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Are we robbing Peter to pay Paul?

Review radiographers should complement and not replace the skills of the wider team

Definitions

To borrow money from one person to pay back money you borrowed from someone else

Cambridge Advanced Learner's Dictionary & Thesaurus © Cambridge University Press)

To take something from one source and use it towards another

Urban Dictionary .com

The land before time – *The 70's*

Who remembers?

DCR(T)
Anatomy and Physiology
Radiation Physics
Hospital Practice and Care of the Patient

Daily scope of practice

Hospital Practice and Care of the Patient

Normal practice in daily work of treatment radiographers
Basic care including, vital obs. BP, Temp etc.
Dressings - aseptic technique
Skincare
Management of side effects

Drivers for change

Calman-Hine (1995) report - **patient centred** care
On-treatment review radiographer role evolved in the 1990's – Therapeutic Radiography; a vision for the future (COR 1997)
Skills Mix project in radiography (DOH 2003)- 4 Tier system
College of Radiographers (2005) - direction on development of benchmark figures for staffing levels
Role development - Advanced Practice
Impetus from Nursing
Rapidly changing Technological Environment in Radiotherapy

Literature Review

Little evidence available around the ‘on-treatment’ review role

Colyer (2000) - new role better serves the needs of radiotherapy patients

Needs to be supported educationally and clinically

The definition of a new role as expressed by DOH ScHARR (1999) funded study is ‘one that is innovative, non traditional or taking responsibility for aspects of care previously undertaken by another group of health professionals’

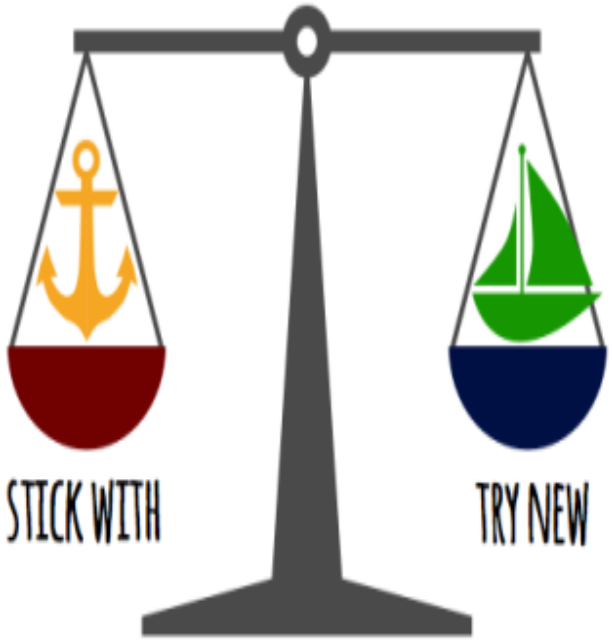
The Ontario Radiation Therapy Advanced Practice Group (ORTAPG) in Canada - outside established scope of practice

Beacon Centre - 2009

Opened 2009
3 x Band 7 Treatment Team Leads
3 x Band 6 Treatment Rads
Newly qualified Band 5s
Repatriation of patients from Bristol over a 12 month period
Patients assessed and reviewed by Clinical Oncologists
Treatment team leads role models for patient care

