

NCEPOD
Systemic Anti-Cancer Therapy
Report
JCCO Response

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JCCO

- Joint Collegiate Council for Oncology
- Representatives from
 - RCR RCP RCPATH (Haematology) RCGP
 - Trainees
 - National Cancer Director
 - Patients
 - Palliative care
- Cover UK (cf NCEPOD not Scotland)
- Representative on NCEPOD

JCCO

- Objectives
 - Implementation of good standards
 - Advice on the Provision of Cancer Services
 - Co-ordination of Training between Clinical and Medical Oncology
 - Advice to Doh on manpower

NCEPOD Systemic Anti-Cancer Therapy Report

- 475,050 SACT in 2006
- Study period June July 2006
- 659/1044 questionnaires returned
- 86% palliative intent

NCEPOD Systemic Anti-Cancer Therapy Report

- 98% patients are alive at 30 days
- 2% patients die within 30 days of SACT
- 35% received care judged as good
- 57% received satisfactory care
- 8% received less than satisfactory care

An opportunity not a threat!

NCEPOD Systemic Anti-Cancer Therapy Report

- Some consent forms inadequate or absent
- Prescription charts poor quality
- 19% decisions to treat inappropriate
- Neutropenic sepsis admissions cause problems
- 27% deaths were hastened by SACT
- End of life care could be improved for some

What should JCCO do in response to “For Better or For Worse”?

- What has JCCO already achieved?
- Issues from this report for the JCCO
- Plans for the future

What JCCO has done since 2006

- Document published
- E-learning
- “Cancer Doctors of the future” review
- Guidelines for practice
- Patient engagement
- Joint audit

- February 2007
 - Cancer network guidelines
 - Service Specification
 - Patient Centred Care



The Joint Collegiate Council for Oncology

Principles to underpin the delivery of radiotherapy and chemotherapy services to NHS cancer patients

This document sets standards for the non-surgical care of cancer patients. They apply regardless of the setting and provider.

The demand for cancer services continues to increase year by year and services are under extreme pressure. Waiting lists are commonplace in radiotherapy and are currently appearing for chemotherapy and for other systemic therapy. Increased capacity will be required to deal with these recurrent deficiencies and to meet increasing demand over the next decade. Building constraints at many cancer centres and units, and the concerns of patients about travelling times have led to devolved radiotherapy or chemotherapy services being considered as part of the solution to the problem.

This document summarises the complex range of issues that must be addressed by clinicians and managers to ensure that the quality and timeliness of treatment and the care of patients is not compromised in any way by the introduction of new radiotherapy or chemotherapy services.

The risks and benefits of various models for the delivery of devolved radiotherapy treatment were assessed by The Royal College of Radiologists' faculty of Clinical Oncology and published in 2004.¹

E-learning

- Core curriculum development
- E-learning for Health bid with Doh accepted 2007; (£1 M)
- Interactive learning for first 2 years of taught curriculum
- Involvement of all medical and clinical oncologists

“Cancer Doctors of the future” review

- Cancer Doctors of the future event Nov 2007
- Workforce census
- Build on this collaborative working
- Next meeting Spring 2009

