Case study 3: The Clatterbridge Cancer Centre NHS Foundation Trust

IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY REDESIGN:

LEARNINGS FROM INTRODUCING IMMUNOTHERAPY TO THE ONCOLOGY TOXICITY MANAGEMENT PATHWAY

KEYTRUDA (pembrolizumab) as monotherapy is indicated for the adjuvant treatment of adults and adolescents aged 12 years and older with Stage IIB, IIC or III melanoma and who have undergone complete resection

Please refer to the Summary of Product Characteristics and risk minimisation materials before making prescribing decisions

This is an MSD promotional resource for UK healthcare professionals only.

This case study was developed alongside healthcare professionals involved in melanoma services in the Clatterbridge Cancer Centre NHS Foundation Trust. It has been organised and funded by MSD. The healthcare professionals involved received honoraria. The contents of the case studies reflect these healthcare professionals' opinion and are not necessarily reflective of those of their NHS Trust.

Job number: GB-OOC-00630 | Date of preparation: October 2023

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Information presented in this document is reflective of the time of interview (June 2023) and may be subject to change.

MSD

KEYTRUDA® (pembrolizumab)

THE CLATTERBRIDGE IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY

The full melanoma service has been fully in place since 2018

The service provides support to all 8 NHS trusts in the Merseyside and Cheshire region

Support is also provided for tertiary centres as well as acute trusts (Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Liverpool Heart and Chest Hospital and the Walton Centre NHS Foundation Trust)

500

Patients under the care of the service at any one time

Access to all NICE and Cancer Drugs Fund (CDF) approved immunotherapy

1000

Telephone follow-up calls made per month

100

Face-to-face patient reviews per month

THE NEED FOR PATHWAY OPTIMISATION

- A key driver was the need for **greater capacity.** Horizon scanning identified more treatments coming through to an already burdened CNS ANP* pathway
- There was a recognition that immunotherapy toxicities are very different, from chemotherapy toxicities as is the need to actively manage these in a growing, and large number, of patients.
- There were also increasing lines of therapy being provided as well as more patients having immunotherapy in combination with their chemotherapy
- There was a need to understand the touch points and differing capacity requirements between straightforward and more complicated treatment pathways. **This highlighted a need for education and upskilling of the whole organisation**

"Now we're seeing immunotherapy combined with chemotherapy. So we're not moving away from these [chemotherapies], we're actually adding to the overall capacity issue. So I think that was really important to talk about what was happening, but also how we would offset the cost of our service with the activity"

Consultant Medical Oncologist,
The Clatterbridge Cancer Centre

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*CNS = clinical nurse specialist, ANP = advanced nurse practitioner

WHO IS INVOLVED IN DELIVERING THE IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY?

There is a multi-disciplinary professional team managing melanoma patients and using immunotherapy which includes:

Reflective of the time of interview and may be subject to change

- *x 1* Consultant clinical lead
- *x 1* Consultant to support immunotherapy and toxicity management
- *x 1* Clinical fellow to support immunotherapy management
- *x 1* Nurse consultant specialist
- *x 2* Advanced Nurse Practitioner
- *x 1* Advanced Nurse Practitioner trainee
- *x 1* Team Lead nurse
- *5-6* Telephone follow-up service nurse team

- *x 1* Service navigator
- *x 1* Care navigator
- *x 1* Data manager

Responsible for preparing clinics, collating results, liaising with patients and the patient experience

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SOME KEY CONSIDERATIONS BEFORE THE IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY REDESIGN

- Development of a model that will be commissioned and sustainable for the future
- Making a clear case for change to stakeholders
  - Why is this different?
  - Why does it need a different approach?
    - In terms of the benefits of a new service
    - In terms of risks to patients and the service of doing nothing
- Long-term planning
  - What is required now?
  - What will be needed in the future?
- The impact of introducing an additional therapy on other services and overall capacity (e.g., drug administration, management of toxicities)

"So I think one of the challenges was the fact that the trust were on board very, very quickly, but then we have to get the commissioners on board, which was a lot longer conversation and took about a year"

Consultant Medical Oncologist, The Clatterbridge Cancer Centre

HOW WAS THE IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY DESIGNED AT THE CLATTERBRIDGE?

