Implementing a nurse-led model of unscheduled cancer care: a statewide evaluation of Symptom and Urgent Review Clinics

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Steering committee members

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Background

The number of Australians diagnosed with and living beyond cancer treatment is exceeding system capacity to deliver timely and equitable access to care.

Symptom and Urgent Review Clinics (SURCs) were established to address systemic, system-level barriers to timely access to care for Victorians requiring outpatient SACT in response to the growing number of patients and a resource constrained health sector.

Background

Symptom and Urgent Review Clinics are nurse-led services that aim to increase access to symptom management support for community-dwelling individuals who are receiving systemic anti-cancer therapy in the outpatient setting.

Aim

To describe the structure and processes of SURCs and how they have been implemented across Victorian health services. In addition, this project aimed to explore potential indicators of quality service delivery that may be used to monitor and evaluate the service going forward.

Methods

1) Semi-structured interviews with SURC affiliates (health care professionals involved in the implementation or delivery of SURCs).

Interview participants were asked to **describe their local SURC model**, including **local inputs or resources**, the **intended users or eligibility criteria**, **activities** undertaken by the SURC nurse and the **intended or perceived outcomes** of implementing a SURC.

- Interviews were conducted online, audio recorded and transcribed verbatim using Otter.ai
- Interviews were analysed thematically (Braun & Clarke)

Methods

2) Surveys were conducted using the Delphi method to build consensus on potential quality indicators.

- Based on the results from the semi-structured interviews, SURC affiliates were invited to participate in a series of surveys to refine quality indicators of SURCs.
- Members from the expert reference group were invited to rate the importance, feasibility and utility of each data point that represented potential quality indicators for SURCs.
- Cut-off for inclusion was set at ≥ 75% ‘agreed’ or ‘strongly agreed’

Results

In June - July 2022, 32 interviews were undertaken with SURC affiliates

- 19 nurses
- 10 health service managers
- 3 doctors

Participants worked across 17 different Victorian health services, of which 53% (n = 9) were metropolitan health services and 47% (n = 8) were regional health services.

The average number of years of experience working in cancer was 17 (SD 9).

Results – semi-structured interviews

There were five key themes generated from the semi-structured interviews:

01	02	03	04	05
Without a SURC	Objectives and benefits of implementing a SURC	The process of implementing a SURC	Common elements of the SURC	Measuring and evaluating care delivery

Theme 1 – Without a SURC

This theme relates to either the process **before SURC was implemented** or the process **without a dedicated resource** to deliver the SURC service for organisations that did not have a dedicated nurse to deliver the SURC service.

- **haphazard management** of patients and caregivers who contacted the outpatient cancer treatment unit before the SURC service was implemented
- **challenge of providing reliable support and follow up of patients' concerns.**

Theme 1 – Without a SURC

"The team leader's role is to keep the floor going and keep the treatment going to adjust the floor to look after the treatments that are happening on the day […] just because they had a phone that patients were coming through to them […] you could manage things sort of haphazardly […] then things get busy, so that sort of drops off." Participant 23 – Regional SURC Nurse

"I think that's probably one of the biggest ones is that the patient might get helped. But there's nothing documented to say how that occurred, or what the management was." Participant 5 – Regional SURC Nurse

Theme 2 - Objective of implementing the SURC

This theme relates to the intention or objective of implementing a SURC service as described by participants. This theme has four sub-themes:

1) local aims
2) organisational aims
3) benefits to patients
4) benefits to nurses.

