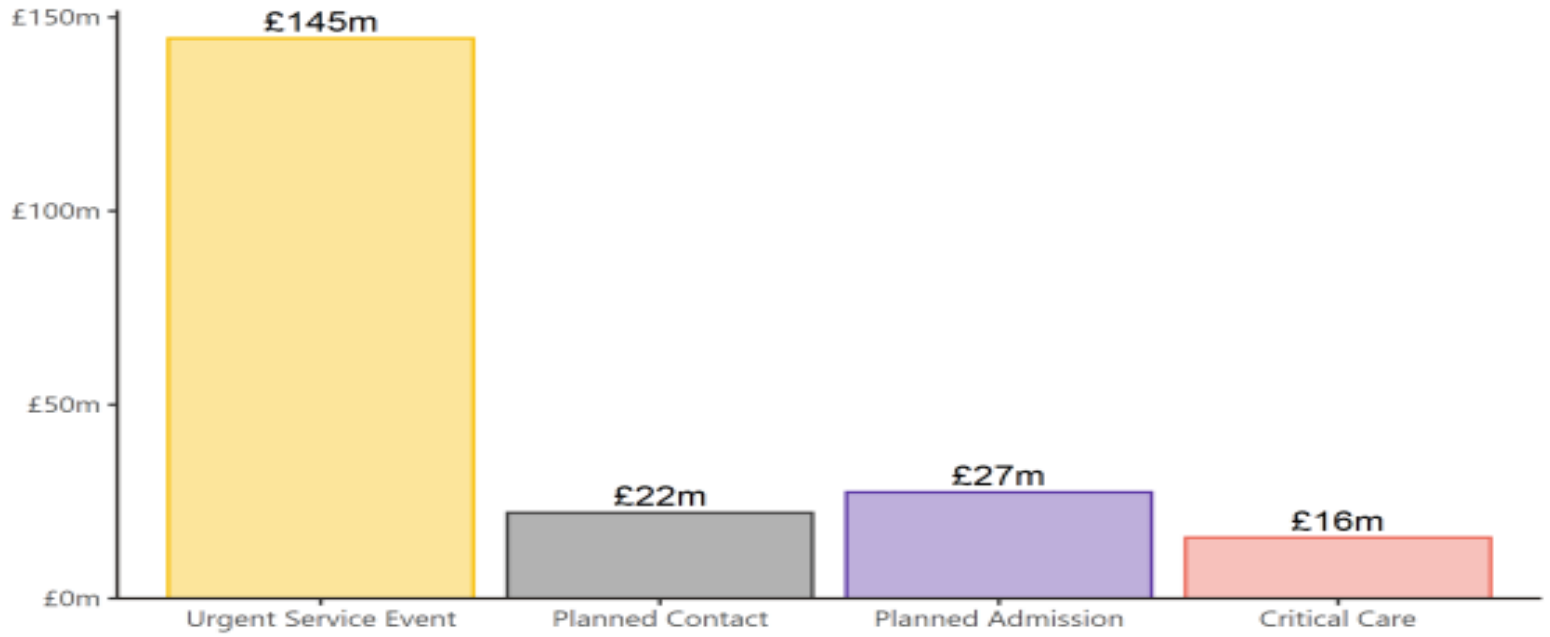
Figure 16 : Patterns of service use for people dying from cancer



8.1 Urgent care accounts for two-thirds of expenditure

The calculated total hospital spend in the last two years of life in Sussex Health and Care Partnership is £210 million. Figure 51 shows spend by activity type. Urgent services dominate spend, consuming two-thirds of end of life resource.

Figure 51 : Total spend by activity type in two years prior to death – Sussex Health and Care Partnership ICS



