Coordination of palliative support networks for the patient and family members: role of oncologist

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DISCLOSURE OF INTEREST

Nil to disclose
Objectives

- Role of Oncologist
- Palliative Care Networks
- 2 key roles:
  - Identification of patients
  - Sharing of information
Role of the Medical Oncologist

- Offer cancer patients a comprehensive and systemic approach to treatment and care
- Ensure evidence-based, safe and cost-effective use of cancer drugs
- Preserve the quality of life of cancer patients through the entire ‘cancer journey’
- Engage in clinical and translational research to promote innovation and new therapies
- Contribute to cancer diagnosis, prevention and research
- Make a difference for patients in a dynamic, stimulating professional environment

Partnering in multidisciplinary and comprehensive cancer care

• Key highlights from ESMO position statement:
  • Oncology MDTs are a tool for combining expertise and skills from different disciplines
  • Medical oncologist can serve as patient interface
  • Increasing number of co- and multi-morbid patients
  • Partnering should be regardless of setting
  • MDT review should happen before proceeding to appropriate therapy
• In terms of palliative care networks, oncologists have 2 important roles:
  • Identification of patients
  • Sharing of information
The Palliative Care Network

London CCG’s

Community Nurses

Marie Curle, Macmillan & Specialist Nurses

Social Services

NHS 111 London

Out of Hours GP’s

London Ambulance Service

Hospices

Acute Hospitals in-patient wards and outpatient depts + A&E

Home

Care Homes & Nursing Homes

GP’s
Identification of patients
Early intervention of Palliative Care for patients with advanced cancer

• Trial evidence of benefits:
  • Improved Quality of Life
  • Reduced depression
  • Less aggressive care at EOL
  • Increased survival
  • Better symptom control
  • Improved prognostic understanding

Temel JS et al. NEJM 2010; 363: 733-42
Bakitas M et al. JAMA 2009; 302: 741-9
Late referrals to PC

<table>
<thead>
<tr>
<th></th>
<th>Time between SPC referral and death: median (range)</th>
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<tbody>
<tr>
<td>RM UGI (N=50)</td>
<td>67 days (3-324)</td>
</tr>
<tr>
<td>RM NSCLC (N=48)</td>
<td>79 days (10-1315)</td>
</tr>
<tr>
<td>RM gynae (N=47)</td>
<td>98 days (12-1235)</td>
</tr>
<tr>
<td>RM renal cell (N=44)</td>
<td>83.5 days (2-1871)</td>
</tr>
<tr>
<td>Leeds cancer patients (N=3903)*</td>
<td>37 days</td>
</tr>
<tr>
<td>MD Anderson all cancers**</td>
<td>1.4 months (0.5-4.2)</td>
</tr>
<tr>
<td>MD Anderson lung cancer**</td>
<td>2 months (1.2-2.8)</td>
</tr>
</tbody>
</table>

*Bennett M et al, BMJ Open 2016; 6 (12): e012576
** Hui D et al. The Oncologist 2012; 17 (12): 1574-1580
Early Specialist Palliative Care (SPC) for oncology patients

- Palliative Care should be available to patients early in the course of their illness
- Integration of SPC into standard oncology care alongside active cancer treatment
- Early and regular assessment for all patients with cancer, regardless of disease stage

Hui D et al. 2016 Lancet Oncology
Hui et al. 2017 Support Care Cancer
**Triggers Tool to proactively identify which cancer patients may benefit from Palliative Care referral**

**Palliative care team involvement alongside active anti-cancer therapy**

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**Specialist Palliative Care Referral Triggers Tool**

*Patient is “Trigger positive” if they have any one of the following:*

- Metastatic cancer progressing after 1st line of treatment
- Performance status ECOG 2 and deteriorating
- Acute oncology or unplanned admission
- Severe or overwhelming symptoms
- Anorexia, hypercalcemia, or any effusion
- Moderate or severe psychological or existential distress
- Complex social issues

RM Partners. London Cancer Alliance Palliative Care and End of Life Care Pathway Group. The Transition to Palliative Care. [http://www.londoncanceralliance.nhs.uk](http://www.londoncanceralliance.nhs.uk)

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**Triggers tool: Underpins a new Integrated Palliative Care and Oncology Service (RM)**
“Triggers”: A New Integrated Palliative Care Service

2 dedicated Clinical Nurse Specialists

### Palliative Care Clinical Team
- Consultants
- Nurse Consultant
- Junior doctors
- Clinical Nurse Specialists

### Oncology Clinical Team
- Doctors
- Clinical Nurse Specialists

Data administrator

Hospital Senior Management: Outpatient transformation group agenda

Community palliative care teams

Patient access to:

5 Lung outpatient clinics across 2 sites

Other tumour types e.g. UGI, sarcoma

Other oncology services e.g. acute oncology
“Triggers”: A New Integrated Palliative Care Service

Initial Assessment
All new outpatient cancer patients

Trigger tool
(oncology team)

Follow-up next clinic

Trigger positive

Trigger negative

Triggers Team Nurse Assessment

- Assessment of palliative care needs using IPOS
- Provide information about palliative care in hospital and community
- Provide information about Advance Care Planning

Intervention to address palliative care needs

Referral to community team or other services as needs require

Advance Care Planning

Monthly follow up to assess needs and outcomes
Data from Q3 of “Triggers” service in lung patients

347/396 (88%) eligible patients reviewed by the Triggers team

219/347 (63%) patients Triggers positive on initial review

79% patients WHO PS 0-1
PC needs of Trigger positive patients (N=214)

- Pain
- Breathless
- Weakness
- Nausea
- Vomiting
- Poor Appetite
- Constipation
- Sore Mouth
- Drowsiness
- Poor Morbidity
- Anxiety
- Family anxiety
- Depression
- At peace
- Able to share feelings
- Information needs
- Practical problems

IPOS 0 or 1 None or Mild
IPOS 2, 3 or 4 Moderate, Severe or Overwhelming
PC needs of Trigger positive patients (N=214)

- IPOS 2,3,4 (moderate, severe, overwhelming) any item: 97%
- IPOS 3,4 (severe, overwhelming) any item: 85%
- IPOS 3,4 (severe, overwhelming) any physical item: 43%
- IPOS 3,4 (severe, overwhelming) any psychosocial item: 78%
“Triggers”: A New Integrated Palliative Care Service

Service development
- Expansion to other tumour groups
- Expansion to other services
- Integration with other initiatives: Survivorship
- Expansion outside RM

Research
- Validate tool
- Test effectiveness of tool

Support from:
Inpatient and Outpatient Transformation Groups
RM PPI
RM Partners
ESMO

- Patient Experience and Living With and Beyond Cancer.
- Reducing Variation
- Supportive and Palliative Care
Sharing of information
Sharing information

- Communication and coordination are integral to quality end of life care
- Regardless of diagnosis, prognosis, care setting or geography
Electronic Palliative Care Coordination Systems

• Coordinate My Care (CMC):
  – Clinical service underpinned by a digital technology
  – Digital urgent care plan
  – Pan London service
  – Can be seen by all the services whom may be caring for the patients eg. the 24 hour NHS medical help line, the ambulance service, the out of hours GP services and the accident and emergency departments
Review of objectives

• Role of Oncologist
• Palliative Care Networks
• 2 key roles:
  • Identification of patients
  • Sharing of information