

## **Yeovil District Hospital NHS Foundation Trust**

### **Acute Oncology Update**

#### **Acute Oncology Event 8<sup>th</sup> July 2014**

#### **The Service**

The AOS service in YDH composes of AOS Lead, Dr Matt Sephton (appointed Aug 2013, full time), Stacey Young (AOS CNS Band 6, full time), Rob Lutyens (Lead AOS CNS Band 7, appointed Nov 2013, full time) and Dr Geoff Sparrow (Associate Specialist, 2 days a week). At present there is a 5 day/week service with telephone advice available from the oncall Oncologist at Taunton 7 days/week.

Inpatient consultant AOS ward rounds occur 3 times/week with the CNSs reviewing patients on the wards daily as required. Urgent patients can be seen by a consultant on days without a consultant ward round, if required.

Daily contact made by AOS CNSs with ED and EAU.

Flagging systems for patients on chemotherapy who are admitted and inpatients with neutropenia and hypercalcaemia.

#### **Pathways**

AOS have clarified the complex MSCC pathway across the county, involving 3 different Trusts and services not held onsite in YDH, such as spinal surgery and urgent radiotherapy. A formal MSCC guideline is being written at present, incorporating the MSCC pathway.

AOS have developed a pathway with Ambulatory Care for the urgent review of outpatients, including those on treatment. This is by the Ambulatory Care team with support from AOS. Appropriate patients include suspected PEs, pleural effusions.

AOS have also worked with FOPAS (Frail Older Persons Assessment Service) to review outpatients, either diagnosed with an incidental new cancer or for a joint review of frailer patients.

#### **Evaluations**

See poster and patient survey (attached)

Neutropenic sepsis audit- we have a rolling prospective audit assessing if patients who present as an emergency with suspected neutropenic sepsis receive IV antibiotics in 1 hour of arrival. Results include:

Month	Dec 2013	Jan 2014	Feb 2014	Mar 2014	April 2014	May 2014	Jun 2014 (As at 16/6/14)
Number of patients	13	14	16	17	17	6	6
% Abx within 1hr	77	71%	94%	94%	100%	50%	100%

Monthly AOS reports- see attached report for April's report, including number of admissions prevented and numbers of discharges expedited.

We have performed a survey for GPs to gain insight into the usefulness of future developments (see attached).

### **Peer Review Compliance**

Please see attached Peer Review self-assessment matrix

### **Future Developments**

We would like to consider advice and guidance for GPs to advise on complex cases which do not fit into a particular system eg liver mets identified on US in primary care.

We would like to consider 2 week wait referral for MUOs and CUPs.

We would like to help develop the pleural service in collaboration with the respiratory team, to improve access to pleural drainage and indwelling pleural catheters.

We will be teaching practice nurses and speaking with GPs later in the year on Acute Oncology topics.

Improve access to oncology information for patients admitted as an emergency.

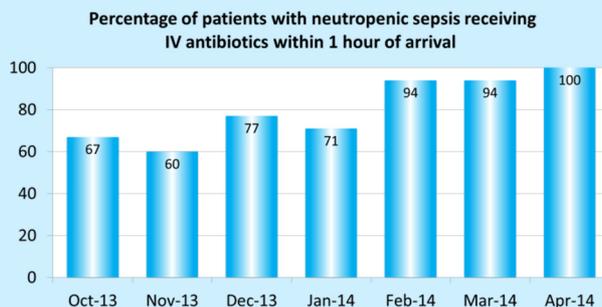
## Acute Oncology Service: the first 2 years

### Introduction

The Acute Oncology Service (AOS) has grown from its infancy starting with the initial Acute Oncology Nurse being seconded to the service in February 2012, to the appointment of the Acute Oncology Lead, Dr Matt Sephton in August 2013, and finally with the arrival of the Acute Oncology Lead Nurse in November 2013. It has grown from strength to strength ever since and the benefits to patients and fellow healthcare teams is becoming ever more evident.