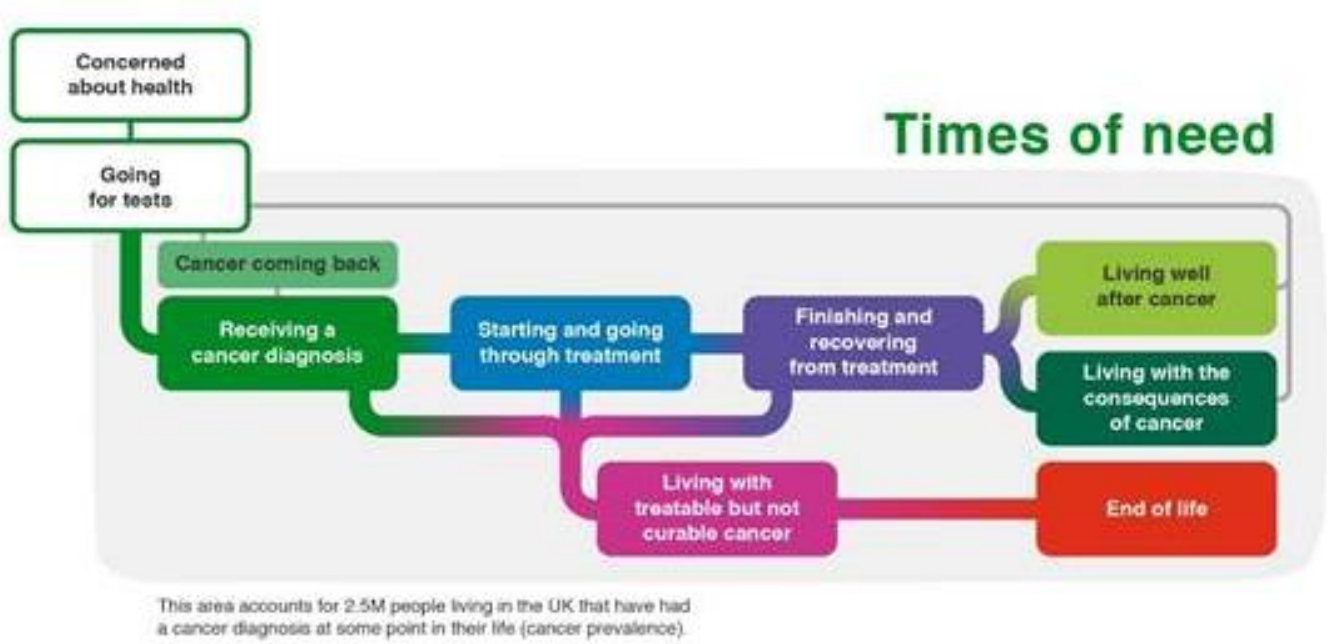
Acute cancer care and end of life – most people who die of cancer have an emergency admission in their last year of life

- Of **4,353** people who died of cancer in NI in 2015
  - **3 OUT OF 4** people (**73.7%** n=3,212) had at least one emergency admission recorded in their last year of life, with 16.8% of people having three or more admissions
  - **1 IN 5 (20%)** spent more than one month in hospital in last year of life
  - **1 IN 4 (25.5%)** of patients with an emergency admission had palliative care recorded as part of their treatment
  - **1 IN 3 (35.8%)** died before discharge from hospital

Acute illness is often a time of transition into incurable disease or end of life care

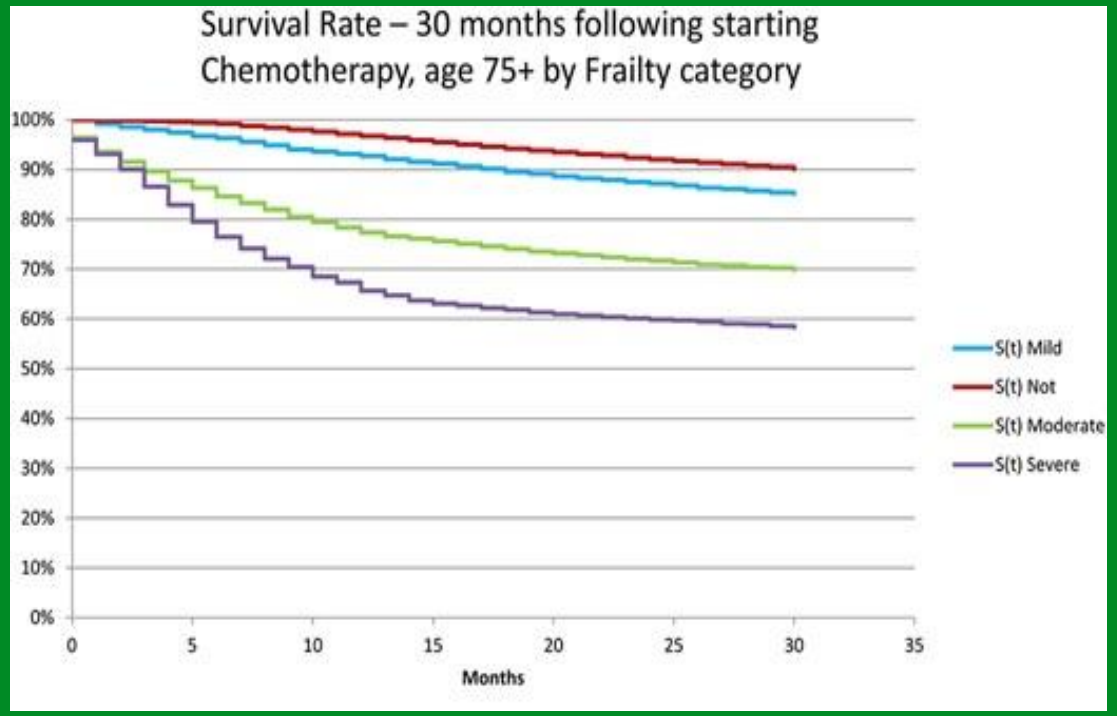
- If we don't 'catch' people at their first admission with palliative needs they are *50% less likely to die at home* *Midhurst Specialist Palliative Care at Home 2011*