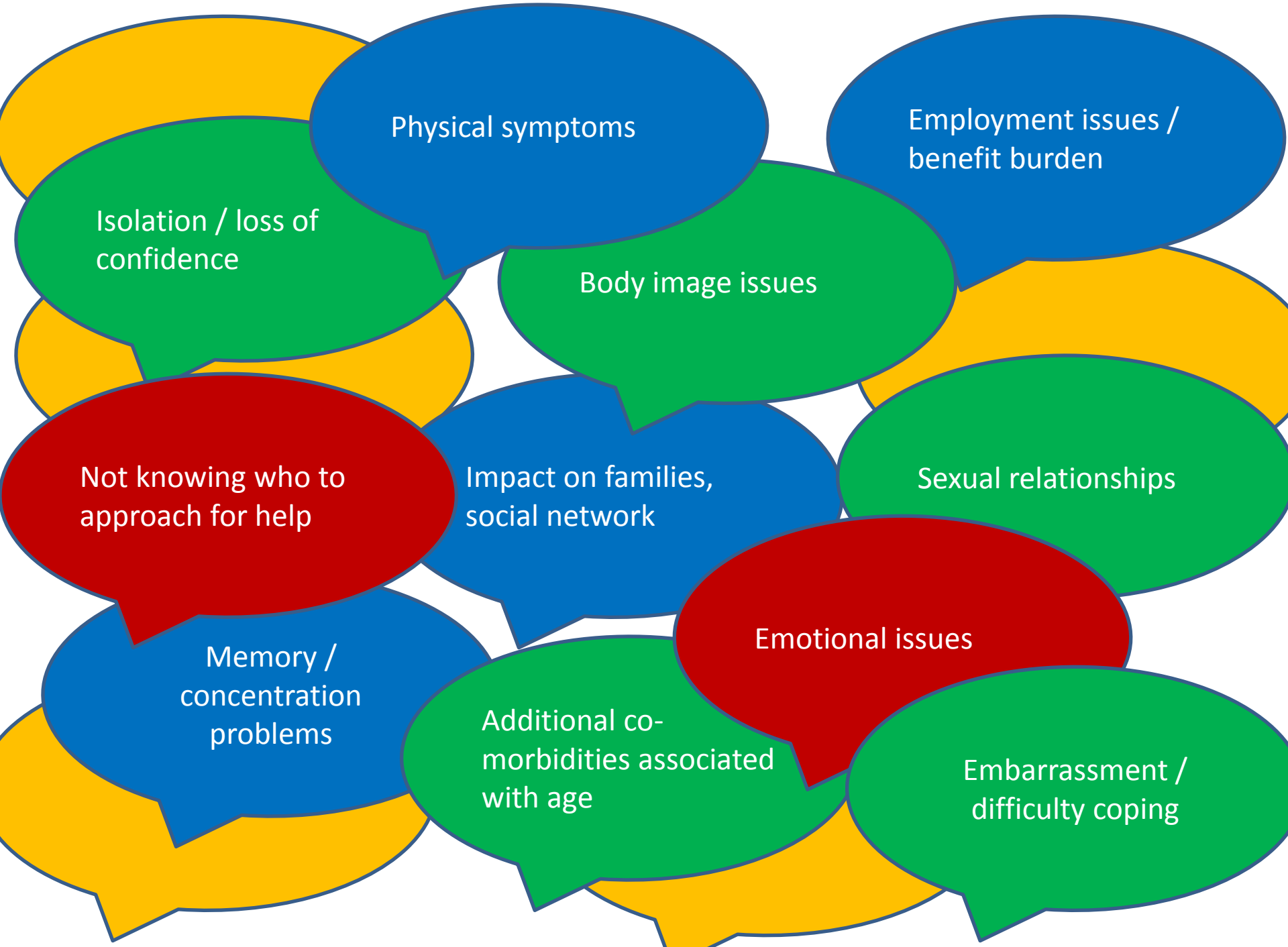
Beacon Centre 2010

- Increased patient numbers-less reviews carried out by Oncologists
- **Secondment 2 WTE Band 7 Radiographers**
- Clinical Guidelines
- Clinical Protocol
- Scope of Practice
- Training Needs- M Level Modules, PGD Training, Shadowing in clinics
- Routes of Referral
- Work Instructions