Theme 2 - Objective of implementing the SURC

Local aims

- Reducing unscheduled phone calls to outpatient nurses
- Reducing late treatment cancellations and associated costs
- Addition of senior cancer nurse within the department
- Reduction in short-notice outpatient clinic appointments

Benefits to patients

- Provide a reliable point of contact
- Access to timely quality care by nurse with cancer expertise
- Opportunity to support patients beyond physical symptoms
- Early symptom reporting and management

Organisational aims

- Reducing ED presentations and unplanned IP admissions

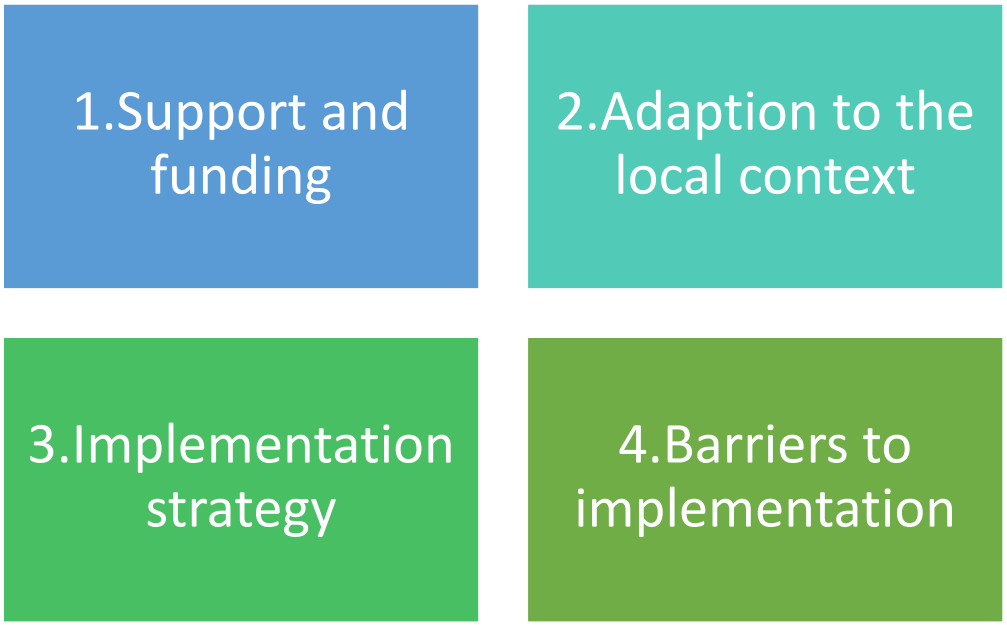
Benefits to nurses

- Opportunities for career progression
- Professionally rewarding

Theme 3: Implementation of the SURC

This theme relates to the process of implementing a SURC, and has four sub-themes:

1) Support and funding;
2) Adaption to the local context;
3) Implementation strategy; and
4) Barriers to implementation.



3.1. Support and funding

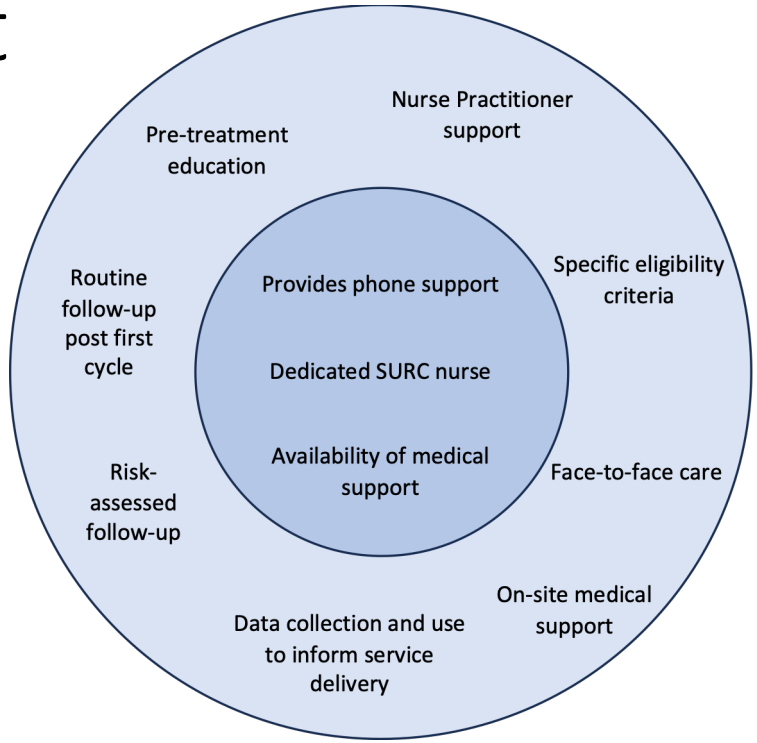
Funding from the Vic Dept of Health was seen as **key to implementation success.**

This resulted in rapid implementation creating external pressure and desire to implement a SURC.

