Acute Oncology Service - Peer Review Report

Trust Name: Northern Health and Social Care Trust	Date of Review: Thursday 22 November 2018

Structure and Process

Number	Indicator	SD	PR	Comments
AO-18-001	Single Acute Oncology Group (AOG)	N	N	No Clinical Oncologist and no named lead for MSCC
AO -18-002	There is an acute oncology team	N	N	The named consultant for the service is on long term absence with no named cover.
AO-18-003	There are acute oncology rotas for advice and assessment	N	N	Commissioned locally for five day service on one site only. Nursing cover is not provided during weekends.
AO-18-004	Information on Acute Oncology for healthcare professionals	Y	Y	Information on intranet and electronic application.
AO-18-005	There is a process for immediate essential patient information retrieval	Y	Y	Region wide electronic patients information systems.
AO-18-006	There are agreed patients pathways	Y	N	Regional pathways agreed but yet to be localised.
AO -18-007	There are clinical guidelines in place.	Y	Y	NICaN Clinical guidelines are in place; these are reviewed and

				updated centrally.

The Northern Health and Social Care Trust provides a comprehensive range of services to a population of almost 436,000 across a geographical area of 1,733 square miles spanning four council areas (Antrim and Newtownabbey District, Causeway Coast and Glens District). There are two major general hospital sites (approximately 30 miles apart), a mental health hospital, local community hospitals, health centres, social services, and a significant network of community services as well as the provision of domiciliary care. The Trust also provides care to people who live on Rathlin, the only inhabited island in Northern Ireland, making it the largest geographical trust in Northern Ireland. The Trust hosts a number of Cancer Multidisciplinary Meetings (MDMs) including lung, colorectal, upper GI breast, haematology and Skin.

There is a new purposed built Chemotherapy Unit (Laurel Unit) based in Antrim Hospital, providing Systemic Anti-Cancer Therapy for lung, gastro-intestinal, breast, colorectal and haematology cancers; as part of the new build there is a HSC funded specialist palliative care inpatient unit. There are two Emergency Departments with one on each of the acute sites at the Antrim Area Hospital and the Causeway Hospital in Coleraine.

The reviewers were pleased to meet with the GI Consultant/Trust Lead Cancer Clinician, Clinical Service Manager, AOS Clinical Nurse Specialists, Macmillan Service Improvement Manager, Macmillan Support Worker, two middle grade Doctors, Macmillan General Practitioner and Specialist Palliative Care Consultant which facilitated an open and honest discussion about the service delivered locally.

The Acute Oncology Group (AOG) was established in October 2015; the lead is currently the GI Consultant/Trust Cancer Lead Clinician with named core members which include AO Clinical Nurse Specialists (CNSs), service manager, middle grade doctors, haemato-oncologist, specialist palliative care consultant, primary care representative, the lead Emergency Department (ED) Consultant and Macmillan support worker. Although there is a named consultant oncologist for the AOG, they are currently on long term unplanned leave. There is no identified lead for patients identified locally as potentially having Metastatic Spinal Cord Compression (MSCC). The group has agreed a comprehensive Terms of Reference which includes the requirements for the meetings to be quorate and an escalation pathway to the Trust Board. The group meet on a regular basis and copies of the minutes provided to the reviewers showed good attendance with all meetings being quorate: there is good administrative and management support for the AOG.

The reviewers were concerned that as the Acute Oncology Service (AOS) has been commissioned to provide a five day cover on one hospital site only, with haemato-oncology commissioned separately; this has the potential for inequality of service to patients.

There is a substantive clinical oncologist who is job planned for five AOS Programmed Activities (PAs) and five PAs within the lung / GU cancer service; however, the consultant has been on long term absence since November 2017. There is no named cover for the lead oncologist and the Trust has failed to recruit a locum consultant on a number of occasions; the reviewers were therefore concerned that the lack of consultant input to the service is impacting on service delivery and development for AOS, discussion regarding potential radiotherapy treatment options and MSCC.