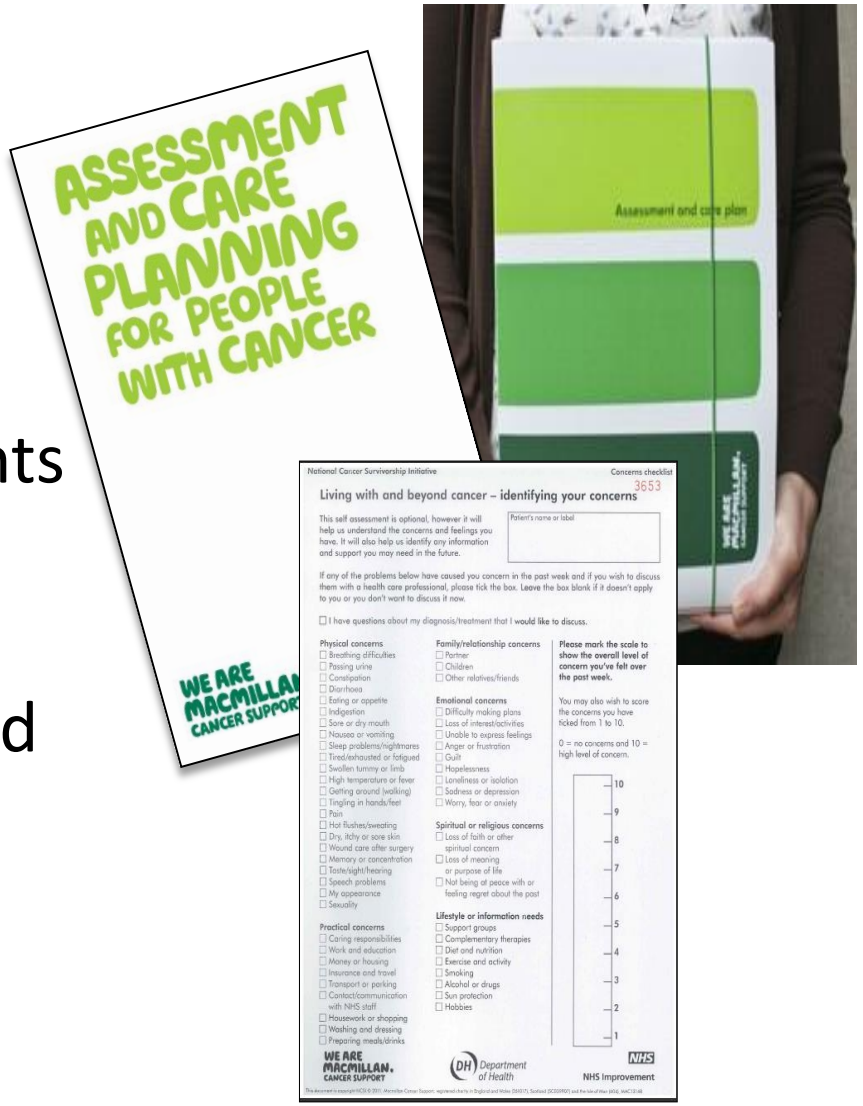
Role development

On-treatment reviews qualitatively different from medical Oncologist reviews
Advanced Practitioner - core member of the MDT
Expert Practice, Clinical Skills, Non-medical prescribing
Site specific or multi-site review roles


Physical symptoms
Employment issues / benefit burden
Isolation / loss of confidence
Body image issues
Not knowing who to approach for help
Impact on families, social network
Sexual relationships
Emotional issues
Memory / concentration problems
Additional co-morbidities associated with age
Embarrassment / difficulty coping