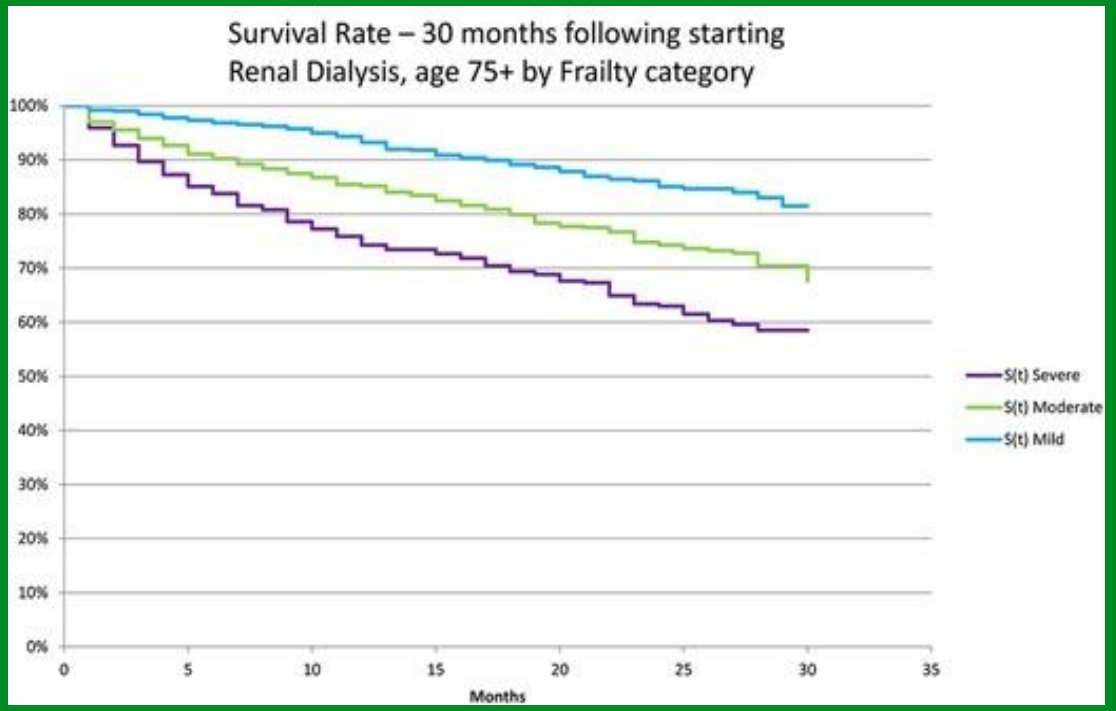
- All acutely unwell cancer patients are at higher risk of death but professionals are not talking about it
    - Just 27% of 265 acutely unwell cancer patients admitted to hospital had a recorded discussion about treatment escalation/CPR ***(macmillan AO medical student** survey 2018*)



