External Review of Medical Oncology Services at the Hunter New England Local Health District

In 2011 HNE Health and Calvary Mater Newcastle commissioned an external review into medical oncology services across the district which examined issues including consistency of reporting tools; service delivery benchmarks; staff specialist workload, workforce management and succession planning; and wait list management. HNE Health and Calvary Mater Newcastle support 21 of the 24 recommendations from that review.

Supported Recommendations:

Recommendation 1: HNE plan for recruitment of medical oncologists across the region according to benchmarks used by Australian Medical Oncologist Workforce Study by Medical Oncology Group of Australia (MOGA). This will also require planning for multidisciplinary staff to support chemotherapy services and collaborations with private providers.

Recommendation 2: It is recommended that no further expansion of sites occur in Hunter New England until an appropriate increase in Medical Oncology FTE has been achieved. As part of the development of a HNE cancer service plan and Medical Oncology Futures Document 2016, medical oncology FTE needs to be reviewed using MOGA benchmarks and consideration given for extra FTE and service planning in Tamworth, Taree and the Hunter Valley (Cessnock/Maitland). Requirements in Taree should be planned in consultation with North Coast/Port Macquarie

Recommendation 3: The cross-cover arrangements and leave management processes are minor by comparison to the inadequacy of the FTE. It is imperative that staff take their recreation leave, especially in a system that is under strain as an inability to do this will result in increased burn-out which will put further strain upon the system.

Recommendation 4:
a) Review of the resident/registrar structure across oncology should be done and consideration made to allocate a resident to the Day Oncology unit. This role is necessary to provide support to nursing staff through patient assessments, management of treatment toxicity effects, writing scripts for patients, managing adverse events related to IV infusions, admission of patients when necessary.
4b) The unit structure should move to a one or 2 medical oncology team structure. Currently each consultant is assigned an advanced trainee and does their own ward rounds. A one or two unit structure would be more efficient and enable more time for clinics, research and administration.

Recommendation 5: The triage oncology nurse should be re-instated. This role needs to expand to include coordination of chemotherapy treatments in the Day Oncology Unit and the Oncology Inpatient Unit. The current method of registrars spending several hours per week sorting through referrals is not efficient and is contributing to blocks in patient appointments and may be partly contributing to the patient waiting list.

Recommendation 6: The ARIA should be used to manage the triage process and resources should be made available to improve the efficiency and uptake of the ARIA system.

Recommendation 7: Proper figures should be kept regarding waiting times across New South Wales. It was not possible to benchmark HNE medical oncology services against similar services. ARIA system only measures day centre activity and therefore

ignores the inpatient workload for Medical Oncology and Medical Oncology consultation service. This is clearly an issue and needs to be harmonised.

Recommendation 8: Pre-chemotherapy reviews need to be pre booked to prevent patients receiving chemotherapy without toxicity assessments and general review.

Recommendation 9: The flow of patients through the Department of Medical Oncology is not very smooth; there would be value in undertaking a process mapping exercise, guided by a trained facilitator, to look at what actually happens during the journey of the patient from referral letter being sent, to chemotherapy being started. The value in such an exercise is that it shows up blocks that might not even be suspected, while allowing effort to be spent on reducing them.

Recommendation 11: A joint academic and clinical appointment of a senior Medical Oncologist should be appointed. Discussions should occur with University of Newcastle for funding at least one medical oncology staff position to ensure adequate links with the medical school and in recognition of the teaching performed by the CMN staff.

Recommendation 12: There seems to be some uncertainty between Calvary Mater and Hunter New England in terms of quantum of Medical Oncology service paid for by Hunter New England for delivery at Calvary Mater and this needs to be clarified so that adequate service provision can be made. There is a feeling in the unit that the lack of clarity in the arrangement may be a potential causative factor in the inability of the department to grow. Historical funding levels may no longer be appropriate given the rapid increase in service demand.

Recommendation 13: Standardise planning for outreach clinics. An increase of FTE of Medical Oncologists would assist service regional and rural clinics. Planning for outreach clinics also needs to consider those in operation at Muswellbrook, Armidale, Taree and Moree. An appropriate step would be for a planning document for outreach clinics that considers population needs balanced against availability of staff, minimum standards for each facility, training and CME for staff, roles and responsibilities, back-fill/cover arrangements, unified treatment protocols and procedures, shared care plans, implementation of communication systems (ARIA or other) across the region.

Recommendation 14: Standardised pharmacy paperwork and write scripts prior to day of chemotherapy. Employ a dedicated Clinical Trials Pharmacist. Outsource all non-trial chemotherapy.

Recommendation 16: The team leader of the administration team (PA's) is currently reviewing the roles and functions of the service. The team leader undertaking this review and implementing changes requires support by management to implement and review any proposed changes.

Recommendation 17: The Director of Medical Oncology should come with a minimum 0.2 FTE protected administration time allocation which is backfilled by increasing the FTE in clinical areas. Likewise the leadership of the Medical Oncology Stream should come with further administrative time (0.3 FTE) and this needs to be organised between Hunter New England and Calvary Mater. Giving sufficient protected administration time to the Director of Medical Oncology would result in clinical sessions being freed up to employ new staff, and the ability to undertake strategic policy development and implementation to accelerate service improvements and efficiencies.

Recommendation 18: Hunter New England should support the development of a stand alone private service with fulltime private medical oncologists. There does appear to be chair capacity in private and it may be possible to purchase services from the private system at least to increase the number of patients able to be treated once they have been seen.

Recommendation 19: Increase funded chemotherapy chairs at CMN from the current 12 to 16 (these are separate from the 4 funded clinical trial chemotherapy chairs) this automatically will reduce the waiting list for treatments quite substantially.

Recommendation 20: Replace the team leader position in the Oncology Day Centre with a Nurse Unit Manager (NUM) dedicated to Day Oncology Centre only.

Recommendation 21: Appoint a junior doctor dedicated to the Oncology Day Centre.

Recommendation 23: The time from the end of triage process to an appointment can be shortened by increasing the number of available clinic slots and medical oncologists, increasing the flexibility of the clinic slots, increasing the efficient use of ARIA to enable smarter clinic booking and increasing the number of doctors available. Clerical support should also be increased.

Recommendation 24: Undertake job planning/sizing for consultant medical oncologists and trainees.

Unsupported recommendations:

Recommendation 10: A unified cancer service (physically and organisationally) may lead to a number of efficiency gains and improved outcomes for the patients of the region. Consideration should be made of unifying medical oncology, radiation oncology, palliative care, research and cancer support services by collocation, and sharing of governance and administrative functions. Strong governance links should be formalised with surgical oncology services.

Recommendation 15: Consideration should be given to installing computer screens by every chair in the day centre. This will allow nursing staff to work more effectively and efficiently, rather than having to move their computers on wheels.

Recommendation 22: Review nursing leadership within the HNE Health. Due to the large geographical area of HNE and the increasing complexity of cancer care across the region there is an identified need for consistency across nursing practices and standards of care, a Director of Nursing/Director of Nursing Clinical Practice would be responsible for overseeing nursing practice across the region.