Acute Oncology (AO) Job Plan Document for RCR/RCP - Draft

The scope of acute oncology has expanded greatly over recent years, particularly as systemic treatments become more effective and complex. For instance, the advent of immune-oncology (IO) therapies has led to a new set of diverse complications necessitating more expert knowledge for AO practitioners. At the same time, the incidence of cancer continues to rise and patients can present to AO with both complications directly due to their cancer, as well as its treatment.

The demand upon AO services is severe, with approximately 3000 calls made per day from patients to AO emergency triage lines, across England alone. At the same time, capacity for urgent care and hospital bed occupancy has become constrained across the NHS, leading to a greater need for admission avoidance and reduced length of stay.

Taken together, there is an immediate need to better define the role of oncology consultants who have AO responsibilities. This should come with support within job plans to enable delivery and development of safe and effective services. The aim of this document is to provide a template upon which to develop job plans for new and existing AO consultants, within medical and clinical oncology. This document recognises there are different models of care across the country, in particular between district general hospitals and larger specialist cancer centres.

Suggested possible responsibilities within an AOS post:

DCC

1. Support AOS nurses (in person/telephone/videoconference etc.)
    a. Complex case load; inpatient/ED/SDEC (which includes clinic and ward-based services), MUO, novel toxicities, end of life transitions, medical comorbidity/ immunotherapy toxicity services where present)
    b. Challenging conversations with patients/carers
2. Acute Oncology MDTs
    a. Team meetings/Board Rounds for weekly AO Caseload
    b. MUO MDT
3. In patient ward rounds
    a. Focus on complex cases
4. SDEC (Same Day Emergency Centre) sessions
    a. Oncology hot clinics (which incorporate more “outpatient like” support for AO assessment and treatment)
    b. Oncology SDEC (standalone or aligned with Medical SDEC)
5. CAU/CUC (Clinical Assessment Units/ Centres for Urgent Care) sessions
    a. Specialist AO Clinical leadership (minimum 1 PA per week)
6. ED support

    a. Oncology in reach models, supporting Advanced Nurse Practitioner (ANP)-led DCC, hot clinics
7. Hotline Support
    a. Senior decision maker role, video-assisted specialist triage
8. Family meetings
    a. Supporting complaints and quality agenda
9. MUO service/ New Cancer Diagnoses work
    a. MUO and Non-Specific Interface, specialist CUP service, emergency presentation of cancer
10. Communication with other teams/GPs
    a. Optimising clinical communication between site specialist teams, secondary care, primary care and AO
11. Remote support (with appropriate governance)
    a. Virtual Consultations, team meetings
12. Virtual Wards
    a. Supporting or leading on cancer virtual ward offer
13. Cross cover
    a. Either within a trust or supporting an Alliance-level (regional) rota

SPA

1. Teaching/training
    a. Supporting Trust level AO education (Generalists) – hospital & community
    b. Specialist AO Education for Oncologists – complex, rare toxicities, Emergency presentation (Type I-III)
    c. Competency of AO nurses and wider team
    d. Competency of Oncology SpRs (AO Curriculum)
2. Service development
    a. QIP, Urgent Cancer Care transformation
3. Management- trust level
    a. Clinical Leadership at Trust Operational and Performance meetings
4. Management- alliance level
    a. Clinical Leadership at Alliance/Regional level
5. Audit
    a. Neutropaenic Sepsis/ MSCC KPIs etc.
6. Support national AO metrics data entry e.g. COSD
7. Research
    a. Leading/developing an AO research portfolio.
8. CPD
    a. Acute Cancer, MUO and medical comorbidities specific
9. Appraisal and revalidation
    a. Against an agreed AO leadership framework

Skill Set

- Specialist knowledge of toxicities caused by SACT (including IO)/RT and their management
- Specialist knowledge of symptoms/complications caused by patients' cancers and how to manage these
- Specialist Knowledge of Emergency presentation of Cancer, including MUO
- Specialist Knowledge of CUP (not required for all)
- Specialist Knowledge of MSCC Pathway
- Ability to rapidly assess and manage a deteriorating patient
- Ability to prioritise according to clinical need who can be safely ambulated/treated elsewhere with a view to avoiding admission and ED attendance
- Ability to provide remote advice and assess patients safely at a distance
- Ability to manage a busy take with limited resources
- Ability to communicate well in all situations with patient, family, range of HCPs
- Training and mentoring (clinicians and allied healthcare professionals, oncology and non-oncology), e.g. supervision of medical trainees managing patients with new diagnosis of cancer admitted as an emergency
- Clinical leadership and visibility, with broad range of key stakeholders across the Urgent Cancer Pathway
- An understanding of how services can differ across large cancer hospitals and DGHs, and an ability to support both models as appropriate
- Urgent Cancer Service Improvement skills and knowledge

Potential Job Plans

Ideally AO should be regarded as its own sub-speciality (e.g. full-time oncologists cover 1 tumour type alongside AO). Suggest all Jobs should include:

- A minimum of 2 AOS PAs
- SPA time dedicated to AOS (0.5 SPA if 2 AOS Direct Clinical Care (DCC) PAs)
- 1 PA, in addition, for those with Trust level leadership of AOS service
- 0.5-2 PAs for Alliance level leadership
- DCC PAs split according to type of role- may be on one day in a cancer centre with multiple AOS consultants or across the week if supporting remotely/covering DGH with smaller team etc. DCC can consist of:
    - F2F or virtual direct patient contact across in-patient/ambulatory/community settings
    - Local/regional AO board rounds with no direct patient contact
    - Regional/National complex case discussion

- Plans for cross cover – these need to be robust, and may involve regional cross-cover, where practical

1. Example Job plan for regional AO lead in cancer centre

Day	AM/PM	Work	Category (SPA/DCC)	No. of PAs
Monday	AM	AOS	DCC	1
	PM	AOS	DCC	1
Tuesday	AM	AOS Alliance	SPA/APA	1
	PM	AOS local lead	SPA/APA	1
Wednesday	AM	Tumour Type Clinic/ Radiotherapy review and planning	DCC	1
	PM	Tumour Type MDT Admin	DCC DCC	0.5 0.5
Thursday	AM	Tumour Type Ward Round Tumour Type Research Meeting	DCC SPA	0.5 0.5
	PM	AOS MDT	DCC	1
Friday	AM	Tumour Type Clinic	DCC	1
	PM	Tumour type CPD etc.	SPA	1
			TOTAL PAs	10PAs
			AOS PAS	4 AOS PAs

2. Job plan for local AO lead supporting DGH

Day	AM/PM	Work	Category (SPA/DCC)	No. of PAs
Monday	AM	AOS lead	SPA/APA	1
	PM	Tumour type clinic	DCC	1
Tuesday	AM	AOS	DCC	1
	PM	Tumour Type clinic Tumour Type Ward Round Supervision of palliative/emergency RT session as a PA	DCC	1
Wednesday	AM	Tumour Type MDT Admin	DCC DCC	0.5 0.5
	PM	Tumour type CPD etc.	SPA	1
Thursday	AM	Tumour type research meeting Tumour type MDT Tumour Type Ward Round	SPA DCC	0.5 0.5
	PM	Tumour type clinic/Radiotherapy review and planning	DCC	1
Friday	AM	AOS	DCC	1
	PM	Admin Tumour type CPD etc.	DCC SPA	0.5 0.5
			TOTAL PAs	10 PA 3 AOS PAs

* Note ratio of DCC to SPA may vary across devolved nations

* In clinical oncology roles it is likely that 2 site-specific clinics may be required to generate 1 PA of radiotherapy planning, though this will depend on tumour site.