MACMILLAN CANCER SUPPORT

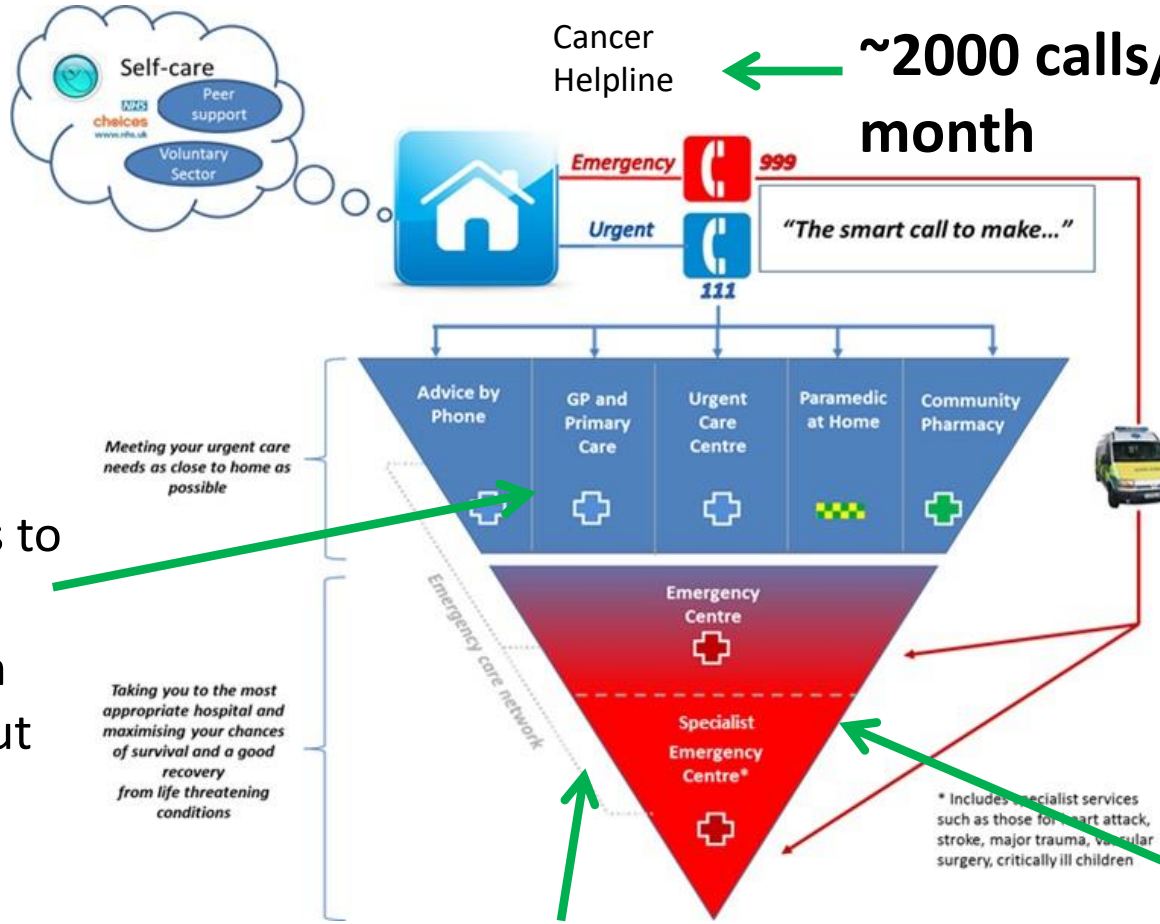
Frailty and Cancer





MACMILLAN CANCER SUPPORT

Acute Admission is a point of transition



6% of referrals to ED/direct admission from primary care out of hours

>10% of paramedic activity

60% conveyance Rate to hospital

5% of ED attendances

15% of ED admissions

80% admission rate

~2000 Acute Oncology inpatient referrals/year across 3 hospital in Merseyside

20% mortality rate at 30 days;

70% mortality rate at 12 months

Is that just in Merseyside?

We asked trusts in 2023 - how many unplanned admissions with referral to AO team in did you have in the 3 months from Jan-March 2022 and what was their mortality at 12 months

Small trust

- Whittington 60 (mortality at 12 months 72%)

Larger trusts with cancer centre

- Brighton 377 (mortality at 12 months 65.5%)
- Plymouth 365 (mortality at 12 months 79%)

MACMILLAN CANCER SUPPORT

So when you access urgent care as a person with cancer, you are….