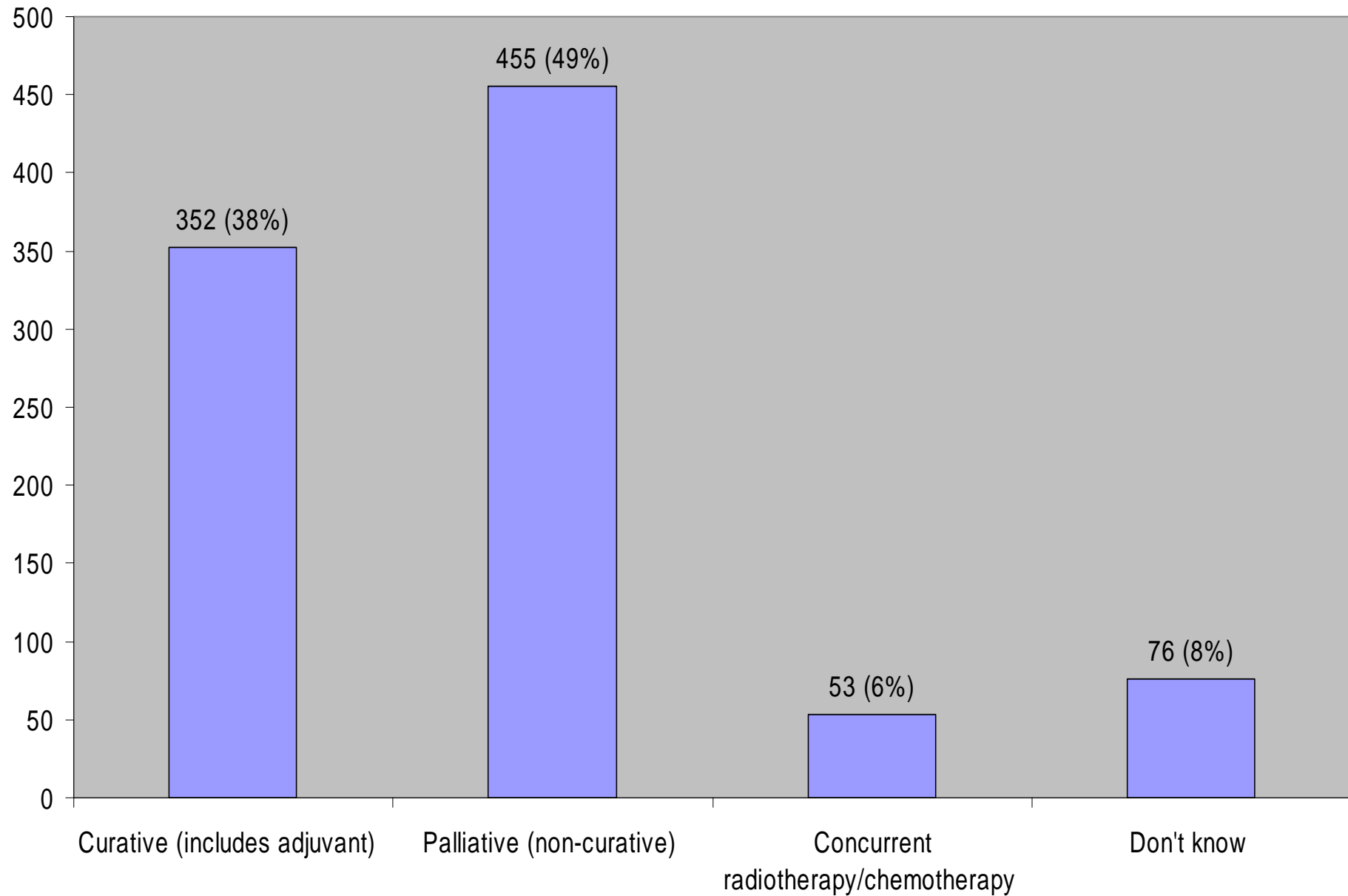
JCCO audit Systemic waiting times for chemotherapy

- **Reasons for selecting topic**
 - Increasing waiting times
 - Impact on patient care
- **Purpose of this audit**
 - To review current waiting times against recommended targets to establish baseline figures for future work
- **Sources of specified targets**
 - JCCO (1993) Reducing Delays in Cancer Treatment: Some Targets. London: RCP & RCR
 - DH (2000) The NHS Cancer Plan: A Plan for Investment: A Plan for Reform. London: DH

