Acute Oncology Service - Peer Review Report

Trust Name: **Southern Health and Social Care Trust**	**Date of Review: Friday 23 November 2018**

Structure and Process

Number	Indicator	SD	PR	Comments
AO-18-001	Single Acute Oncology Group (AOG)	Y	N	The AOG is chaired by the Head of Cancer Services. No clinical oncologist or lead for MSCC
AO -18-002	There is an acute oncology team	N	N	No oncologist currently supporting service due to long term absences. Service not commissioned for haemato-oncology
AO-18-003	There are acute oncology rotas for advice and assessment	N	N	Service is commissioned for weekdays only – therefore nursing cover not provided seven days a week
AO-18-004	Information on Acute Oncology for healthcare professionals	Y	Y	Available on Trust intranet site
AO-18-005	There is a process for immediate essential patient information retrieval	Y	Y	Regional electronic patient records system
AO-18-006	There are agreed patients pathways	Y	N	Agreed regional pathways have

				not been adapted to include local contact details.
AO -18-007	There are clinical guidelines in place.	Y	Y	NICaN Clinical guidelines are in place; these are reviewed and updated centrally.

The Southern Health and Social Care Trust (SHSCT) is an integrated Trust, providing acute and community hospital services together with a range of community health and social services to a population of approximately 360,000. Acute services provided include diagnostics/MRI, emergency care, theatres, day procedures, endoscopy, and inpatient acute care with intensive care services available in the main Craigavon Hospital site. The Acute Oncology Service (AOS) is commissioned at Craigavon Hospital only.

The Daisy Hill Hospital site is thirty miles away from the Craigavon Area Hospital and has inpatient beds plus an Emergency Department (ED) but with no on site MRI. Craigavon Area Hospital is designated as the Cancer Unit for the Southern area of the province providing ambulatory systemic anti-cancer therapy/chemotherapy services. Patients with cancer are not treated with standard multi-modality cancer therapies at the Daisy Hill Hospital but do present via the ED; where they are triaged, treated and or then transferred to Craigavon Hospital. Patients are referred to the Trust with all of the common cancers for diagnostic and surgical treatment; this includes breast, colorectal, gynaecology, urology, lung, upper GI and thyroid. Some of the rarer cancers are managed on a shared arrangement and proceed to the Cancer Centre in Belfast for surgery such as lung and gynaecology. Paediatric and orthopaedic related primary cancers are directly referred to the cancer centre. Patients have access to site specific Clinical Nurse Specialists (CNS) for each of the following tumour sites; lung, colorectal, breast, gynae, upper GI, skin, haematology, urology plus head and neck.

The oncology consultant service is delivered as an outreach service by the Belfast Health and Social Care Trust (BHSCT) with visiting oncologists providing outpatient clinics enabling onsite chemotherapy. Radiotherapy treatment is provided by BHSCT.

The Mandeville chemotherapy unit is based at the Craigavon Hospital and provides a telephone helpline for patients attending for chemotherapy treatment. Out-of-hours, the helpline is available through the haematology ward. The Trust has recently piloted a three-month trial whereby a band 3 member of the healthcare team triages the calls received, as many were found to be in relation to request for changes in appointments times rather than calls requiring clinical help and support. Historically, the Mandeville unit has provided a service for the management of paracentesis and pleural effusion but with no current speciality doctor provision; this service has been relocated to another Trust. This change in location of service provision will have had a detrimental impact on the ease, speed of access and continuity of care for local patients. During the review discussion, the Head of Cancer Services reported that this service could be re-established as a nurse led service if appropriate nursing resources were available.

The Acute Oncology Service (AOS) was established in 2013 with agreed funding for 1.0 whole time equivalent (WTE) Acute Oncology Consultant and 1.5 WTE Acute Oncology CNSs with 0.5 WTE Support Worker. There is also a 1.0 WTE Oncology Speciality doctor based in the Mandeville Unit.

The reviewers were pleased to meet the Acute Oncology CNSs, Chemotherapy Sister, Macmillan General Practitioner, Research Nurse, Administration Manager, Specialist Palliative Care Consultant, ED Consultant/Clinical Director, Head of Cancer Services and Macmillan Cancer Service Improvement Lead which facilitated an open and honest review of the local service.

There is an Acute Oncology Group (AOG) which is currently led and chaired by the Head of Cancer Services. The group has named core membership from haemato-oncology, specialist palliative care, primary care, clinical nurse specialists with named secretarial support. The AOG has named extended members who attend meetings on an ad-hoc basis when their particular expertise is needed. The GP representative who attended the review meeting reported that the group had been pro-active in involving primary care, and they complimented the hard work and competence of current AOS CNSs. There are agreed Terms of Reference for the AOG which include the frequency of meeting, with three having been held within the last year. Copies of AOG minutes showed good attendance. There are established escalation procedures in place for highlighting issues and registering risks at Board level. However the AOG is not quorate as there is currently no named oncologist nor is there an identified lead for Metastatic Spinal Cord Compression (MSCC); this will impact on service development and delivery of the AOS. The lack of a named lead for MSCC within the Trust is further compromised by the lack of a regional coordinator. The reviewers were informed that there are often delays in the AO team being advised on whether MSCC patients referred to the spinal team are suitable for surgical treatment or not. The reviewers were concerned that these potential delays may seriously compromise patient experience and best clinical outcome.

