GIG CYMRU NHS WALES

Rhwydwaith Canser Cymru
Wales Cancer Network

Peer Review:	**Cancer**
Sub-site:	**Acute Oncology Service (AOS)**
Health Board/Region:	**All-Wales**
Cycle:	**First**
Date of review:	**July 2018**

This report describes the findings and themes observed by clinical review panels during the first round of the acute oncology service (AOS) peer review in Wales 2018.

SERVICE DESCRIPTION

OVERVIEW OF THE REVIEW

Cancer patients commonly have complications of their cancer diagnosis and treatment, and will seek advice from and attend their local primary care facility, secondary care medical admissions unit or specialist oncology centre on an unscheduled basis.

Acute oncology refers to the assessment and management of patients presenting in this way and includes signposting to relevant specialties or services.

A national steering group within NHS Wales was involved in the development of the peer review measures which were designed to assess the quality and performance of acute oncology services (AOS), against the All Wales National Standards for Acute Oncology Services (June 2016). This is the first time that AOS have been reviewed in Wales. It was noted that the teams were at different stages of maturity and have developed differing models of service dependent on resource and geography.

The main focus of this review included:

1. Shape and function of the acute oncology service, including the management acute hospital admissions relating to cancer;
2. Management of chemotherapy induced neutropenic sepsis;
3. Diagnosis and management of Metastatic Spinal Cord Compression (MSCC)
4. Malignancy of Unknown Origin (MUO), including Carcinoma of Unknown Primary (CUP)

SHAPE AND FUNCTION OF THE SERVICE

Structure:

The service model that has been developed across most Heath Boards to ensure adequate assessment, signposting and management of patients presenting to the acute services, is a nurse-led model including AOS nursing teams working Monday to Friday with variable clinician input and support. The amount of clinical time allocated to the service is dependent on the agreement reached within individual Health Boards. Across Wales, there are currently 6 allocated consultant sessions for acute oncology led by oncologists, haematologists or acute medical physicians.

In some instances, consultant sessions were not filled despite support from the Health Boards for such posts. A common theme throughout Wales was of insufficient time allocation for senior clinicians acting as clinical leads, particularly for the management of Malignancy of Unknown Origin.

Administration support for the services across Wales was also noted to be variable.

Education:

Key to the acute oncology service and in addition to direct clinical care, the AOS teams play a key role in raising awareness, developing relationships and education within their organisation and across the wider Health Board stakeholders. There was clear evidence of regular education of the Emergency Department teams and Acute Admission Unit teams in particular. On the whole this was well delivered both locally and nationally. The All Wales initiatives, including agreement on All Wales SACT (systemic anticancer therapy) alert cards, development of immunotherapy alert cards, and generic protocols accessible via the AOS support app are excellent examples of collaborative working.

Access to patient records:

Patients commonly receive their primary cancer care in a different hospital to where they receive emergency cancer care. In many cases acute hospital teams cannot access key patient details such as cancer stage, treatment intent, recent treatment delivered and imaging. This risks patient safety in the form of inappropriate clinical decisions being made on the basis of incomplete information, a lack of patient focused care and additional workload on already very busy frontline staff. This may also impact negatively on admission rates and length of stay.

There was evidence of continued improvement in relationships and understanding between oncology services and the acute admissions units, but this needs to continue to be worked upon and is hindered by poor flow of clinical information and access to patient notes, particularly out of hours. This needs to be a focus of activity moving forward.

24 hour advice:

Patients receiving systemic cancer therapy should have access to a 24 hour telephone advice line. There was evidence that this was provided to all patients across Wales, from the two cancer centres in south Wales and by the cancer centre and one cancer unit in North Wales. There is wide use of the standardised UKONS triage tool and evidence of audits of the triage service. This work will continue to develop with more complex and varied treatments now available to patients and consideration being given to new models of triage including centralising the telephone services to cover a wider population.

7 day service:

The AOS are aspiring to deliver a 7 days a week service, but currently no service is providing this. North Wales are currently looking at options to deliver this, but it is acknowledged that with small teams this is very challenging to deliver effectively. Further work is needed nationally to identify the possible models for 7 day working by considering alternative ways to deliver support (for example a regional advice line). The Cwm Taf team have been actively analysing data of their service with this in mind.

