Clinical Services Review

Cancer Services Workshop Wider Cancer Issues 22 January 2014

Summary Workshop Report

Presentations

Introduction to the workshop	Sharon Adamson
Cancer issues arising from the Clinical Services Review	Sharon Adamson
Current and future cancer services in Scotland	Dr David Dunlop

A PDF copy of the presentations is available.

Workshop 1 Lead Mr George Welch

Front door model to support emergency care of patients with cancer

- There are established pathways, but these require to be refined and need to be consistent.
- There is a single point of access, but the admission process needs to be streamlined.
- Co-ordination of MDTs and feedback from MDTs could be improved. MDTs should take the lead in care co-ordination, including establishing closer working relationships with diagnostics. Consider a care co-ordinator role, as in upper GI.
- The diagnostic component is important, related to need not age.
- 7 days per week access to nurse specialists for support.
- Information available via the portal and via Trakcare could be used to improve real time information sharing.
- Communication supported by IT systems to join up information is essential in this area. Consider use of the patient held record or establish a unified patient record. The eHealth system under study, led by NHS Lanarkshire, gives remote access to patients, GPs, specialists and specialist nurses.
- The acute oncology assessment and admission unit at the Beatson has improved access. It would be useful to review the Beatson interface with acute receiving. Consider oncologist input to the front door for information and presence.
- There is a role for ANPs in providing support at the front door.
- A balance between palliative care beds in the acute sector and community is required.
- There are issues around managing frail elderly cancer patients in the community to avoid unnecessary hospital admission. There is a co-ordinating role for district nurses, pulling together social care support and the input of carers.

Workshop 2 Lead Dr David Dunlop

Provision of increased oral chemotherapy in the community

- This workshop was an opportunity for a valuable cross professional discussion around the challenges and barriers to delivery of cancer care and treatment in the community.
- There is concern from general practice around workload, which would need to be resourced and supported. Explore GP reservations and address where possible. Some GPs are keen to participate in an enhanced service.
- There is enthusiasm from community pharmacy to support provision of increased oral chemotherapy, perhaps moving towards an enhanced role for pharmacy as prescribing providers. Explore with pharmacy what they could offer and discuss with GPs. Good GP/ pharmacy relationships would be required.
- The Enhanced Community Cancer Services model could be explored as a model of making this work in practice. The features of this model are:
    - One enhanced practice serving a particular geographical locality and group of GP practices;
    - Service supported by nurses and pharmacists, enhanced IT, laboratory facilities or quick access to nearby laboratory facilities, robust protocols to be followed for various scenarios, effective out of hours patient pathway that is well known and communicated effectively to patients.
- Patients require informed choice regarding options for receiving aftercare in the community. Support and reassurance for patients, perhaps with access to a patient advice line, would be required, both during and after treatment.

Workshop 3 Leads Mr Jonathan Best and Dr David Morrison

Future capacity to manage cancer care – balance between acute, community and third sector

- Clinical pathways must be individual to each patient, and must include planning and preparation for discharge. Patient education regarding their role is important.
- Holistic needs assessment and end of treatment assessment is key to planning individual care. Self management models of care could be developed as part of individualised care.
- There is a new holistic service starting in Glasgow City in February 2014, from which we will be able to learn and develop.
- Third sector and community services are available, but communication is required to increase awareness of these. More awareness for the acute sector of what is available and the potential value of alternative services would help in continuing to change perceptions.
- Clinical nurse specialists play a key role as point of contact and link between services.

Workshop 4 Lead Dr David Morrison

Interface between cancer services and care of the elderly services

- Geriatricians currently try to provide timely and prioritised liaison with cancer services, as there is not enough resource to respond to all potential demands. This works better in some areas of GGC than others; e.g. Paisley geriatric involvement with orthopaedics is helpful.
- Services for onward referral; e.g. rehabilitation, day hospital, need to be developed.
- Suggest setting up a group of geriatricians with an interest in oncology, who would become known to and part of oncology services. Additional resource; e.g. Macmillan funded, may be possible.
- MDTs and geriatric assessment teams are key to developing links between oncology and geriatric services. Introduce a different MDT approach, with specialties, including geriatrics, meeting to consider a group of referrals without formal MDT. The lung cancer MDT represents good practice in terms of geriatrician involvement.
- There are examples of good practice from which we can learn and develop further initiatives; e.g. geriatricians working in surgery and orthopaedics, and Macmillan clinical nurse specialists providing pre-operative assessment resulting in reduced length of stay.
- Introduce a point of contact for each elderly person in cancer services to link with all services as required.

Workshop 5 Lead Mrs Karen Murray

Requirements to support palliative care and end of life care out with hospital with effective advanced care planning

- Effective communication tools for advanced care planning are required. Use "Thinking Ahead, Making Plans" more widely. Other examples that could be developed are the Marie Curie discharge form and the Heart Failure Advanced Care Plan.
- The advanced care plan needs to be kept up to date by all professionals caring for the patient. Shared patient records which can be accessed from multiple areas, such as used in Spain and New Zealand, would facilitate this.
- Clarity is required regarding who is responsible for arranging palliative care.
- Develop specialist community palliative care teams to provide 24/7 care in patients' homes, as required. Use NHS Continuing Care resource to provide 24/7 access to immediate care.
- Specialist nurses can provide valuable input; e.g. in the gap between effective treatment stopping and the need for palliative care, as in heart failure.
- There is a role for district nurses with palliative care training, who would link in to palliative care pathways at an early stage. District nurses could help with addressing care needs of frail elderly palliative care patients, including those with reduced cognitive function, through appropriate assessment and referral.
- Support and ongoing palliative care training for GPs is required.
- Establish palliative care beds to meet the needs in localities; e.g. NHS run care home beds.