The reviewers were informed that recruitment for oncologists including locums is a real challenge and the management team have been unsuccessful on a number of times in their attempts to recruit to this role. The lack of an Oncologist is exacerbated by the long-term absence of the speciality doctor which means the service is further compromised as there is limited support for the nursing team. The head of cancer services stated that the team are hopeful that they may be able to recruit a locum GP with special interest. The reviewers were concerned that this lack of consultant oncologist/specialist doctor input to the AOS has the potential to impact on the timely triage, care and treatment of patients.

The commissioned service model for the Acute Oncology provision currently is for a single site and does not take in to account that cancer patients have the potential to be admitted to each of the Trust`s sites via the two EDs; while the service model does not allow nursing resource to be physically present on both sites; the AO nursing team at Craigavon Area Hospital provide advice during week days on request to staff in Daisy Hill Hospital. The reviewers were concerned that this has the potential for inequality of a face to face assessment service for patients. The reviewers were advised that there is also an increased demographic of older people accessing services on the Daisy Hill campus. Due to the limited number of WTE hours by the AOS CNSs and the current team`s medical staffing challenges, there is restricted or no time to fully support the cohort of cancer patients over five days and certainly not for an expanded seven day service.

The team reported good working relationships with palliative care team with one of the AO CNS attending the weekly MDT meetings which are held on a Monday; this is further enhanced by the co-location of the office accommodation which is shared by other site specific CNS. The good communication skills were reported to help deliver patient centred care.

The Emergency Department leadership from the clinical director committed to improving timely Neutropenic Sepsis management is commended.

They have, in conjunction with the AOS CNSs, developed a patient hand held alert card. All oncology patients are educated to carry the card with them should they attend the hospital, especially via the ED. The “red card” explains to the emergency department receptionist, triage nurse and doctors within ED that prompt action is required in terms of assessing and treating the patient. The card also has the details of the nurse led telephone helpline which patients are encouraged to use if they have any concerns or become unwell. There is a separate 24/7 oncology advice line hosted by Belfast Health and Social Care Trust which is specifically for other healthcare professional staff from across the region. .

The AOT facilitate the diagnostic pathways for patients presenting with either Cancer of Unknown Primary or Malignancy of Unknown Origin and the team appreciated the need for rapid transfer of care to the site specific MDT or Specialist Palliative Care team.

The Trust isn’t designated as a MSCC Centre; the AOT including the ED clinical Director were passionate in acknowledging their frustrations and the effort required to access MSCC surgical opinion from the spinal service within the Royal Victoria Hospital in Belfast; which they expressed was far from satisfactory with the potential for delays. MRI was only available 6 days a week on the Craigavon Hospital site with patients having to be transferred from the Daisy Hill Campus to Craigavon or directly to the Cancer Centre in Belfast. The team feel the pathway will be improved with the appointment of new northern Ireland MSCC co-ordinator with improved speed and rapid access to appropriate diagnostics and treatment for patients presenting with suspected or confirmed MSCC.

The AO service benefits from highly skilled nurses who lead the service on a day to day basis. The senior of the two nursing staff has completed the NICaN AOS nursing competencies and has completed advanced health assessment and non-medical prescribing training. The second nurse who is currently covering the AO service has been seconded to cover the substantive post holder who is currently covering a vacancy in another speciality. The nurse is currently undertaking her Degree in Specialist Practice and will be completing her competencies for the AO service. Both of the CNSs are members of the Macmillan Community of Practice Programme which was a forum for networking and sharing good practice across the region as well as attend the bi annual clinical supervision which is available to all cancer CNSs. The AOS CNSs in conjunction with the chemotherapy sister support the competency assessment and ongoing updating of nurses who manage the telephone helpline using the UK Oncology Nurses (UKONs) triage assessment tool.

The reviewers were impressed by the patient’s informatics systems. The regional Electronic Care Record and new regional Information System for Oncology and Haematology (RISOH) which is available across all Trusts and healthcare professionals working within primary care. Locally there is no flagging system to inform the staff within ED or elsewhere in the hospital that a patient is currently receiving oncology treatment. The team are aware of a pilot in the Northern Trust that alerts admitting staff to patients’ chemo / cancer status on admission and would like to see it implemented in their own organisation. Consideration should also be given as to an electronic alerts system to notify the members of the AO team when patients have been admitted; currently the AO CNSs look through patients’ records to see who has been admitted overnight/during weekend to see if there are any patients who require assessment. General Practitioners have developed an alert on their electronic patient record system which lets them know patients who are receiving chemotherapy or radiotherapy; this again enables appropriate triage, support and advice from primary care with onward secondary care. The primary care lead highlighted his ambition to use the UKONs toxicity screening tool in primary care to look at reducing the “time to door” for suspected neutropenic patients.