3.2. Adaption to local context

Adaptability was an important aspect of implementation.

Core and adaptable components were described by participants (figure).



3.3. Implementation strategy

- Engaging with key stakeholders through a steering committee
- Consumers were not always included
- Recognise the need for organisational buy-in and support from medical leadership to advocate for sustainability
- Small number spoke of formal implementation strategy including promotion internally and externally, pathways to care (e.g. radiology, access and demand)

3.4. Barriers to implementation

Physical infrastructure

- Physical space for nurse to work and for F2F reviews/treatment
- Limited space impacted ongoing delivery of the SURC and resulted in ED referrals

Access to IP beds

- Access to IP beds a common barrier to effective service delivery
- At times this resulted in referring to ED to facilitate IP admission

Human resources

- Availability of appropriately qualified nurses to deliver care
- Availability of medical support impacted efficiency

Funding

- Obtaining funding beyond initial pilot
- Demontrating cost-benefit to the organization
- 'Piggybacking' onto other funding opportunities

Theme 4 – Elements of the service

Context

Patients treated with SACT experience symptoms while at home and require access to advice to manage symptoms or seek health care

Patients/caregivers are often unable to access timely quality care from clinicians with cancer expertise

CDU staff are under-resourced to respond to increased demand for advice from community-dwelling individuals receiving SACT

SURC Nurse-led service
Telephone based service with capacity for in-person review when required

Co-located in the chemotherapy day unit

Hours of operation
- During business hours
- After hours and weekend service

Inputs

Human resources
- Nursing EFT
- Nurses with appropriate knowledge, skill, experience
- Medical / NP support
- Clerical/ admin support
- Access to allied health

Physical resources
- Physical space – clinic room +/- access to additional space
- Computer/desk set up
- Portable phone/mobile phone
- Equipment/consumables

Information technology
- IT system (existing)
- Data collection system
- Data analysis (skill/resource)
- Mobile phone/infrastructure to send images
- Communication infrastructure (e.g. email, messaging with medical staff)

Education and training
- Education and training for new SURC nurses
- Ongoing support for the SURC nurse (supervision, debriefing)
- Structured time for CPD

Governance
- Governance structure /steering committee

Outputs

Activities

- Introduce and promote SURC
- Telephone triage
- In-person care
- Assess/manage symptoms
- Assess & respond to supportive care needs
- Assess health literacy
- Patient education (formal/informal)
- Follow-up/outreach care

- Communication with other HCPs (receive and respond to telephone calls, send communication letters)

- Data (collect, analyze, report)

- Provide education to other HCPs (e.g. side effects, assessment, management)
- Promote SURC to HCPs and potential referral sources

Reach

- Community dwelling individuals receiving SACT (IV +/- oral)
  - Who are commencing or changing treatment
  - After completing cycle 1
  - Who have contacted the hospital after hours / outside SURC hours
  - Who have been referred by other HCPs
- Caregivers of eligible individuals
- Patients who are in the CDU and who present with symptoms
- Eligible patients admitted to the inpatient area who are not admitted to a cancer-specific ward
- Post discharge from an inpatient admission

- Flexible criteria for those who don't have an alternative

- GPs
- Cancer specialist physicians
- Other healthcare professionals

Outcomes - impact

Short term

Patient/caregiver
- Increased patient contact/ activity
- Documentation of patient assessment / care
- Increased access to timely quality care
- Increased access to specialist cancer advice/care (patients, caregivers, other HCPs)
- Increased access to in-person care and hospital admission
- Reduced costs for patients
- Increased access to support for caregivers
- Improved patient and caregiver health literacy and service navigation