Patient flagging:

IT systems are used across Wales to flag cancer patients attending acute services. Different systems are in use across the organisations with varying degrees of success. In some cases, their lack of sensitivity leads to teams actively triaging large numbers of patients to identify who they do need to review. An all Wales approach should be considered here, alongside the All Wales PAS. It is acknowledged that a mature AOS with good links with the acute admission/emergency department teams are less likely to utilise a flagging system and likely to rely on appropriate and timely referrals to the service.

Database:

AOS teams across Wales use the same standalone database set up as an All Wales initiative. It is not within the informatics systems for NHS Wales. Although it has been very useful in providing some detailed data on activity, it was noted that a number of Health Boards were unable to supply data for peer review requests/questions. There is now an opportunity to review and refine the data captured to reduce burden of manual entry/clinical time, but also to ensure the data collected is clinically relevant. This should be integrated across Wales into the planned cancer informatics solution currently under development and could be integrated into the Wales Clinical Portal (WCP).

Cancer Centre / Cancer Unit relationships:

A good working relationship between the Cancer Centres and the units delivering much of the treatment for patients within their Health Boards is important. It was clear from the review that there were some challenges with communication, support and responsibility between the units and centres. This is more challenging in South Wales where the

patients travel across Health Board boundaries for treatment and may receive treatment in a hospital different to their acute hospital. There was an awareness of this problem within both the Cancer Centres and cancer units and is an area for improvement moving forward by greater collaboration between Health Boards and the Cancer Centres.

Haemato-oncology:

There was evidence that each Health Board team had clear relationships with or an understanding of their local haematology service in respect of identifying patients accessing the acute services with side effects of treatment.

NEUTROPENIC SEPSIS

Neutropenic sepsis is a life threatening complication of some anticancer treatments. Acute oncology standards mandate that antibiotics should be administered within 1 hour of arrival at hospital.

Across Wales one standardised chemotherapy alert card is in use, which all patients should receive at the beginning of their treatment. In addition, patients are given written and verbal information on key risks associated with cancer treatment and will sign a consent form prior to receiving their treatment. Patients experiencing symptoms will contact the 24 hour number provided to access an initial phone assessment and attend the nearest cancer unit or centre (whichever is closer), if they are suspected to have neutropenic sepsis. The UKONS triage tool is used at telephone triage. There was evidence of all the above routinely being undertaken across Wales.

However, Health Boards in Wales are not achieving the 'door[1] to needle[2] time' response, with only 20-68% of patients being recorded as having been administered antibiotics within 1 hour of arrival in hospital with a suspicion of neutropenic sepsis. Many teams documented improvements in door to needle time however the average response in Wales is about 1 hour 30 minutes. It was noted that where PGDs (patient group directions) are in place treatment times are generally better but are not standard practice in any Health Boards across Wales yet. It must be noted that not all units or centres could provide this information for peer review.

Although all oncology teams collect data on deaths within 30 days of chemotherapy it was not possible to see how many deaths were due to neutropenic sepsis in this peer review. There will be a plan to address this nationally through the working of the Wales Cancer Network AOS group.

The consensus of the review panels suggest that 'door to needle time' is a quality performance indicator for measuring the progress of improvements in response to dealing with neutropenic sepsis and should be routinely collected by all teams.

METASTATIC SPINAL CORD COMPRESSION (MSCC)

Metastatic spinal cord compression (MSCC) is a well-recognised complication of cancer and is an oncological emergency. MSCC occurs when there is pathological vertebral body collapse or direct tumour growth causing compression of the spinal cord. Spinal cord compression leads to the permanent loss of neurological function if the pressure is not relieved quickly.

Once MSCC is suspected patients should receive a magnetic resonance imaging (MRI) scan within 24hours. This should be followed by a specialist surgical opinion within 6 hours.

[1] Presentation of a patient with suspected neutropenic sepsis at an acute admissions unit.
[2] The administering of antibiotics

North Wales struggle with access to out of hours MRI in some areas of the region, but have surgical services provided by the Walton Centre in England. The surgical service provision was felt to be timely and easy to access by the North Wales service.

There were no problems with any south Wales services accessing MRI out of hours. However, there were significant issues in accessing surgical opinion with the exception of Cardiff & Vale (C&V) which has the specialist spinal surgery team on site.