The AOT use the NICaN developed pathways, however these still need to be localised with Trust contact details and onward referral points to the Cancer Centre when appropriate. This information would be especially important for out of hour's staff who may be unfamiliar with the pathways or infrequently treat cancer patients.

The NICaN guidelines are accessible on the trust intranet and hard copies are available on all wards, the team recognised that these need regular version control. There is an electronic application which can be downloaded to telephone and other hand –held electronic devices with the NICaN guidelines which all staff are encourage use. The team has undertaken education and training of nursing and medical staff across the two acute sites and contribute to the medical staff induction programme. The AOT attempt to attend the ED weekly on a Wednesday at change over to capture as many healthcare staff as possible as well as taking every opportunity to train individuals when patients are being assessed on the ward.

Patient Experience

Number	Indicator	SD	PR	Comments
AO-18-201	Patient feedback is obtained and used to evaluate the service	**Y**	**Y**	A survey was completed

The team has undertaken an informal patient feedback exercise involving a relatively small number of patients; it was reported that the comments received were positive and so no further action plans have been developed. The reviewers encourage the team to consider other ways to obtain feedback which may result in more meaningful information which the team could use to further develop the service. There is a dedicated patients and families suggestion box located on the chemotherapy unit; but the volume of patients utilising this mechanism of feedback is very low with on average only one comment posted per month.

The AOT are also considering asking the Trust's Cancer Service User Group' to assist in gaining feedback together with the 10,000 Voices project which looks at patient's stories as a way of informing service improvement. There is a Macmillan Information and Support centre situated in the main entrance of the Craigavon Hospital which may be another means of gaining feedback from patients.

The Trusts has participated in the 2018 National Cancer Patient Experience Survey: however, at the time of the review meeting the results had not yet been shared.

Clinical Outcomes

Number	Indicator	SD	PR	Comments
AO -18-101	The service is collecting and reviewing the acute oncology minimum dataset	Y	Y	Commended for continuing to collect given staffing issues

AO -18-102	The service is collecting and reviewing the MSCC minimum dataset (Applicable only to hospitals agreed by the network as definitively treating cases of MSCC with surgery and/or radiotherapy.)	N/A	N/A	Not designated as a MSCC treatment centre.

The Trust has continued to collect the minimum dataset as set out by NICaN with support from the administrative team. The data is currently verified by the AOS CNS. The reviewers commend the team for continuing to collect this data through recent staffing issues.

The AOT collected quarterly information on neutropenic sepsis and from July – September 2017 there has been an improvement in the door to needle times in Emergency Department for 75% of patients receiving treatment within one hour and the remaining 25% within 2 hours. The team consider the improved time from the previous quarter had been as a result of the close working relation between the ED teams, ED Clinical Director and AOS CNSs. The team acknowledged the challenges of ED staff turnover and further continued work was needed to sustain and improve this. Patients presenting to the Mandeville unit were included in the audit for July and September period, there were seven patients admitted; of which three patients were seen within the 60 minutes, three patients were seen within 1-2 hours and one patient was seen more than three hours; the delays in treatment were associated with the unit`s capacity and associated activity.

Good Practice

Regular AOG meetings in 2018 with good attendance.

Committed, respected and strong nurse led service.

Expanded scope. expertise and advanced skills of the AOT CNSs.

Macmillan Information and Support Centre in the main entrance.

Emergency Department Leadership and commitment to improve timely Neutropenic Sepsis management.

Patient held alert Card which outlines the role of ED staff if they attend hospital due to unexpected difficulties.

Improvement to door to needle times in Emergency Department to 75% within 1 hour.

Primary Care/GP Practice Alert System for use in all GP practice by health care professionals.

Continued commitment to NICaN data collection and quality assurance despite staffing challenges.

The Macmillan Community of Practice for CNSs.

Specify Immediate Risks
Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the zonal team.
An "Immediate Risk" is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

None identified

Specify Serious Concerns
A "Serious Concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

1. The service model for the Acute Oncology provision currently commissioned is for a single site and doesn't take in to account that cancer patients have the potential to be admitted to each of the Trust`s sites via their two EDs; this has the potential for inequality of service to patients.
2. There is currently no oncologist with any named cover to take the lead for AOS or agreed replacement plan for a locum; this will impact on service development and delivery for AOS, MSSC and radiotherapy.
3. There is no speciality doctor to support the nursing team which has the potential to impact on the timely triage, care and treatment of patients.
4. There is no named lead for MSCC within the Trust and this is further compromised by the lack of a regional coordinator which may seriously compromise patient experience and best clinical outcome.
5. There are only 1.5 wte Acute Oncology Clinical Nurse Specialists, which is insufficient to provide support and expertise for the commissioned five-day face to face service to the two hospital sites each with an emergency department. Due the level of cancer service provision across the Trust there is limited or no time to fully support the cohort of cancer patients and expanded seven-day nursing cover.

Areas for Improvement/Consideration/General concerns

Consider the development of a nurse led abdominal paracentesis and pleural aspiration service.

Increase the methodologies for feedback for cohort of patients surveyed for feedback on the AO service and consider obtaining feedback from families.

Update locally agreed pathways to include relevant contact information.