- Employing a data manager was an important step to understanding and interpreting the current service, and what a new one would look like
- Working with the trust business intelligence team, various data sources (e.g. EPR, patient admission data) were used to support the pathway's development

The team firstly **mapped out their existing pathway,** highlighting where they felt there were project management risks.

This data was used to gain traction with trust management and finance teams, and to **optimise referral of patients for immunotherapy from other departments**.

An immunotherapy management cycle was developed encompassing **recognition, review, and implementation of immunosuppression, referral to immunology outpatients follow up, discharge and ongoing malignant care**.

THE CLATTERBRIDGE IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY

REFERRAL

Patient identified using decision aid

Booked into telephone clinic with IO team by admin team

Patient booked to see consultant in 3-4 weeks

ASSESSMENT

Patient assessed using patient assessment tool and outcome documented on SACT toxicity form

Bloods taken

Steroid started as per protocol or hormone stability assessed if patient has endocrinopathies

PENULTIMATE ASSESSMENT

Once patient has reached 10mg prednisolone, the patient's treatment team is made aware to consider reinstating IO if the adverse event has resolved to a sufficient grade

Patients with ongoing endocrinopathy would receive weekly follow up until resolved

ADRENAL ASSESSMENT

A week after a patient has completed steroid therapy, adrenal function reviewed (0.900 cortisol assessment)

If low, manage per adrenal failure protocol, patient continues in telephone clinic

DISCHARGE

When steroids finished and adrenal function assessed or endocrinopathy is managed, patient discharged

Adverse events should be reported and treatment modifications should follow the Summary of Product Characteristics

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SACT = systemic anti-cancer therapy, IO = immuno-oncology

WHAT EDUCATION AND TRAINING WERE IMPLEMENTED TO FACILITATE THE NEW PATHWAY?

A new learning package was created (a knowledge skills and framework and a competency framework). All the nurses new to the team spend a month in a supernumerary position focused on education where they shadow different elements of the service

Nurses also attend the stakeholder reference group (SRG) teaching sessions and weekly meetings concerning more complex patients (including patients on neoadjuvant and adjuvant treatments)

HOW IS THE PERFORMANCE OF THE PATHWAY MONITORED AND MAINTAINED?

- Clinicians are excellent at knowing what therapeutics are coming their way. The service **supports this process of introducing developments in immunotherapy agents**
- Immunotherapy nurses attend **each site reference group quarterly meeting** (e.g., urology, respiratory) as a point of contact for each
- This facilitates **two-way engagement** to make sure that clinicians from the immunotherapy team understanding what's happening on the horizon and what might impact the service

WHAT CHANGES TO THE SERVICE ARE NEEDED OR EXPECTED IN THE FUTURE?

- **Creation of an annual report** to help understand integration with existing oncology
- Introduction of a pre-habilitation programme for immunotherapy patients to improve patient wellbeing
- Development of **moving forward strategies**

> ***"We are really fortuitous because of the infrastructure that we've put in place around immunotherapy, that we are normally in a position to introduce the newest indications as soon as they're approved, or very, very close to it"***
>
> *Consultant Medical Oncologist, The Clatterbridge Cancer Centre*

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*Clinical Nurse Specialists

WHAT WOULD YOU RECOMMEND TO ANOTHER CENTRE ESTABLISHING A NEW IMMUNOTHERAPY TOXICITY MANAGEMENT PATHWAY?

Planning

- Identify key stakeholders required for the pathway revisions, including non-clinical colleagues
- Engage early with service management and finance teams
- Determine the funding process required for the service change well in advance as this may take a long time
- Identify, nominate and empower a motivated clinical lead at the start
- Strongly consider having a data project manager as part of your team. Understanding of your clinical / non-clinical data will help determine requirements for future service provision

Staffing

- Integrate education regarding immunotherapy toxicity and toxicity from emerging cancer treatments into oncology registrar training
- As your team gets bigger, maintain good communication with the extended team and wider stakeholders is key
- Have regular touch points with wider stakeholder teams to support a 2-way engagement and dialogue

Service

Understanding the process and writing down your patient flow to consider:

- What happens if your patient has an uncomplicated pathway?
- What happens if a patient has a complicated toxicity pathway?
- Where do patients get referred?
- Where are the touch points?
- How many times do you see them?
- Where does the capacity and support come from?

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