Best Supportive Care in cancer: working models require resource and accountability for delivery if patients are to benefit

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Background

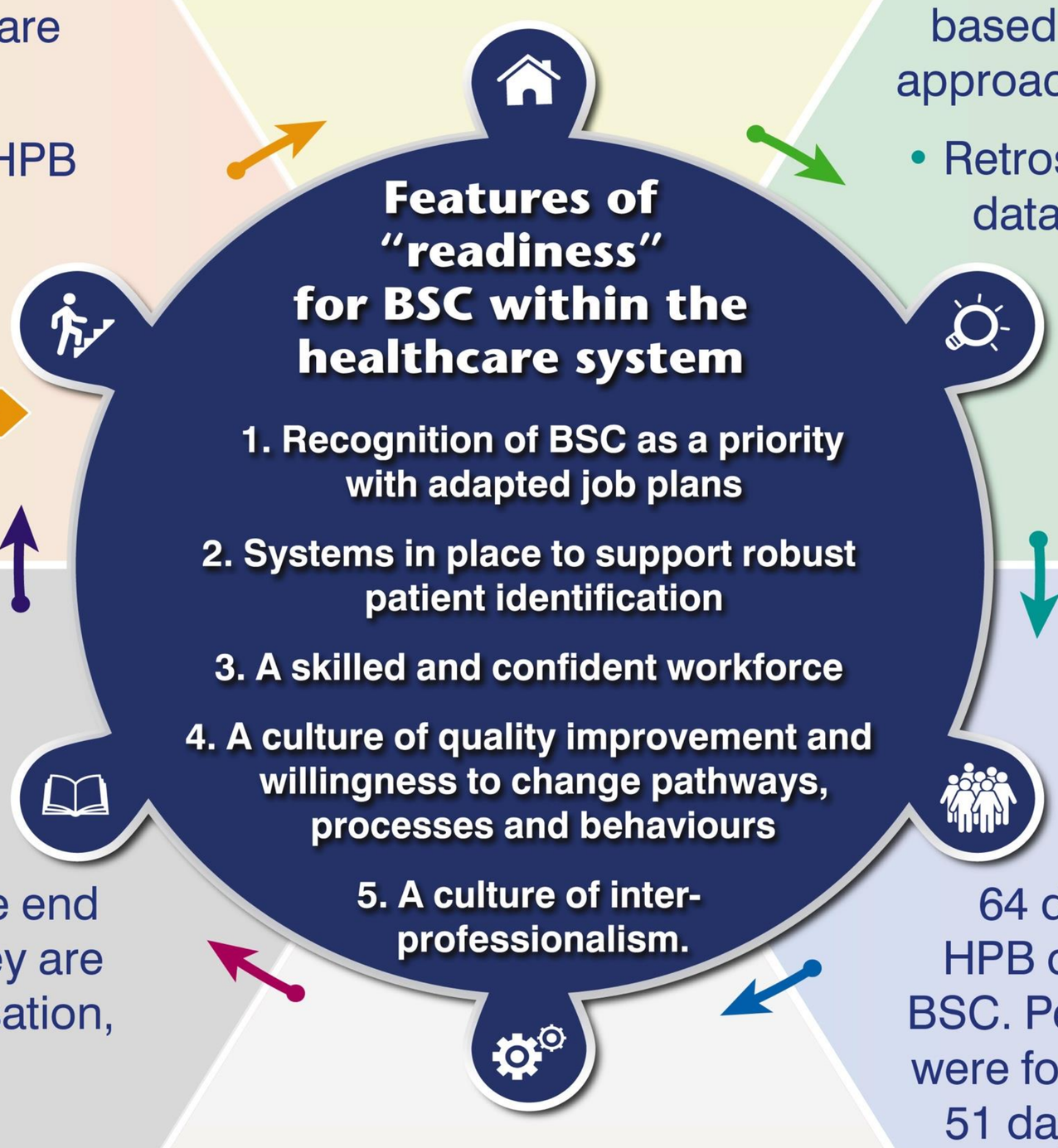
- Best Supportive Care (BSC) is the recorded plan for patients who are unable (or who choose not to) receive cancer treatment. In practice, there is a lack of consensus about what BSC is and who is responsible for its delivery.
- A working model of BSC in lung cancer, funded by Macmillan, was developed in 2015 in Fife, resulting in major improvements in quality of care.
- In 2018, Macmillan provided funding to NHS Fife to develop new models of BSC to people with hepatobiliary (HPB) cancers and cancers of unknown primary (CUP).

Next steps

- A national study to evaluate outcomes and experiences for people with poor prognosis cancers.
- Cancer specialist nurses, district nurses and specialist palliative care in Fife to work together on a shared care pathway.
- Working with national HPB cancer network to develop minimum standards of BSC and quality performance indicators.

The plan

- BSC delivery was to be shared between Oncology, Primary Care and Specialist Palliative Care teams. Specialist palliative care teams are typically small. The intention was to develop sustainable models based on a shared care approach.
- Retrospective and prospective data collection & descriptive statistical analysis enabled patients' diagnostic pathways and outcomes to be described.



Key learning

- People with HPB cancers and CUP 'for BSC' are often near the end of life at diagnosis. They are at risk of overmedicalisation, missing out on honest conversations, timely symptom control and realistic goal-setting.
- BSC requires resource and accountability for delivery. Otherwise it risks remaining an empty label that means nothing more than 'no cancer treatment.'

The population

- Median survival from diagnosis was 64 days for people with HPB cancers who were for BSC. People with CUP who were for BSC lived on average 51 days.
- Two thirds of people with HPB cancer and over half of those with CUP were in hospital at diagnosis.
- Over half of BSC HPB and BSC CUP patients had a biopsy, often in their last weeks of life.

The reality

- Major challenges implementing shared care models of BSC were encountered, reflecting chaotic clinical pathways and a lack of dedicated resource for robust identification and delivery.
- As a result, **no improvements in the quality and reliability of BSC were seen**. This is in stark contrast to the improved outcomes of a parallel service development in end-stage renal failure for people who were for BSC.