All other Health Boards in South Wales reported difficulties in accessing timely and appropriate surgical opinion. There was lack of clarity regarding whether the service in the South West is provided by Morriston Hospital or C&V. Whilst the number of cases suitable for surgery is low, there is a need to clarify the service model and responsibilities in order to improve timely access for patients across South Wales. This is the first step to understanding performance of accessing surgical opinion within a recommended standard.

Consideration is being given to piloting a MSCC coordinator across South Wales once the service model has been established.

The consensus of the review panels is that patients suspected to have MSCC should have an MRI within 24 hours and then surgical opinion within 6 hours. This should continue to be measured as a quality performance indicator for measuring the quality of the service.

Patients who are not eligible for surgery may receive urgent radiotherapy. Despite continuing pressures on cancer centres to deliver radiotherapy in a timely manner, there were no concerns raised around the timescales for MSCC patients accessing radiotherapy services. There are good examples of care, for example where Velindre Cancer Centre would provide transport to facilitate timely access to radiotherapy for patients from neighbouring Health Boards.

The Health Boards are working with the Wales Cancer Network to develop an All-Wales policy for MSCC, which will pull together some of these themes and also focus on rehabilitation and support for patients with symptomatic MSCC.

Malignancy of Unknown Origin (MUO) / Carcinoma of Unknown Primary (CUP)

'Malignancy of unknown origin' (MUO) and 'carcinoma of unknown primary' (CUP) are cancers that have been diagnosed, but where the primary tumour cannot be identified. They often present at an advanced stage and have a poorer prognosis.

A basic requirement for all patients diagnosed with cancer is that they should be managed and discussed by a multidisciplinary team (MDT). Historically MDTs have been set up by tumour site so MUO and CUP patients may not fit the criteria for a site specific MDT and can be discussed at multiple different MDTs or none at all.

There are MUO/CUP MDTs set up in Betsi Cadwaladr and Abertawe Bro Morgannwg University Health Boards (Swansea patients only), with the remaining Health Boards lacking a dedicated MUO/CUP MDT. In these instances, patients are managed by a tumour site MDT according to clinical pathways or without MDT supported decision making. For the South East Wales patients there may be an opportunity to expand the Velindre Cancer Centre daily meeting to facilitate an MUO/CUP MDT for South East Wales patients if funding can be agreed.

AOS teams have been very effective in providing patient centred care for this group of patients, often acting as key worker. They work with and give expert advice to acute teams regarding working towards a diagnosis in those who would be suitable for treatment and saving patients from unnecessary diagnostic tests who may have a poorer prognosis.

The AOS teams are collecting data on the number of CUP patients seen, investigations cancelled, etc. to demonstrate the value this service brings to the patients, as well as patient stories.

PRIMARY CARE

Primary care has a key role in the detection and ongoing care of cancer patients in the community. Only in a few areas in Wales can primary care refer to, or access AOS easily. However, GPs can seek advice directly from treatment support lines, junior on call staff or directly to consultant teams. Patients would benefit from closer working between primary care and AOS. This would be aided by across sector electronic patient record access and raising awareness that health care workers may access triage/emergency helpline access as well as patients.

PATIENT EXPERIENCE

There was some evidence of AOS teams trying to collect patient experience and feedback in order to inform the service improvements. This has been a challenge for the teams and there are plans to work nationally on patient feedback in the future with support from the patient experience expert within the Wales Cancer Network.

GENERAL SUMMARY

The acute oncology teams across Wales are small teams providing a predominantly nurse led service with often very limited access to medical clinical leads. Despite this there are excellent examples of the impact that they have made in improving the cancer patient experience and supporting the acute admissions teams to manage unscheduled care for acutely unwell cancer patients.

Acute oncology teams are fast to act and see patients who are identified to them by referral or a flagging system, and in most instances patients receive their first intervention by the AOS team within the first 24 hours.

It should be recognised that as a small service in each Health Board and Trust, it can be isolating for the teams and staff; however, the teams were pulled together by the Wales Cancer Network to work collaboratively at a national level. This provided peer support and the ability to align the service across Wales. It is a contributing factor to the success of implementing AOS within NHS Wales.

Across the peer reviews of the service the panels were consistent in identifying areas of priority for the service nationally. The reviews enabled a greater understanding of what characteristics make a high quality acute oncology service and where the gaps are.