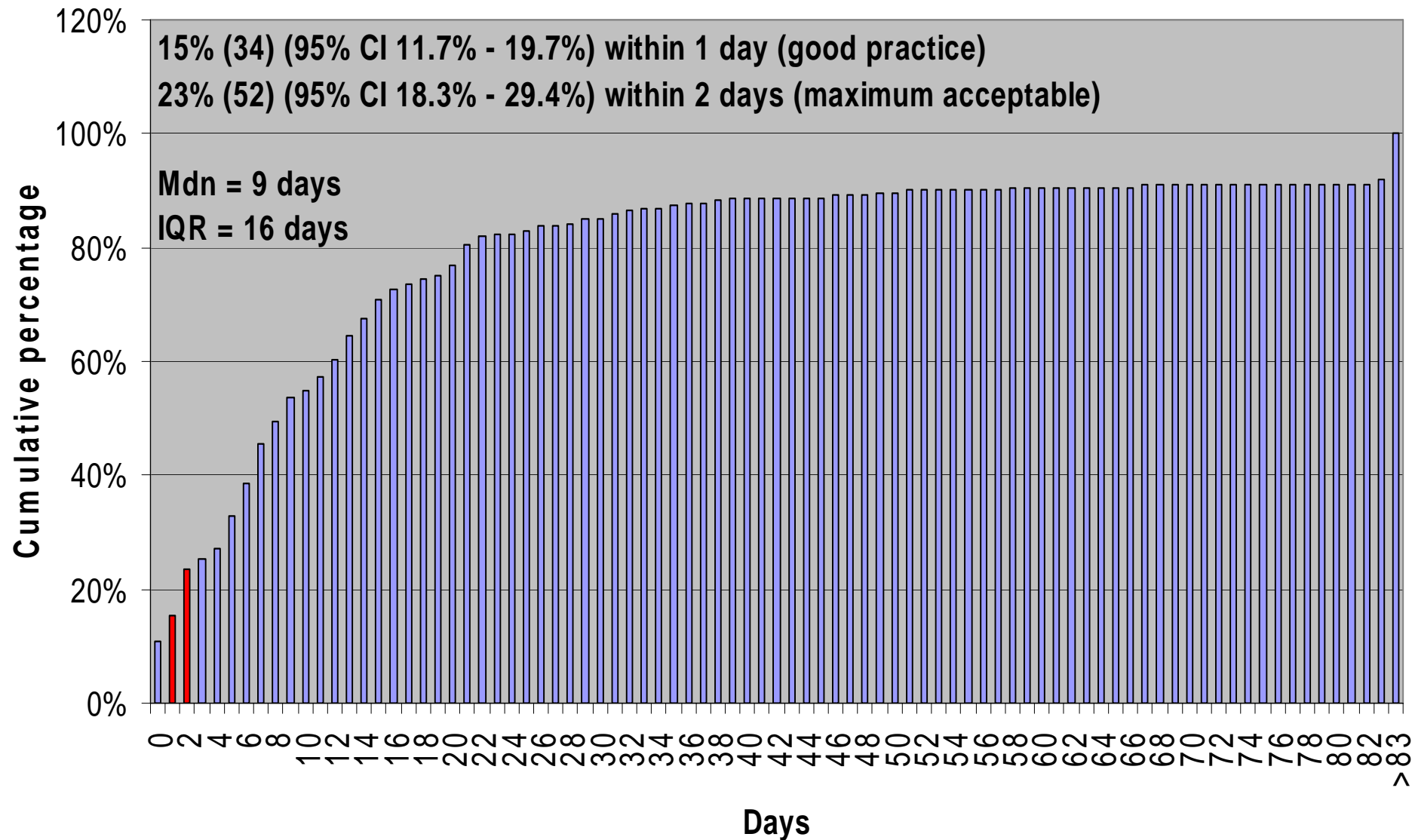
Targets

- JCCO (1993) first oncology consultation to start of chemotherapy
 - Urgent chemotherapy
 - Good practice 24 hours
 - Maximum acceptable 48 hours
 - Intensive (radical) chemotherapy
 - Good practice 1 week
 - Maximum acceptable 3 weeks
- DH (2000)
 - One month (31 days) DTT to FDT
 - Two months (62 days) urgent GP referral to FDT

Treatment intent (*n* = 936)



Waiting times from first oncology consultation to start of urgent chemotherapy ($n = 222$)



ISSUES for the JCCO

- The management of all cancer patients should be discussed at regular MDT meetings
 - We need to define the specific MDT for palliative chemotherapy –not the same as initial diagnosis
 - Not the same for all cancers (eg breast vs lung)

NCEPOD Report

- In the 30 day period a total of 47050 SACT were delivered
- There were 1044 deaths (2%)
- This number is low but raises challenges for quality and safety for the oncology community