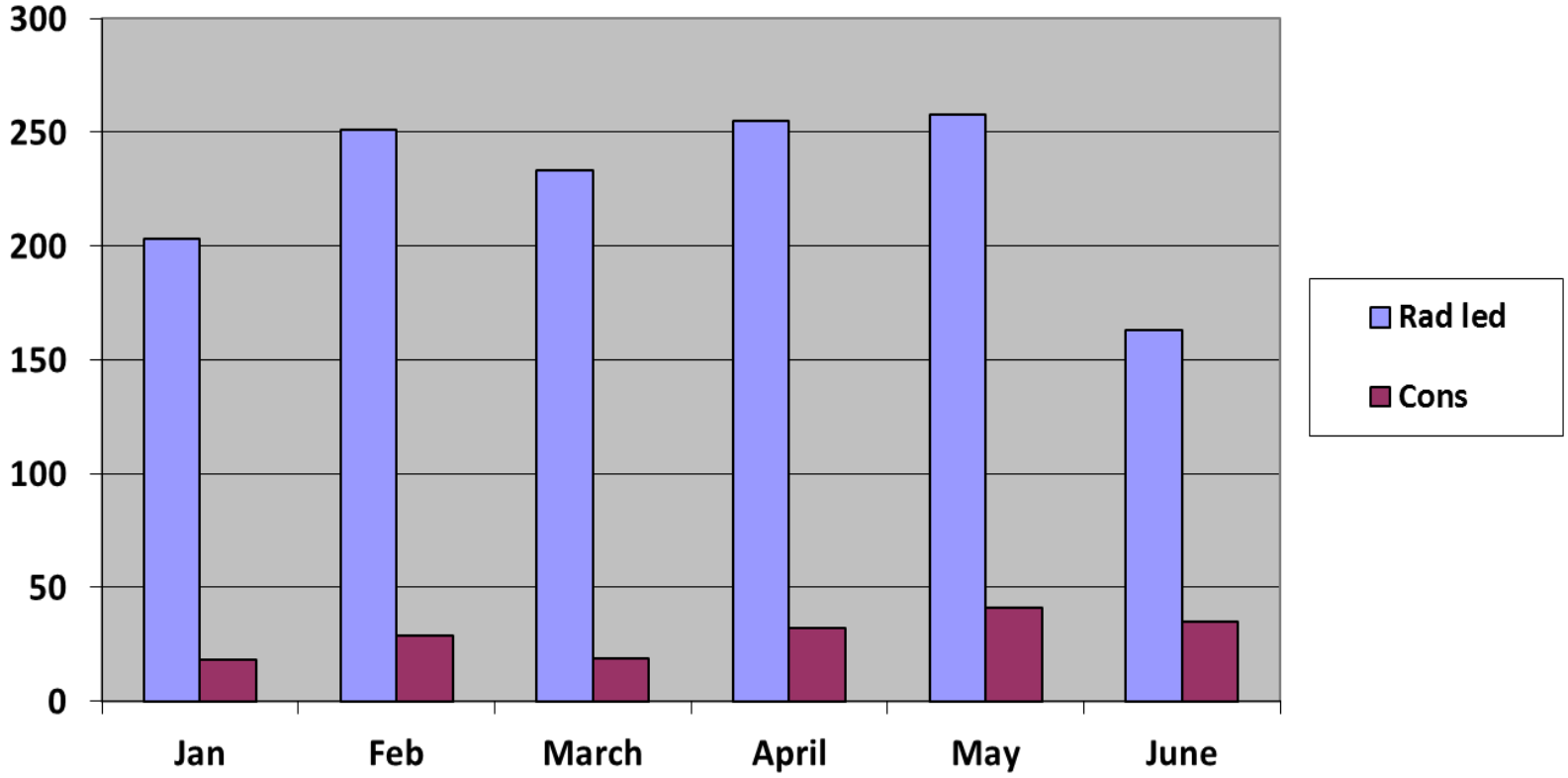
National Cancer Survivorship Initiative (NCSI 2013)

- Holistic needs assessments
- Treatment summaries
- Care planning
- Cancer care reviews
- Health and well-being events
- Recovery package
- Living well beyond cancer
- Macmillan and NHS England partnership (2014)



Recovery Package

On Treatment Reviews in Radiotherapy 2014-the captured review activity showed a 37% increase in radiographer led reviews in 2014 and significant reduction in Consultant reviews