CHARACTERISTICS OF A GOOD SERVICE

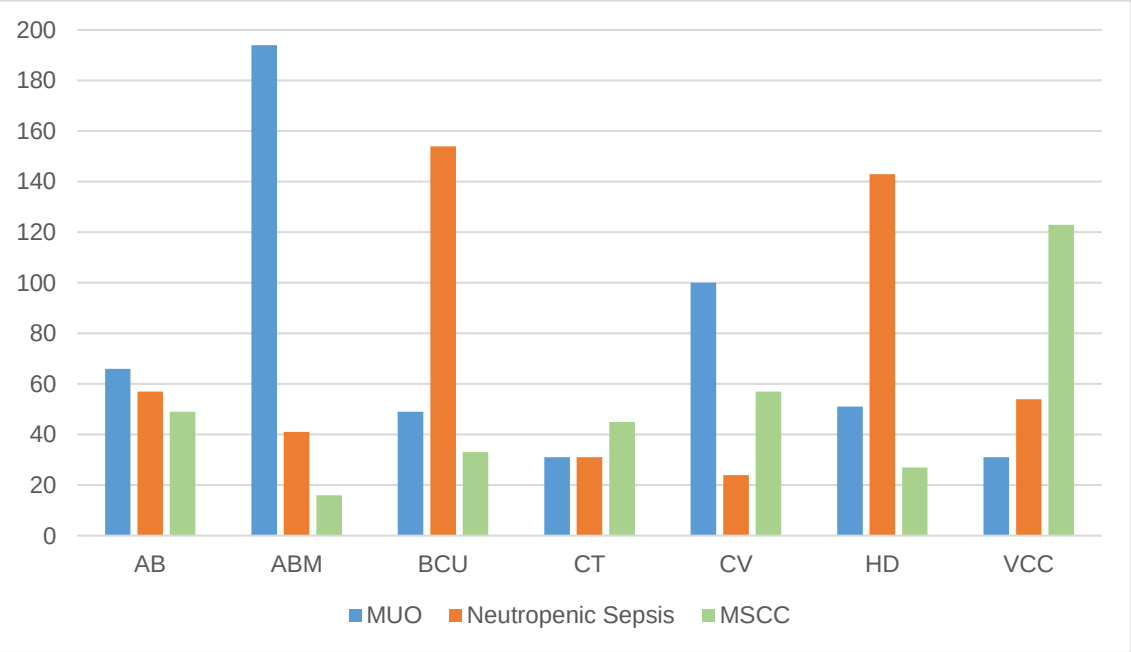
- Good relationships with other specialities such as admission and triage departments, palliative care, haematology, oncology and primary care
- A quick and accurate response to administering antibiotics to suspected neutropenic sepsis patients
- A fast response to diagnosing MSCC patients and providing surgical opinion in optimum time
- Providing a diagnosis and treatment plan for unknown cancers
- 24 hour telephone advice service which provides one standard of care with an out of hours package
- Cross cover arrangements across sites (admission units)
- An automated flagging system to identify potential patients
- The provision of education and training
- Dedicated time of a medical clinical lead
- Administration and data collection support
- Evidence of audit and service improvement

MAIN CHALLENGES IDENTIFIED AT PEER REVIEW

- Low and variable rates of spinal surgery for patients with MSCC compared to UK standards and England.
- Lack of clarity around the service provision for spinal surgery in South Wales
- Lack of clear long term funding for several teams
- Lack of funded consultant sessions (particularly for consultant oncology led care for Malignancy Unknown Origin)
- Variable access to CUP/MUO MDT discussion
- Although teams had led improvement in door to needle time for administration of antibiotics the majority of patients do not receive antibiotics within an hour of arrival at hospital.
- Inconsistent data collection via stand-alone database