More likely to be conveyed to ED

More likely to be admitted to hospital

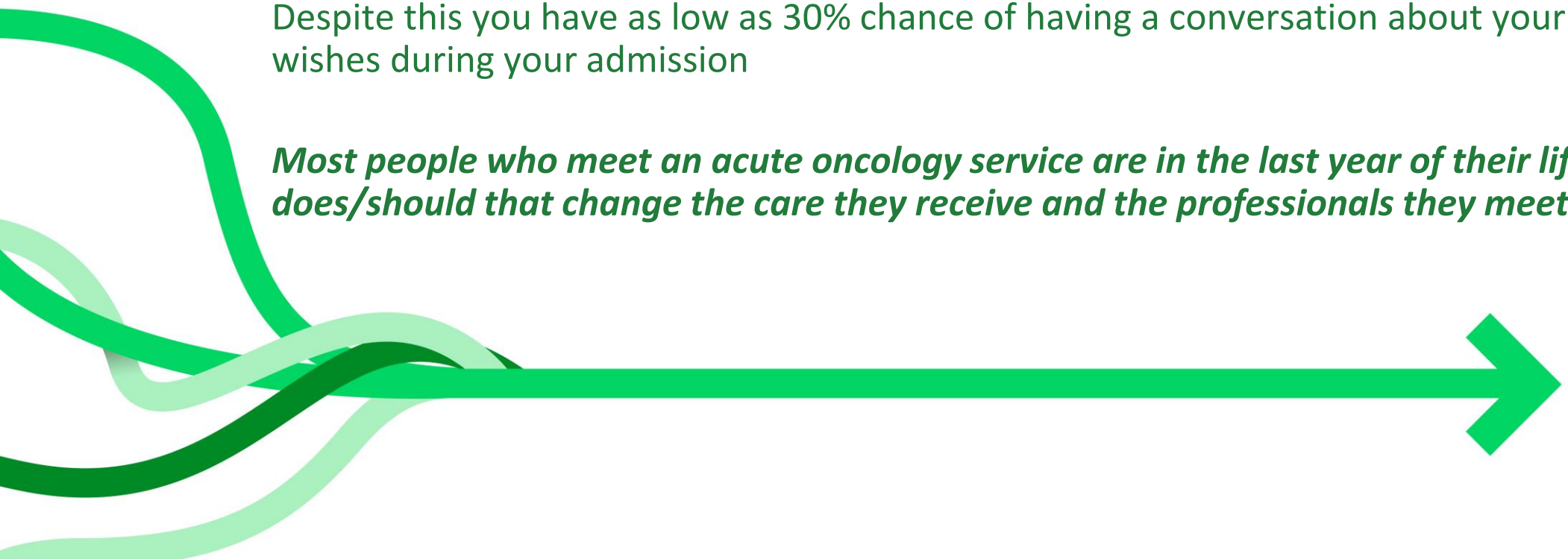
More likely to stay longer than someone without cancer as one of their coded diagnoses

More likely to die within 30 days of admission

Less likely to survive 12 months from your admission

Despite this you have as low as 30% chance of having a conversation about your advance wishes during your admission

Most people who meet an acute oncology service are in the last year of their life – how does/should that change the care they receive and the professionals they meet?



MACMILLAN CANCER SUPPORT

Ambition:

Every person with cancer who has an unplanned acute admission has an opportunity for a personalised care planning conversation and care plan completed

MACMILLAN CANCER SUPPORT

When a person living with cancer is admitted into hospital through emergency and unscheduled care, this often marks a turning point in their illness. Healthcare professionals working in acute cancer care should:

See it – recognise an acute admission as a point of transition for a person living with cancer.

Say it – take the opportunity to talk to the person and their family about what matters to them, including risk of acute illness, future admissions & death

Share it – ensure this conversation is the basis of an advance care plan to be shared more widely.

MACMILLAN CANCER SUPPORT

What would it look like to provide excellent personalised holistic care in acute settings?

MACMILLAN CANCER SUPPORT

What would excellent personalised holistic care look like for people who have an acute cancer admission?