### Improving Antibiotic Door-to-needle Time (ADNT)

By setting up a prospective neutropenic sepsis audit with electronic data capture on iPad, the number of cases of suspected neutropenic sepsis has been more accurately recorded, allowing us to gauge better the size of the challenge of improving ADNT. The percentage of patients with suspected neutropenic sepsis who received IV antibiotics with 1 hour of arrival between October 2013 and April 2014 are:



Key steps to achieving these results include:

- Development of an **electronic audit tool** for iPad for auditing cases of suspected neutropenic sepsis.
- Weekly audit reports to closely monitor performance.
- Comprehensive **teaching and education program** for staff in the Emergency Department (ED) and Emergency Admissions Unit (EAU).
- Improvements in the flagging system to help identify patients at risk of neutropenic sepsis.
- Implementation of a **patient-group directive** (PGD) for the administration of Tazocin in at risk patients.
- Collaborative working with staff in ED and EAU

### Patient Flagging Systems

There are currently 3 flagging systems in place to better identify patients:

- 1) **Flagging for patients on chemotherapy**- the chemotherapy scheduler is responsible for activating the flag when a patient starts chemotherapy and removing the flag 6 weeks after chemotherapy has stopped. When a flagged patient is admitted on PAS, an email is sent to the acute oncology email address.
- 2) **Flagging for inpatients with neutrophil count  $<1.0 \times 10^9/l$**  - it has been possible to work with the pathology department who will automatically send an email to AOS daily with a list of inpatients with a neutrophil count  $<1.0$  within the previous 24 hours.
- 3) **Flagging for inpatients with serum corrected calcium  $>2.8$  mmol/l**

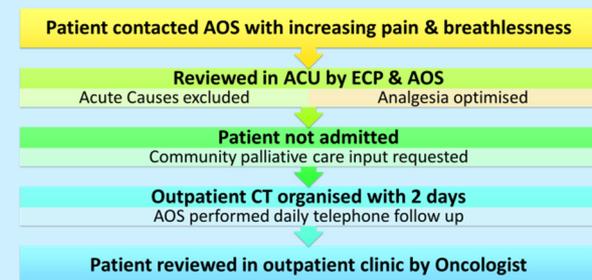
Work is ongoing to allow flagging of an oncology patient to ED staff when a patient attends ED.

### Collaborative Working

AOS is working alongside the **Ambulatory Care Unit (ACU)** in providing an assessment service for outpatients with problems that may be solved as outpatients or problems that may otherwise have necessitated admission. ACU is staffed by Emergency Nurse Practitioners with additional support from the ED medical team. AOS then provides specialist oncology input. Examples of suitable cases for ACU include:

- Possible pleural effusion or ascites that may be dealt with as an outpatient
- Possible DVT or PE suitable for ambulatory pathway
- Chemotherapy-induced nausea and vomiting
- Acute deterioration when it is uncertain if admission is required

The benefits of collaborative working with ACU have included admission avoidance, improved integration of AOS with ED and admitting teams, and sharing specialist expertise in assessing oncology patients with ACU and ED. Here is an example of how an admission was avoided:



AOS has also started to work with the **Frail and Older Persons Assessment Service (FOPAS)**, in supporting a number of cases of new malignant diagnoses identified incidentally during investigations.

AOS share a good working relationship with both **the hospital and community palliative care teams**. Members of AOS attend the palliative care MDT on a weekly basis for discussion of both in- and outpatients.

### Positive Patient Experience and Feedback

To ensure that AOS is providing a valuable and positive experience for patients, a patient survey was undertaken in January and February 2014. 50 postal surveys were sent patients who had any contact with AOS, either just over the telephone or during an inpatient stay. 24 surveys were returned to us, giving a 48% response rate. Key findings include:

- 92% of patient felt **prepared** about what to do and who to contact if they had a problem.
- The majority of patients contacted the hospital on the **same day** that they had their problem or felt unwell.
- 79% of patients said that there was **nothing** that would have improved their recent experience.
- 50% of patients felt that the staff had to rely on information provided by themselves or their family/carer.
- It was mentioned that **coordination between ED and the hospital** could be improved to ensure medical teams have adequate oncology information about a patient being admitted.

It is hoped that the introduction of a new digital dictation system will give other departments better access to oncology information out of hours.