ISSUES for the JCCO

MORBIDITY AND MORTALITY
AUDITS SHOULD BE A
STANDARD OF CARE AND
PART OF ROUTINE APPRAISAL

ISSUES for the JCCO

- Management of out of hours care (especially febrile neutropenia)
- Management of Patients' Expectations of care (especially at end of life)

ISSUES for the JCCO

- Professional Education for consultants and trainees
- Liaison with other disciplines (eg palliative care)
- Guideline development
- Systematic audit
- Workforce planning
- Revalidation

ISSUES for the JCCO

- The drive for increasingly site specific specialised care for patients with cancer and the drive for local delivery of care can cause tensions in the effective and safe delivery of care



Out of Hours Care

- Development and dissemination of local guidelines and policies
- Who delivers local acute care for cancer patients (and where)?
- Education of junior staff and nursing staff
- Centralised triage system for out of hours calls
- Patient education

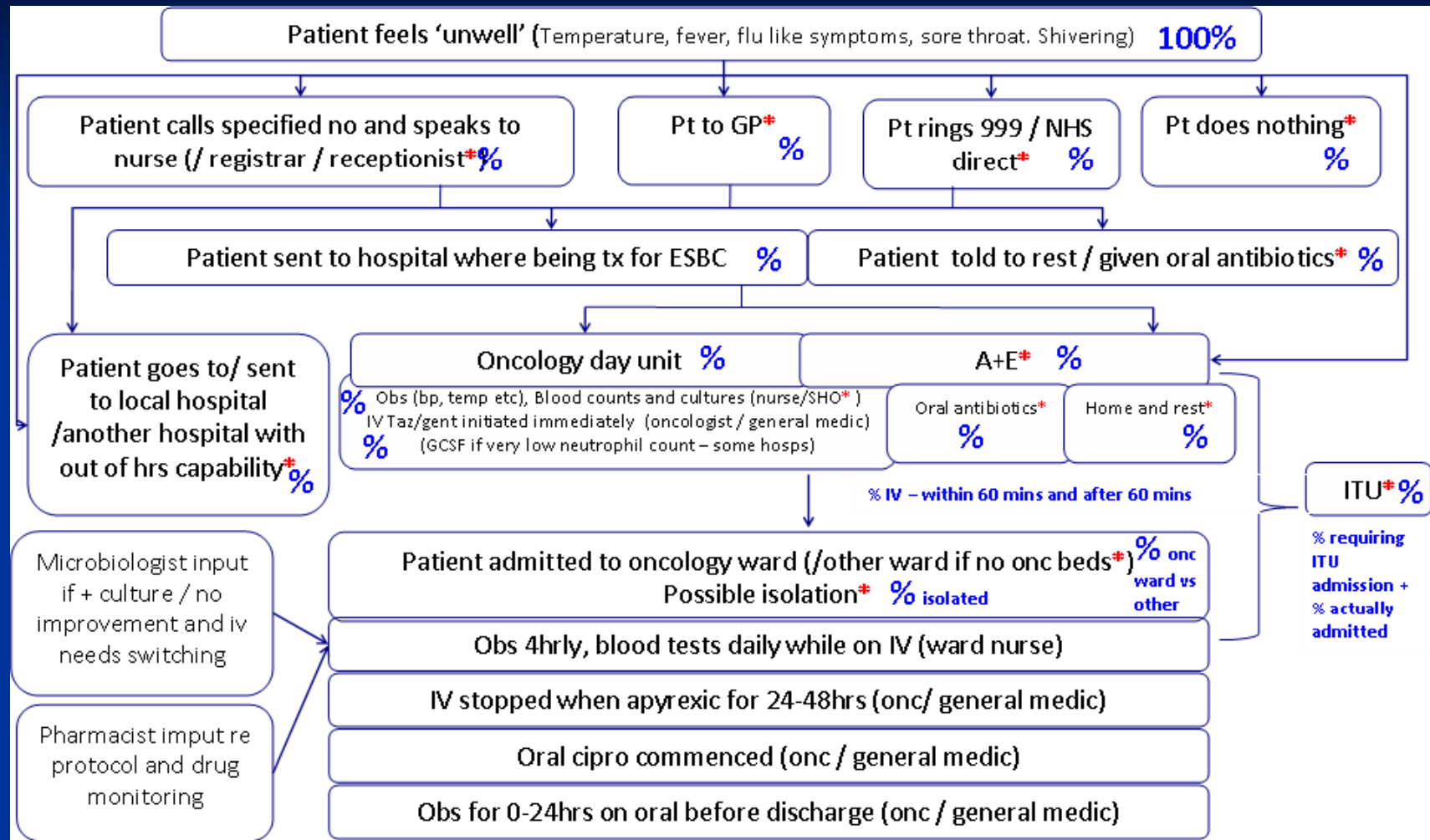
Out of Hours Care

- 93% services compliant with information regarding complications of chemotherapy

BUT

- 17% patients delay seeking advice >24h
- The sources for advice are not standard (or indeed recommended)
- 50% hospitals report nurse led education clinics
- 22% hospitals initiate follow-up phone calls to patients

The FN Pathway



*** Potential weak points**

% primary * and secondary GCSF
% primary * and secondary antibiotics

How Can We Improve This?

STAFFING(1)

- All unit delivering SACT must have agreed policies for out of hours care
- This must be led by haematology and oncology
- 24 access to consultant by telephone
- 10 WTE Consultant Oncology presence at units delivering SACT. This includes a Chemotherapy and governance lead role in each site
- This implies some linked posts with centres to deliver safe AND specialist care

How Can We Improve This?

EDUCATION (2)

- Education of junior staff in Oncology AND A and E is essential
- Rolling Audits of Neutropenic sepsis should be conducted locally and discussed at network level
- Patient Education is a priority

Who to contact?

When to contact?

How to contact?

How Can We Improve This?

PREVENTING NEUTROPENIA (3)

- Use of Growth Factors;
 - Secondary prophylaxis
 - Primary prophylaxis
- Door to needle time
- Use of prophylactic antibiotics

Clinical Trials; eg SIGNIFICANT
ORANGE

Could We Prevent Neutropenia?

EORTC GUIDELINES.

Could we establish national guidelines in the UK?