In the absence of a consultant oncologist, the AOS is led by 1.8 whole time equivalent (wte) CNSs and 1.4 wte speciality doctors with reported robust working

relationships with additional support provided from specialist palliative care, emergency department clinicians and primary care. The current lack of an oncology consultant has resulted in the working practice of the AOT contacting either the visiting oncologists or the on-call oncology registrar at the Belfast City Hospital Cancer Centre for advice and support; it was reported that both mechanisms work well. The Belfast City Hospital also provides an out of hour's helpline for healthcare professionals where calls can be escalated to the consultant oncologist on-call service. In the absence of a consultant oncologist supporting the AOS, the Trust has developed a nurse-led service which the reviewers considered to be of a high standard. The CNSs are well supported by two specialty doctors. The mutual respect between team members was noted by the review team during the discussions. The AOT acknowledged the well-established informal support provided by the haemato-oncologists.

The AOS team are based on the Antrim Area Hospital site and are providing face to face assessment of patients five days a week. The AOT also provide telephone and email advice to staff looking after patients at the Causeway Hospital. Hospital staff and the oncology patients can access the helpline which is managed from the Laurel Unit (Chemotherapy Unit based on the Antrim Area Hospital site). The team are exploring ways in which to expand the service to include patients attending Causeway Hospital ED and for patients presenting with Cancer of Unknown Primary or Malignancy of Unknown Origin, however the current AO workforce is not sufficient to support these additional patients and a seven day AO service.

The AOS CNSs with support from the speciality doctors have been proactive in ensuring patient safety, outcomes and experience with no compromise in service provision, working with local clinical colleagues and those in the cancer centre. One of the CNSs has 0.2 wte of her role dedicated to supporting "Teenagers and Young Adult" (TYA) cancer patients; this time can be allocated flexibly which means she is able to prioritise and cover both services pro rota over a five day week.

The Macmillan Support Worker commenced with the team in June 2018 and supports the CNSs by collating information relating to those AO patients who have been admitted, organising patient appointments, ensure blood forms are sent out with the patient as well as helping maintain and update information on the AO database. The Macmillan Support Worker also helps with any audits undertaken within the service. This allows the CNSs to focus on their clinical work and service development. The reviewers shared the teams concern that this post is only funded on a temporary basis and consider the potential loss of this support would be detrimental to the team as it would reduce the clinical time available to the nurses. The Clinical Service Manager is developing a business case to secure funding for a substantive post.

The AOS benefit from two committed highly skilled nurses who lead the service on a day to day basis. They have both completed the NICaN AOS nursing competencies as well as being in possession of health assessment and non-medical prescribing skills. The CNSs are active members of the Macmillan Community of Practice Programme which is a forum for networking and sharing good practice with other AOS CNSs across NI. They also attend bi annual clinical supervision which is available to all cancer CNSs. In addition, clinical supervision can be provided by the Specialist Palliative Care Consultant. The clinical nurse specialists have both completed advanced communication skills training. The CNSs support the competency assessment and ongoing updating of nurses who manage the helpline based on the chemotherapy unit using the UK Oncology Nurses (UKONs) triage assessment tool.

The reviewers received positive feedback from the Trusts Clinical Lead for Cancer on the invaluable and impressive service the AOT were delivering given the

staffing challenges; the reviewers commend the highly motivated Acute Oncology CNSs and Speciality Doctors who have worked cohesively to maintain the service.

There is no named lead locally for MSCC. The AO team reported that they are able to refer suspected MSCC patients to the cancer centre at Belfast Health and Social Care Trust; however, the reviewers were concerned that the lack of a single point of ownership for MSCC patients, especially at weekends and bank holidays, may mean that there is little or no oversight of the referral pathway. It was also reported that in the absence of a network MSCC lead, there are acknowledged difficulties with obtaining information about referrals to the central service. There is representation by the AO nursing staff from the Belfast Health and Social Care Trust at the weekly spinal surgery MDT meetings; they are able to inform the appropriate Trust AO nursing team when treatment decisions are made. The team feel the pathway will be improved with the appointment of new regional MSCC coordinator who will hopefully improve the speed of diagnosis and rapid access to appropriate treatment for patients presenting with suspected or confirmed MSCC.

There are agreed NICaN pathways available to the team, however, these have not yet been localised with contact details for the Trust staff. This would be helpful especially for new members of staff or those who use the service infrequently; the team has adapted the NICaN MSCC pathways which are due to be formally signed off locally in January 2019. Evidence submitted highlighted the use of excellent training slides; there was regular teaching for nursing staff and including the junior doctor induction. The reviewers considered it would be helpful to include the out of hour`s contact numbers for the Cancer Centres at Belfast and Western Trusts on the posters and Trust intranet. The AOT are commended on methods to implement AO guidelines within clinical areas as well as encouraging and showing staff how to download and use the electronic application.

