Multidisciplinary Approach to Prostate Cancer Management

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Conflict of interest

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Learning objectives

– To review the development of roles within the multidisciplinary team
  – Role of the pharmacist
  – Support workers

– Look at examples of changes that have improved functioning of clinics and interaction with other members of the multidisciplinary team

– Outline the non-medical prescribing services that is provided at RMH within Prostate Cancer clinics and the impact on service
Changing practice and delivering multidisciplinary care
Prostate cancer incidence

- Prostate cancer is the most common cancer diagnosed in men in 2016
- Increasing incidence
- 40,489 (26%) or 1 in 4 of all male cancers registered in 2016
- Predicted incidence rates projected to rise by 12% in UK between 233 cases per 100,000 males in 2035

- Need to look at ways in which we can delivery safe and efficient service to our patients.

Changing cancer services over the years

– The NHS Cancer Plan (2000) – outlined new ways of working in order to streamline cancer services around the needs of the patient.

– Extended roles of nurses and specialisation of nurses
– Development of Clinical Nurse Specialists

Changing cancer services over the years

Front Line Care: the future of nursing and midwifery in England (2010)

Prime Minister’s Commission reported that direct access to nurse-led services would:

- Improve cost effectiveness
- Improve health outcomes
- Increase use of nurse-led clinics

Development of cancer support workers

Role developed by Macmillan, Department of Health in England and NHS Improvement and National Cancer Survivorship Initiative (NCSI) (2011)

- 33% of cancer care could be delivered by a trained, unregistered, NVQ 3-4 (Band 4), practitioners.

Main purpose is to:
- Help coordinate care
- Support self-management
- To navigate health and social care system during and following completion of cancer treatment.
- At RMH – (pilot site) Started with 1, now have 4 Support Workers
Lord Carter Report (2016)

- Unwarranted variation costs NHS £5bn p/a
- Including cost of clinical staff, pharmacy, medicines, diagnostics
- £6.7bn spent on medicines in hospital
- Better use of workforce
- Moving towards a patient centred organisation


*Changing role of hospital pharmacist*

- Hospital pharmacy transformation project was set up to help implement changes.
- Target **50% of pharmacists should be actively prescribing** underlining the significant shift towards a greater patient facing clinical role.
- Pharmacists and pharmacy technicians to spend more time in patient facing medicines optimisation activities
- Electronic prescribing

NHS long-term plan - December 2018

By 2028:

– Increase cancer survival

– Early diagnosis – increase number of cancers diagnosed at stage 1 and 2 from 50% to 75%

– Patient Experience – all patients have access to a CNS or Support Worker

– Personalised care – NHS Comprehensive Model for Personalised Care (living with and beyond cancer)/ improving quality of life

– Increasing numbers of patients on treatment in both a curative and palliative setting

CNS, clinical nurse specialist.

What are the challenges?
Common challenges:

– Increasing numbers of patients in clinic
– Increasing number of patients on systemic treatment – more treatment options for patients with advanced/metastatic disease
– Increasing complexity of patients
– Ageing population – comorbidities, polypharmacy
– Disease progression – switching treatments/treatment sequencing
– Patient experience – busy clinics, time, continuity of care
– Living with cancer – holistic needs, ED and LUTS often missed

ED, erectile dysfunction; LUTS, lower urinary tract symptoms.
What is the best clinic model for metastatic prostate cancer patients?
Aims of any clinic model

1st principles for all care:

– Safe practice
– No harm to patients
– Streamlined patient service
– Must be sustainable
Advanced prostate cancer - mHSPC and CRPC

- Complex needs
- Majority of clinics are consultant led
- New diagnosis
- Disease progression
- Patient reassured seeing a doctor
- Medical model with focus on treatment toxicity, response to treatment
- Personalised care/living with and beyond cancer: long term ADT, LUTS, ED, psychological support may not be addressed

CRPC, castration-resistant prostate cancer; ADT, anti-androgen therapy; ED, erectile dysfunction; LUTS, lower urinary tract symptoms; mHSPC, metastatic hormone-sensitive prostate cancer.
Nurse led clinics

- Common in all parts of the cancer pathway: diagnostics, treatment, follow up and palliative symptom control
- Efficient way of delivering care to large numbers of patients – face/face, telephone follow up, Skype
- High levels of patient satisfaction
- No difference in survival outcomes, recurrence or psychological morbidity found in nurse led clinics
- Holistic approach to care
Nurse led chemotherapy clinics

- Increasing service demand on chemotherapy units and outpatient clinics.
- Changes in prescribing legislation – increasing number of NMPs
- Assess toxicity and fitness for treatment
- Nurses often reinforce strategies for self-care
- Approved proformas and electronic prescribing increase safety
- Relies on doctors or NMP if dose modifications needed or supportive medicines required or physical assessment
UKONS - best practice for nurse-led chemotherapy clinics