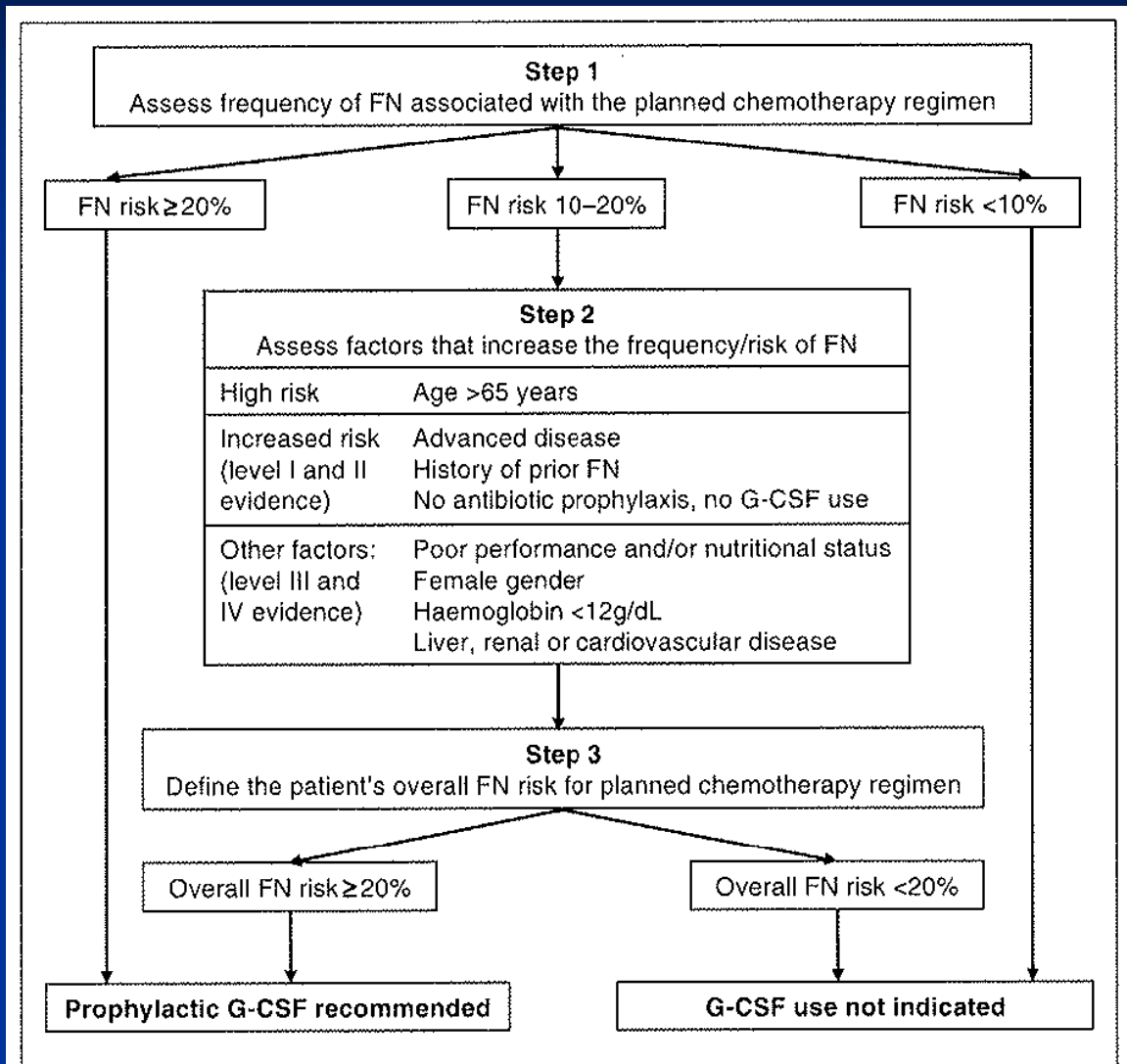