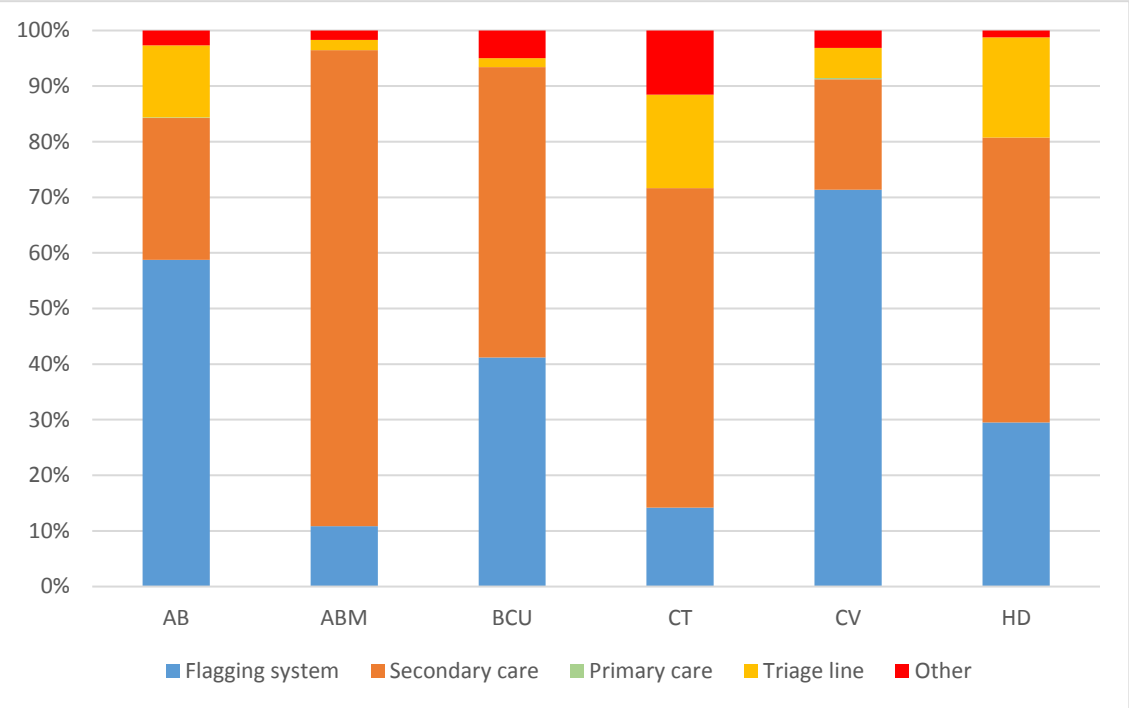
The following data tables show the 2018 review, which used data from the 2017 calendar year.

REFERRALS



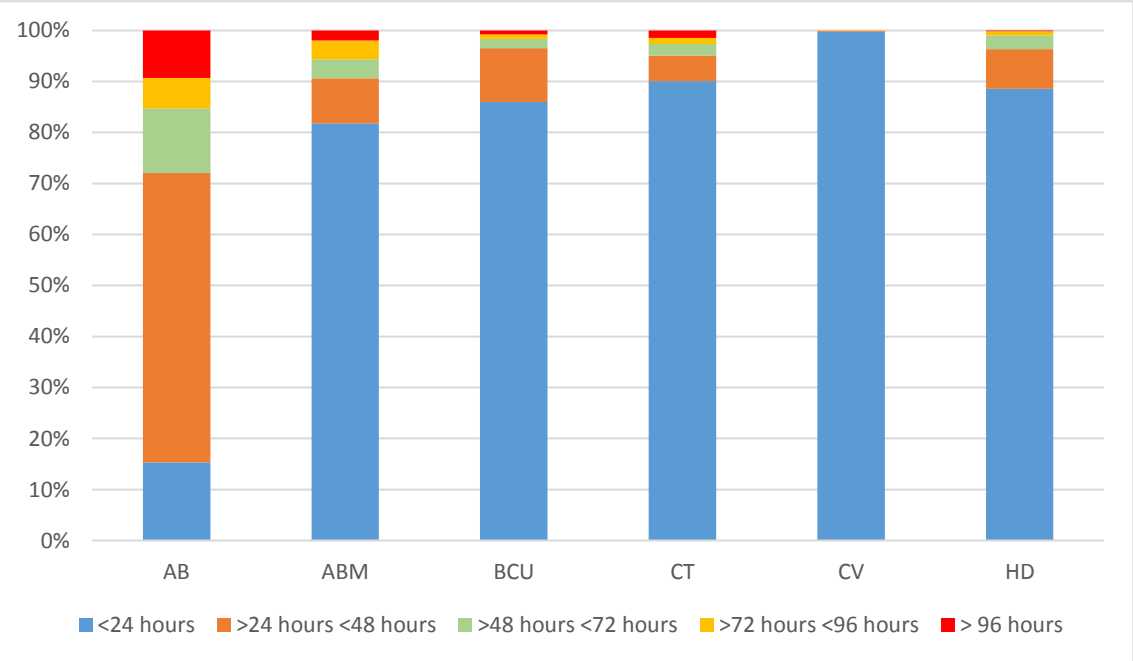
N.B. Other and inappropriate referrals were removed from the table as these figures ranged from 427 to 6,186 and would overshadow the figures shown.