- One size doesn’t fit all
- Nurses should not duplicate the medical model of assessment
- Provide safe, effective delivery of chemotherapy and co-medications
- Added value – holistic needs

**Non-medical prescribing** will become a gold standard for nurse-led chemotherapy clinics

How will they/Who will influence this? – Is it realistic?
United Kingdom Oncology Nurses Society

Increasing number of NMP’s has improved care by:
  – Avoiding delays in treatment where a doctor’s signature is required
  – Enhances nurse involvement in decision making

But….They recommend that:
  – Nurses should not work in isolation
  – Robust support
  – Increase the number of nurse prescribers within nurse-led chemotherapy

NMP, non-medical prescriber.
Benefits of working as a multidisciplinary team

– Most cost effective delivery of care when professionals work together

– Unified/holistic approach to patient care

– Opportunities for professional development and supported learning within the team


Multidisciplinary (one-stop) approach to treatment
The RMH approach
Past clinics at RMH

– Clinics were doctor only
– Increasing pressure on already busy clinics
– Change in treatments – more patients on treatment
– Patients with advanced disease on systemic treatment where seen in busy clinics alongside patients having radical curative treatment
– Focus on medical model of assessment – no LUTS/ED
– Limited assess to Clinical Nurse Specialist Support

CRPC, castration-resistant prostate cancer; ED, erectile dysfunction; LUTS, lower urinary tract symptoms. RMH, Royal Marsden Hospital
Pharmacist-led CRPC clinic

- Consequence of the Carter Report increase in the number of pharmacists prescribing.
- Piloted a Pharmacist NMP led CRPC clinic however...
- Not sustainable as:
  - Limitations of medical knowledge
  - Limited physical assessment skills
  - Lack of written protocol to inform practice
- Pharmacists able to complete NMP course without undertaking a physical assessment course.

NMP, Non-medical prescriber; CRPC, castrate resistant prostate cancer
My journey to ANP CRPC

ANP, advanced nurse practitioner; CNS, central nervous system; CRPC, castrate resistant prostate cancer; ITU, intensive treatment unit;
Present:

- Transformation team at Royal Marsden Hospital – streamline service, improve patient experience, utilise existing staff
- Increasing the number of NMP’s
- Advanced practice in AHP’s such as specialist radiographers
- Support workers
- Multidisciplinary clinics with doctors, prescribing pharmacists, ANP, CNS/Support workers

AHP, allied health professions; ANP, advanced nurse practitioner; CNS, clinical nurse specialist; NMP, non-medical prescriber.
Multidisciplinary Prostate Clinic at RMH- Hub and Spoke Model

Pre clinic meeting (incl. radiology meeting)

- Pharmacist
- Research Nurse
- Consultant
- Radiologist
- ANP
- CNS + Support Worker/ H2H
- Early Docetaxel HSPC – nurse-led clinical confirmers Band 6
- Clinical Fellow/Specialist Registrar
- ANP

ANP, advanced nurse practitioner; CNS, clinical nurse specialist; HSPC, hormone sensitive prostate cancer; H2H, hospital to home.
Multidisciplinary team - the value added

- Pharmacist – Medicines optimisation
- Research Nurse - trials
- Consultant – complex decision making /consent
- Pre clinic meeting (incl.radiology meeting)
- Early Docetaxel mHSPC – nurse-led clinical confirmers Band 6
- Radiologist – scan review/appropriate imaging
- ANP – advanced assessment/NMP
- Clinical Fellow/Specialist Registrar – medical management/consent
- CNS + Support Worker/ H2H- holistic needs/information

ANP, advanced nurse practitioner; CNS, clinical nurse specialist; mHSPC, metastatic hormone sensitive prostate cancer; H2H, hospital to home. NMP, non-medical prescriber
Benefits of a one-stop/ two-stop model of care

Logistics
- X rooms required
- X specialist equipment

Efficient?
- X pts per week
- What previously would have taken. 2/3/4 appts now takes 1!
- Same day imaging and reporting? – reduces hospital visits
- Hospital to home team

BUT.....
Doesn’t need to be all the bells and whistles
Satellite clinic: Consultant + ANP + support worker
Numbers:XX
Benefit: Closer to home care

ANP, advanced nurse practitioner.
What have we learnt?

– Improved patient experience (currently service review)
– Not everyone needs to be a prescriber although must have robust support in place
– Patients benefit from seeing different specialities – LUTS/ED/medicines optimisation
– Pharmacy queries (dosing, drug interactions) are dealt with easily
– Clinical queries resolved quickly
– Learning opportunities and development of roles
– Patients need educating about different roles.

ED, erectile dysfunction; LUTS, lower urinary tract symptoms.
Key areas to consider?

– Target population/scope of service?
– Evaluate your service – what can you do, target population
– Patient experience / expectations?
– What do you need to achieve change in your service and how do you measure it?
– Changing roles but...
  – how will your old role be filled?
  – Rob Paul to pay Peter?