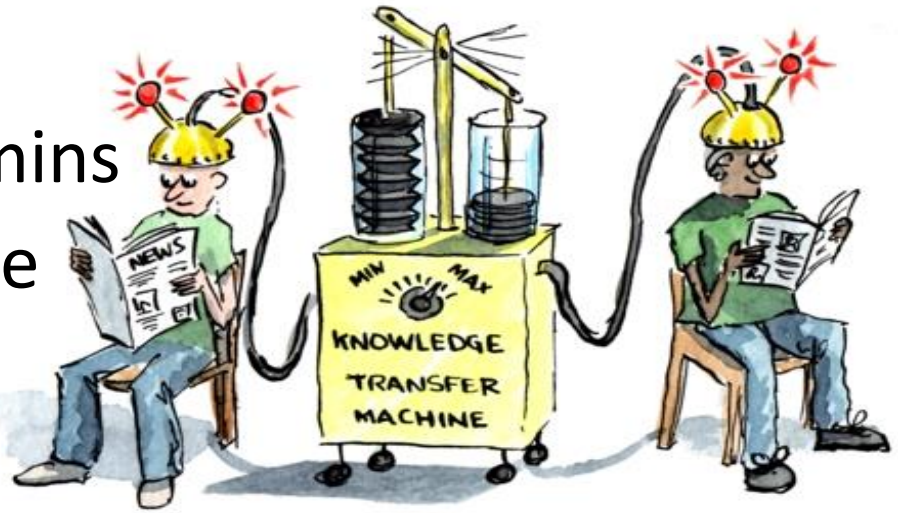


Service development expansion 2014
to implement recovery package

- 1 Late Effects Consultant radiographer
- Supplementary Prescriber(Me)-qualified 2014
- Evaluation of the review service
- Change from clinical management of patients to more patient centred holistic care management
- 2 Full time Band 7 Macmillan radiographers
- Return simple routine assessments to the treatment team
- Treatment staff acknowledge they have lost skills

Revised service

- Grading of reviews from Simple to Complex Levels
- Complex reviews- scheduled 40 mins instead of usual 10 mins
- **Staff training -** simple reviews on set
- PGD training
- **Triage Tool** developed by me-implemented on set



Assessment levels

Level 1

- Simple review involving introductions, visual check of skin / mucous membranes
- Advice given with or without written information / leaflet
- On treatment assessment (carried out on the treatment machine by the treatment radiographers
- Telephone review where simple advice is offered
- Signposting to Cancer Information Centre / complimentary therapies

Level 2

- As Level 1 above **plus:**
  - Visual check of skin / mucous membranes **plus** the addition of simple wound management / intervention (dressings / application of cream(s) / gels, oral preparations etc.)
  - Telephone conversation leading to the provision of supporting advice / information (which involves posting out of literature / collection or goods)

Level 3

- Medication dispensing under PGD
- Review of medications / interventions / blood microbiology / culture and sensitivity results etc.
- Telephone review leading to subsequent GP referral
- Telephone conversation with another Trust based health care professional for provision of continuity of care
- Pre- treatment education sessions where prophylaxis medications

Level 4

- As level 3 above **plus:**
  - Consultations of an intimate nature (vaginal dilation, erectile dysfunction, sexual health
  - Wound care involving aseptic technique.
  - Complex intervention and liaison with other departments for provision of ongoing care or investigations (eg. organisation of voiding scan, arranging catheterisation, NG tube, liaison with MAU / HCP's on other wards)
  - Palliative care referrals
  - Organisation of community based support (eg GP / DN / practice nurse)

Level 5

- As level 4 above **plus:**
  - Clinical examinations
  - Intervention leading to admission, (pre-booked as TCI to Beacon or as emergency through MAU)
  - Intervention requiring supplementary prescribing
  - Telephone review / Consultation involving acute distress.

Level 1

- Visual skin check
- Advice with/without written information
- First day chats
- Toxicity scores recorded
- Signposting to Cancer Information Centre/ Complimentary Therapies

Level 2

- As Level 1 **plus**
- Wound management
- Simple dressings
- Application of gels, oral preparations etc.

Level 4

As Level 3 **plus**
Consultations of intimate nature (vaginal dilation, erectile dysfunction, sexual health)
Complex intervention/liaison with other disciplines for provision of care e.g.Voiding scans, NG tube care, Admission

On-set Toxicity Triage tool

Various assessment tools available
Ours based on Radiation Therapy Oncology Group (RTOG) toxicity scoring - AOS Triage tool
All green graded scored side effects should be manageable on treatment set
Some amber graded side effects may need referral to the Review team - depending upon duration and severity
All red graded toxicity scores to be escalated to the Review team **IMMEDIATELY**