ROUTE OF REFERRAL



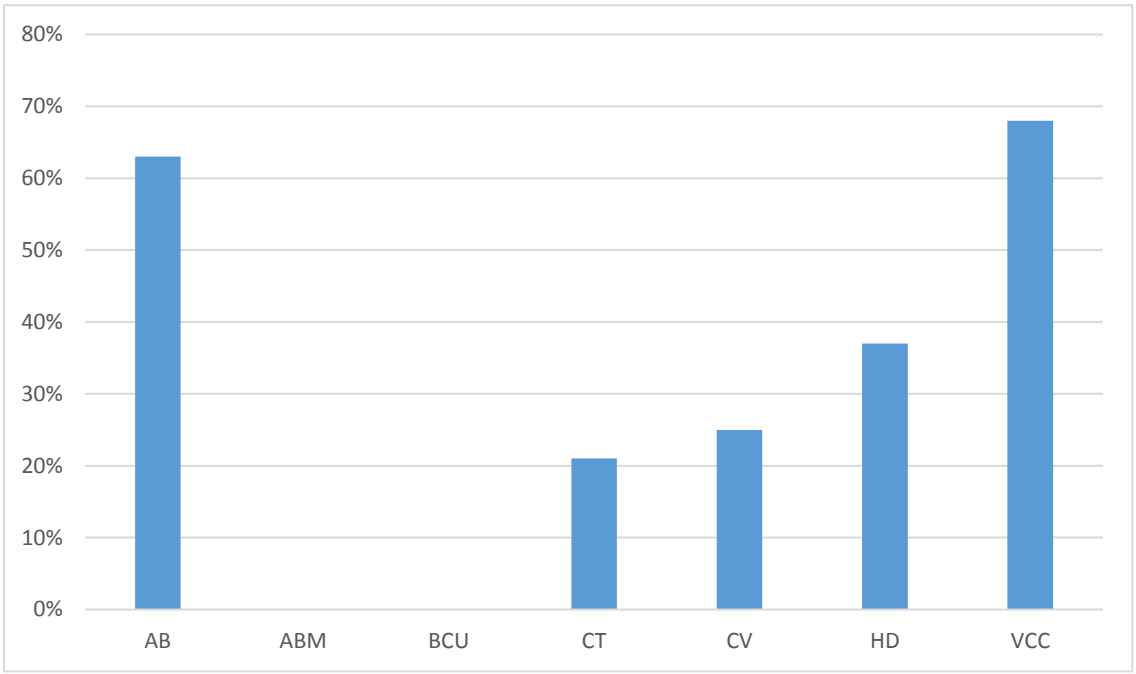
N.B. Velindre Cancer Centre did not submit data.

INTERVENTION BY ACUTE ONCOLOGY TEAM



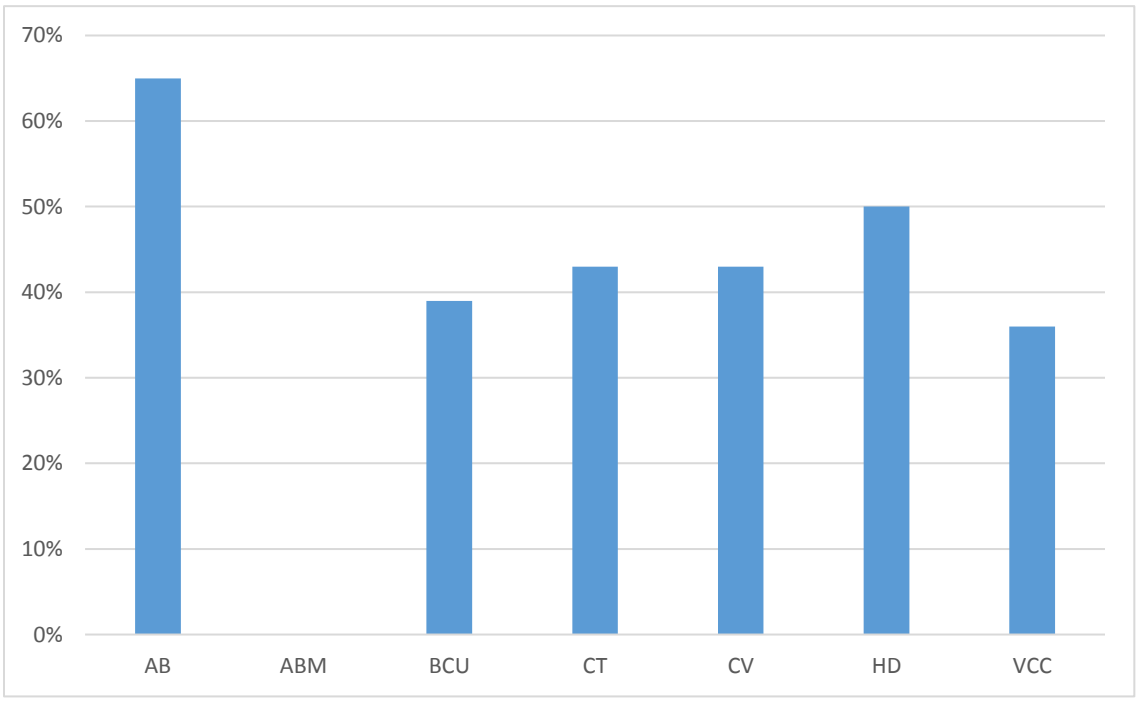
N.B. Velindre Cancer Centre did not submit data