The reviewers were impressed by the patient's informatics systems used across the region. The Northern Ireland Electronic Care Record and RISOH- a new Regional Information System for Oncology and Haematology are available across all Trusts within NI; the IT systems allow teams to access oncology patient records and provide continuity of patient care across different Trusts. The Northern Trust have a flagging system within the emergency department on the electronic system to alert staff that the patients is a known cancer patient receiving chemotherapy. There is also an alert on ECR (the electronic care record) which is available to health care and GP services throughout Northern Ireland which again will flag that a patient is on chemotherapy. The Trust open ward system highlights to the AO team all patients admitted to a ward with cancer, or on chemo cancer related treatment complications; this information is collated at 08.00 daily into a report for the AO team.

The Northern Ireland electronic record system is available to primary and secondary care and in addition the Regional Information System for Oncology and Haematology is available across the oncology network. The team should be highly commended for pursuing electronic chemotherapy alerts on ECR and their bespoke ED symphony system for flagging patients to AOT for those patients attending ED who are receiving SACT, including those presenting at Causeway Hospital. Proactive methods to identify patients from the post-take ward round lists as well as direct referrals.

Patient Experience

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

The team has undertaken a small pilot survey of 12 patients to gain feedback about the service delivered locally. The reviewers were advised that generally, the feedback received had been very positive, and had not highlighted any areas for improvement. However, the AOT were aware that some improvements to the service could be made but recognised that due to the current staffing challenges the focus had been on providing a responsive service to patients. The team have highlighted in their work plan the need to undertake an evaluation of the service with healthcare professionals as well as service users.

Data is collected on a quarterly basis and submitted to NICaN who provide participating Trusts with a regional report. Locally the Macmillan Support Worker helps with the collation of the data. The team plan to evaluate the 30 day readmission rate at the end of 2018. The team is commended on their contribution to a comprehensive regional data set given their workforce challenges and the co-production of a poster presented at the UKONs conference in November 2018.

Clinical Outcomes

Number	Indicator	SD	PR	Comments
AO -18-101	The service is collecting and reviewing the acute oncology minimum dataset	Y	Y	
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	Service is not responsible for definitive treatment of MSCC patients

The team has undertaken a neutropenic audit for door to needle times in 2017 and 2016 and there have been improvements noted; in 2016 only 11% of patients received antibiotics within in one hour whereas this had improved to 39% in 2017, however there was a deterioration from 2016 to 2017 for patients receiving antibiotics in 2 hours of presentation from 72% to 54%. The team recognise the need to improve door to needle time and this is reflected in their work plan, they are currently piloting the introduction of a neutropenic sepsis care bundle to the chemotherapy unit.

Summary of Good Practice

Commitment and motivation of MDT.

Mutual team respect of each other and from across the organisation.

Good informal working relationships with Haemato-oncologist and Specialist Palliative Care Consultant/Team.

Locally developed AOS teaching slides resource pack.

Proactive and tenacious and commitment to teaching in the ED to raise awareness of the AOS.

Active Primary Care Macmillan GP Facilitator/Primary Care Lead.

Strong management support for the nurse led service.

The ambition for the development of a career structure for CNSs and expansion of the AOS CNS nursing service.

The nurse leadership, expanded scope, advanced assessment and non-medical prescribing skills.

The support of the two Speciality Doctors.

The Macmillan Coordinator/Administrator.

The access to on site HSC funded Specialist Palliative Care beds.

The clinical supervision of AOS CNSs from SPC Team.

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 into account that cancer patients have the potential to be admitted to each of the Trust`s sites; this has the potential for inequality of service to patients.
2. There is currently one clinical oncologist with 5 PAs for AOS who is on long term absence with no named cover to take the lead for AOS nor agreed replacement plan for a locum; this will impact on service development and delivery for AOS, MSSC and radiotherapy.
3. 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.
4. There are only 1.8 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. 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 an expanded seven day nursing cover.

Areas for Improvement/Consideration/Concerns

Secure substantive funding for the part time AOS Macmillan Coordinator/Administrator.

Increase the methodologies for feedback for cohort of patients surveyed for feedback on the AO service.

Consider seven-day nursing provision.

Ensure local contact details have been added to regional pathways.