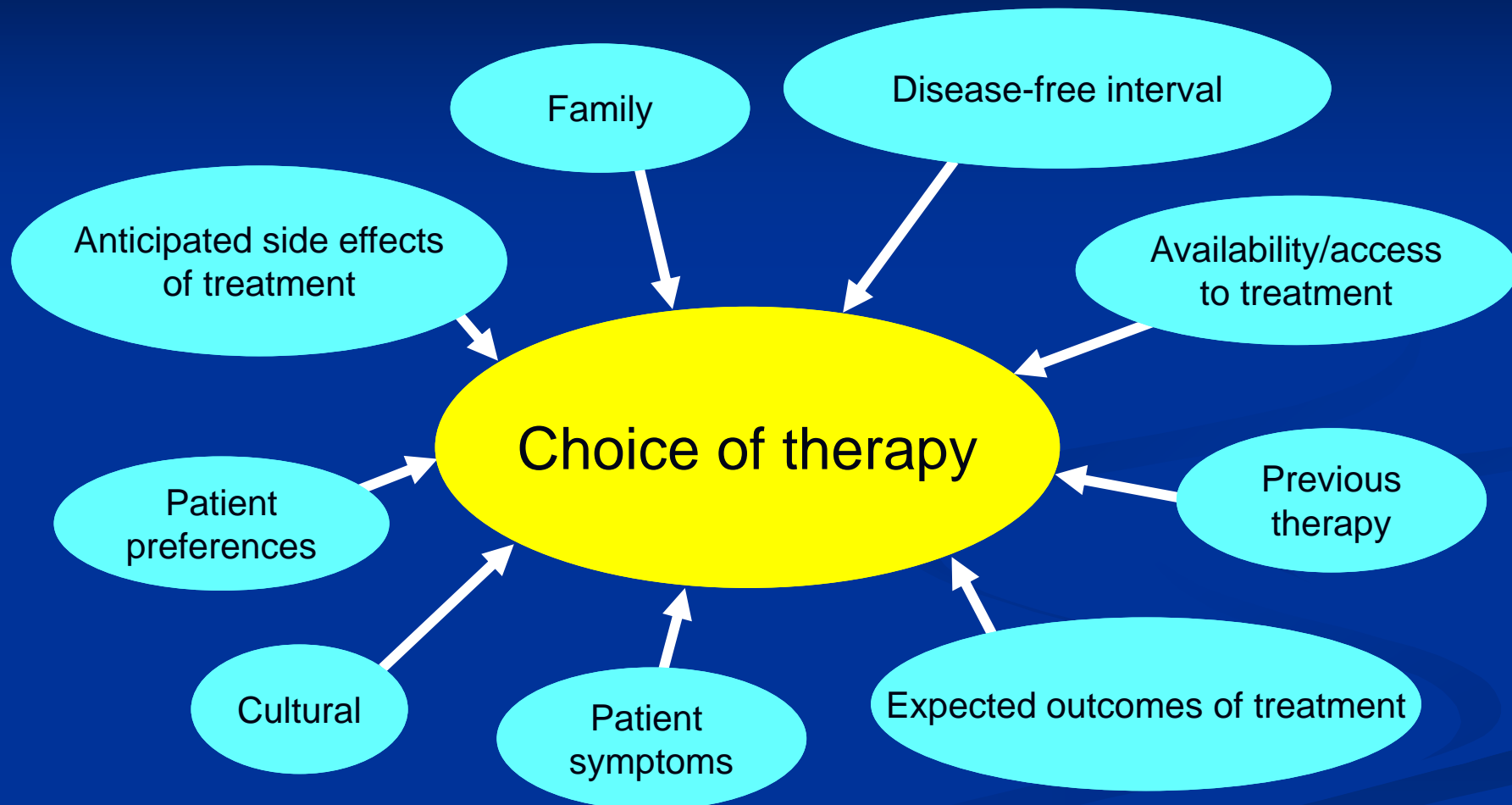