Local
- Reduced calls to CDU nurses and registrars
- Reduced same-day treatment cancellations

Organisational
- Reduced low acuity ED presentations

Long term

Patient/caregiver
- Improved support for patients during treatment and with treatment/cancer related sxs
- Improved symptom management (via surc feedback and education)
- Earlier reporting of symptoms
- Improved self-management of symptoms
- Improved patient experience
- Improved self-efficacy of patients/caregivers

Local
- Availability of senior nurses as a resource in the CDU
- Increase in delivery of education for nurses on common SURC sxs – increase in CDU knowledge
- Review common complaints and delivery of / quality of care
- Improved quality of service delivery
- Reduced number of late treatment cancellations
- Improved clinician satisfaction (being able to offer additional support)
- Senior cancer nurse resource
- Cancer nurse career progression opportunity
- Improved communication to GPs

Organisational
- Improved organisational reputation
- Reduced pressure on inpatient beds

Assumptions
Availability of appropriately qualified and skilled staff
Patients are able to access the service
Adequately resourced to deliver service

Internal/external factors
Availability of funding, COVID-19, local support for SURC, availability of IP beds when patients need admission

Theme 5 – Measuring and evaluating quality service delivery

- Patient satisfaction or experience
- Activity as a proxy for measuring trust and satisfaction
- Hours of operation
- Technical skills and expertise of SURC nurses
- Timely access to telephone and in-person review
- Knowledge and awareness of the service
- Process to identify ‘at-risk’ patients and proactive follow up / outreach
- Data collection and utilisation
- HCP referrals
- Referrals to ED because of capacity
- ED presentations post SURC contact
- Alignment with current best practice evidence

Potential quality indicators

- Individuals involved in implementing or delivering a SURC service, or in health and cancer policy were invited to complete a Delphi survey **to identify potential quality indicators** for the SURC model.
- **34 people responded to the first Delphi round, and 24 responded to the second round.**
- The SURC expert reference group was then invited to rank the **importance, feasibility, and utility** of the preliminary quality indicators.

Necessary quality indicators

Three of the preliminary quality indicators met cut-off criteria (≥ 75% agreed or strongly agreed) for all three domains (importance, feasibility and utility) and were deemed ‘necessary’.

1. SURCs have a documented process in place to **inform all patients and caregivers** of SURC and its role
2. Organisations have a documented process in place to record that SURC nurses complete the **appropriate training** in patient assessment, telephone triage, communication, and supportive care
3. It is recommended that nurses working within SURC have relevant **post-graduate qualifications** and maintain **relevant continuing professional development** hours

Supplementary quality indicators

Six of the preliminary quality indicators met criteria for 'supplementary' quality indicators (≥ 60% agreed or strongly agreed).

1. SURCs have a documented process to **assess patient's awareness and knowledge of SURC**
2. All patients are **aware of and understand the role of the SURC**
3. SURCs have a documented process to **identify and prioritise individual**s who **need proactive follow-up**
4. SURCs have a documented process in place to collect data about the **number of patients directed to an ED for review because of SURC capacity and resource restraints**
5. SURCs have a documented process in place to collect **patient experience data** on a biannual basis (this includes timely access, receipt of care via telephone and physical review)
6. Organisations have a documented process in place to ensure all patients commencing systemic anti-cancer therapy receive a **dedicated pre-treatment education session**

Quality indicators

- 20 of the 23 potential quality indicators were rated as ‘important’ by the expert reference group
- This indicates that they felt that the indicator **targeted an important area** where there is a clear gap between the actual and potential level of healthcare that can be influenced by improvements in the quality of care but that the **data was not feasible**, or not understandable by the intended audience.

Take home message

SURCs are a highly valued component of cancer care. Stronger support is needed for implementation, evaluation and monitoring.