On-Treatment Review ToxicityTriage Tool

TOXICITY	GRADE 0	GRADE 1	GRADE 2	GRADE 3	GRADE 4
Appetite ? Onset-how long	None	Loss of appetite < 5%weight loss from baseline Encourage intake of high calorie foods Monitor weight weekly Refer to dietician	Oral intake significantly decreased & <15% Wt loss from baseline Refer to dietician Alert review team-schedule for review	>15% Wt loss from baseline Dietician Consultant Enteral support required	
Constipation How long since bowel opened? What is normal? Does patient have any abdominal pain/vomiting? Has the patient taken any medication?	None	Mild-no bowel movement in last 24hrs Dietary advice Increase fluid intake Supportive nutritional leaflet	Moderate -no bowel movement in last 48 hr If associated with pain/vomiting alert review team-schedule for review If no pain/vomiting Laxido 1-2 sachets Should work within 12 hours	Severe- no bowel movement in last 72 hours – Alert Review Team who will inform consultant for assessment	Obstruction/toxic mega colon
Diarrhoea Consider Infection How many days has this occurred?	None	Increase to 2-3 stools per day Over pre treatment movements Bristol Stool Chart- Fybogel may be appropriate	Increase 4-6 stools per day Nocturnal stools or moderate cramping Loperamide 2mg – 2 tablets after stool then 1 tablet after	Increase 7-9 stools/day or incontinence or severe cramping Alert review team-schedule to be seen same day	Increase > 10 stools Bloody diarrhoea Needs URGENT assessment/admission

Service Benefits of revised service

- Reduces the risk of a single point of failure as all radiographers become skilled across all areas of practice
- Provides dedicated in house competency based training
- Utilises resources and staffing levels appropriately - Review team undertake more complex reviews (i.e level 4 and 5's)
- Holistic needs assessment
- Recovery Package-Discharge Summaries
- Survivorship issues

Patient benefits of revised service

Re-focus the radiotherapy service around the patients needs

Streamline the patient care pathway through treatment by continuity of care

Enhance the patients experience by meeting their needs and reduce possible side-effects and symptoms by timely interventions and communication

Empower for self management

Staff Training needs

Allocated time with on-treatment review team during preceptorship
Induction training
Standardise and support excellent practice
Provide robust framework for toxicity assessment
Promote use of tools, policies and guidelines
Train Treatment Team Leads and Band 6s in PGD dispensing

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

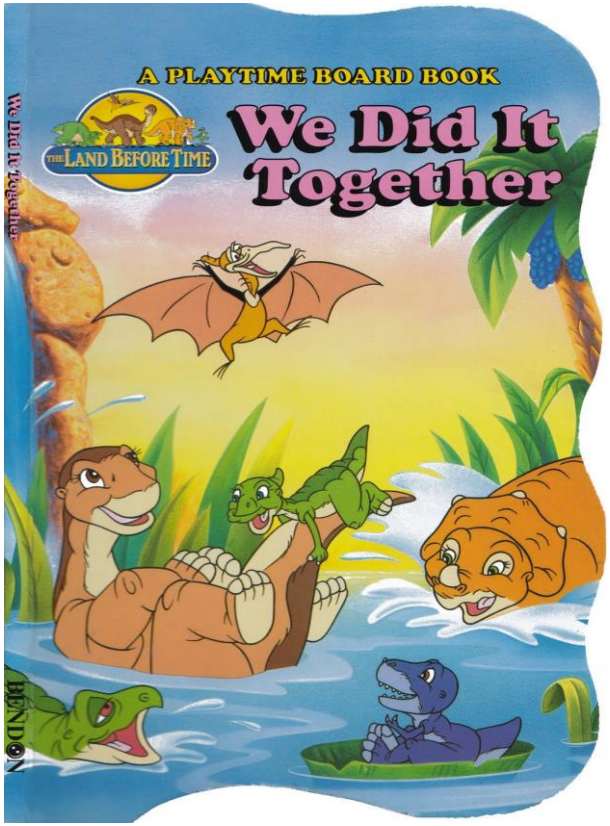
Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.*

Better treatment and care for all. *It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes: for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

‘We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is co-ordinated between primary and acute care, so that patients are assessed and care planned appropriately’

Acknowledgements



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