Fig. 1 – Patient assessment algorithm to decide prophylactic G-CSF usage.

NCEPOD REPORT: Chemotherapy with Palliative Intent

- Applies to 86% of patients in report
- Median age 65 years
- 37% had significant co morbidity
- 21% had ECOG performance status 3 or 4
- In 92% cases SACT was initiated by a consultant
- Consent forms not standardised

SACT FOR PATIENTS WITH ADVANCED CANCER



Treatment choice is influenced by patient and disease characteristics, and prior therapy

What Matters in 'Palliative' Chemotherapy?

DOCTORS

- Overall survival
- Tumour response
- Progression free survival
- Symptom control
- Quality of life
- Palliative care

PATIENTS

- Live longer
- Make cancer smaller
- Keep cancer at bay
- Feeling better
- Having some fun
- They're giving up on me

Patients and doctors may use different languages!

Expectation and Reality

- Patients may accept high toxicity for very small gains (Slevin BMJ 1980)
- Communication about the benefits of chemotherapy at end of life may lead to false expectation (Aubrey et al BMJ2008)
- We are expected to maintain 'hope'
- 'Burnout' is high in oncologists! (Ramirez)

How Can We Do Better?

- Ratio of number of Oncologists to patients
- Relationship with Palliative/ Supportive Care and Primary care
- Communication skills training;
 - Breaking bad news
 - What do statistics really mean
- Professional mentorship and support
- Continuing Professional Education

Consultant Workforce in Oncology

	2000	2007	%increase	2012 Predicted
Medical oncologists	133	225	69%	395
Clinical oncologists	307	506	65%	395
MO + CO	440	731	66%	1031
Haematologists	527	680	29%	804

These are the only doctors who should be prescribing SACT

Assessment of Quality of Decision Making

- Audit of consent procedure;
 - Side effects
 - Life expectancy
- Documentation of attendance at communication skills course
- Survey of patient's experience (NHS CPESP)
- Morbidity/mortality audits

Royal Colleges and Professional Development

- Continuing Professional development of;
 - Postgraduate medicine for oncologists
 - Training in Palliative care
 - Curriculum development
- Development of leadership skills
- Do our approval processes for consultant posts reflect service needs

What else do our Patients Need?

- Key worker throughout disease
- Option of Early link with supportive care
- Appropriate information
- Coordinated pathways

The JCCO would support implementation of The End of Life Care Strategy (2008)

Why good leadership is important



Why good leadership
is important



Role of the JCCO