NEUTROPENIC SEPSIS: PERCENTAGE OF PATIENTS RECEIVING ANTIBIOTICS WITHIN 1HOUR



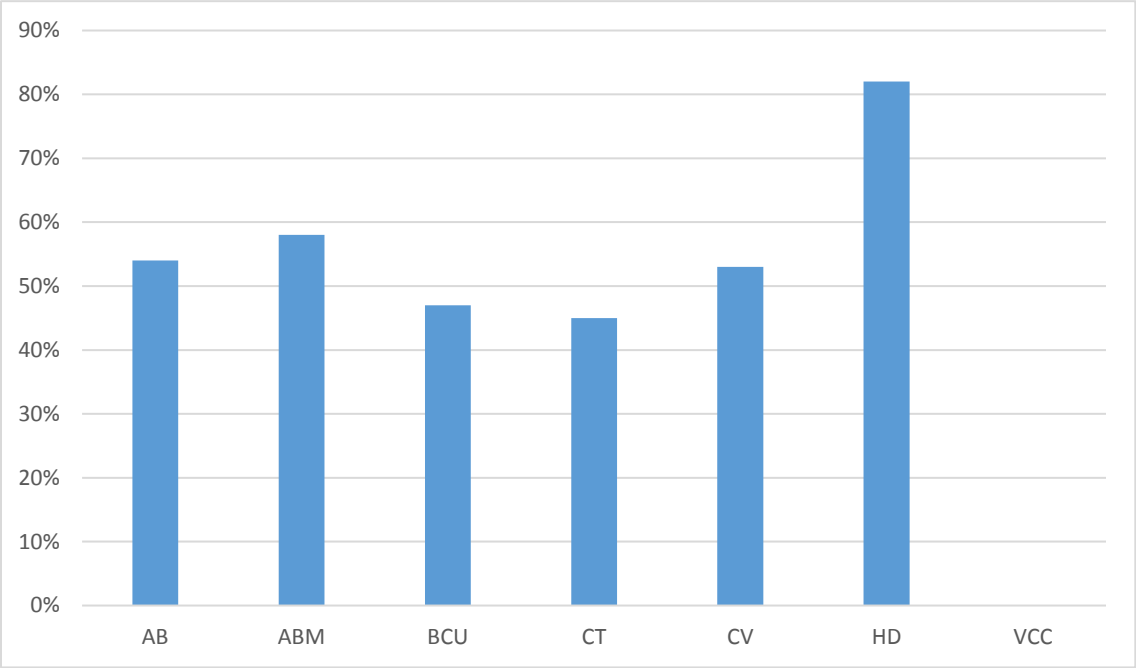
N.B. ABM and BCU did not submit data.

MSCC: PERCENTAGE OF PATIENTS RECEIVING AN MRI WITHIN 24HOURS



N.B. ABM did not submit data.

MUO/CUP: PERCENTAGE OF PATIENTS WHO RECEIVING A SITE SPECIFIC DIAGNOSIS



N.B. Velindre Cancer Centre did not submit data as they are not a diagnostic centre.