For a person living with cancer

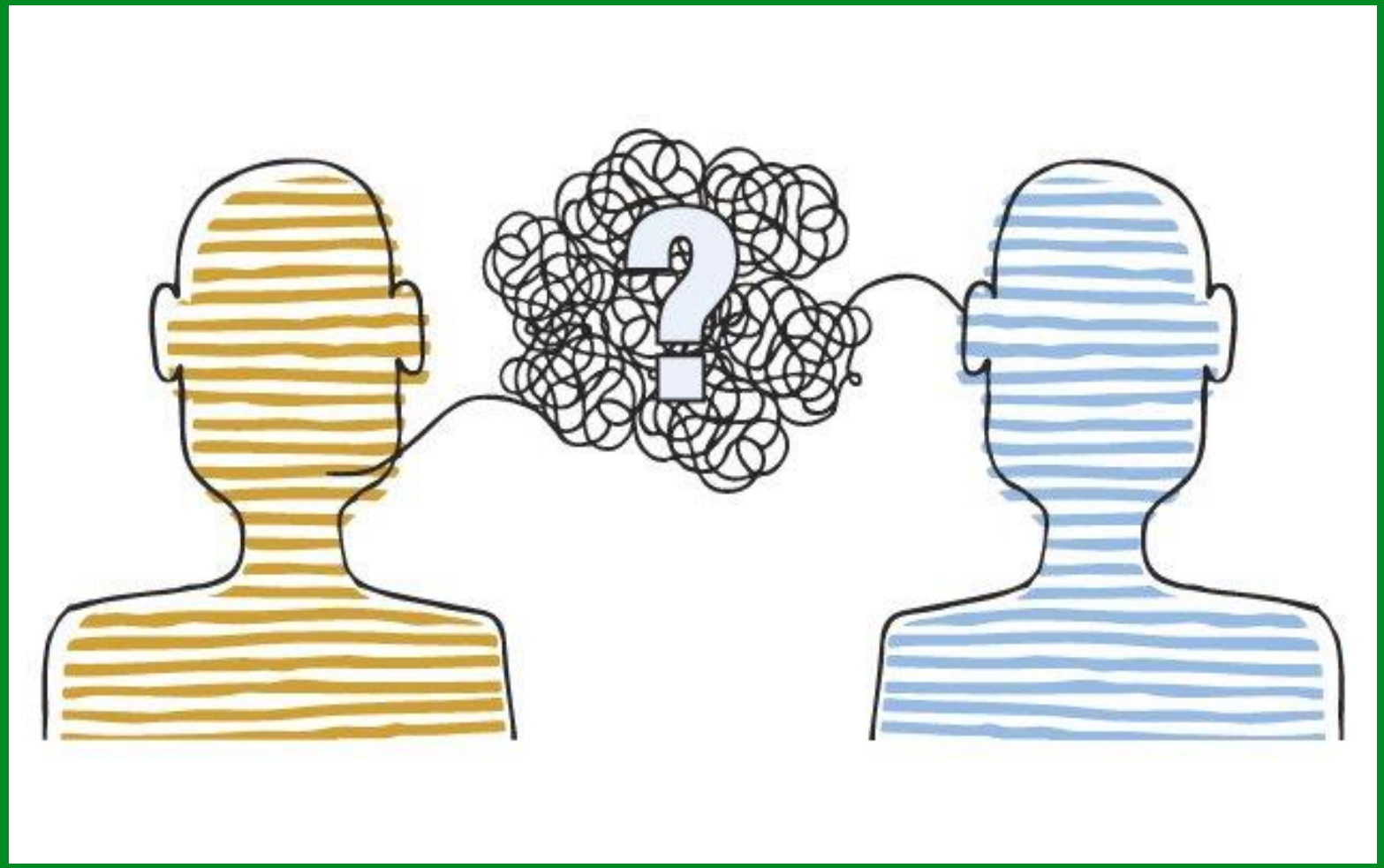
- Pre acute care- Consent for treatment including risk of admission and ‘what matters to me’
- Acute care- Recognition of time of transition by HCP providing acute cancer care
- Time to have care planning conversation – either at the time with AO professional or other professional after admission
- Documented personalised care plan accessible across setting

Examples

- Cancer support worker within AO team (north Bristol)
- Benefits advisor working across acute and community setting (Sunderland)
- Advance care planning on MAU (non cancer UCLH)
- Significant admission note to treating oncologist (Merseyside)

MACMILLAN CANCER SUPPORT

What are the barriers to providing this holistic care?



MACMILLAN CANCER SUPPORT

What are the barriers to providing this holistic care?

See it

- Do people working in acute cancer care recognise the transition point? If not, why not?
- Is there reluctance to prognosticate with novel treatments
- What evidence do we need around acute admissions?
- Do HCPs look at wider holistic needs in healthcare settings

Say it

- Who's responsibility is it?
- Who has time? Does it have to be a health care professional?
- Do HCPs lack confidence in having advance care planning conversation
- Do professionals in acute cancer care have links to community services to meet peoples' needs

Share it

- Information sharing between HCPs and between organisations

MACMILLAN CANCER SUPPORT

What do you think that oncology training needs to include to ensure the care oncologists provide meets the needs of acutely unwell patients?

MACMILLAN CANCER SUPPORT

What evidence do we need in acute cancer care to change practice in (acute) oncology?

MACMILLAN CANCER SUPPORT

RCR guidance

MACMILLAN CANCER SUPPORT

Thankyou

Dr Ashling Lillis

@AshlingLillis

MACMILLAN CANCER SUPPORT