The specialist nurse role using KPIs as a possible metric for performance of the service. The workload analysis showed that lung cancer specialist nurses were spending a large amount of time (58%) on administration. This was primarily on work to support meeting the two-week wait target, as well as administrative and clinical support for the multidisciplinary team meeting, such as booking routine investigations and providing secretarial support to the cardiothoracic service. This was in direct contravention of best practice, which acknowledges specialist cancer nurses should have input into managing services but does not mean they should bear the burden of administration (NCAT, 2008). This was not a productive use of nursing time.

The team decided to make the service more patient focused. It was unclear how patients’ needs were being met or if care was not as good as expected, so we telephoned a selection of patients (n = 30). The basis for selection was no recent (>30 days) contact with any member of the multidisciplinary team. They had had little contact with the lung cancer nursing team, collected data on the nature and frequency of readmissions to the acute centre were for symptom control in the previous six months. Before these admissions, they had had little contact with the multidisciplinary team and the patient (that is, the point to which intervention was escalated).

In line with the workload of most lung cancer nurse specialists, the majority of patients in this group were having active supportive care or symptom control only. Patients were contacted regularly as necessary, at least once a month. Colleagues in the community palliative care team as well as hospice and GP colleagues were able to respond to issues as a shared caseload. If a patient with advanced lung cancer had an issue with dyspnoea, this could be assessed and managed in the community or admission arranged for an acute cause.

Acute oncological emergencies that could not be managed in the community, such as pleural effusions, came back to the acute centre, as did patients needing any other acute intervention. This meant management was in line with best practice guidance in lung cancer and supportive care (NLCFN, 2009; DH, 2007; National Institute for Clinical Excellence, 2005).

The lung cancer nursing team collected data on the nature and frequency of readmission. The previous six months (January-June 2009) were used for comparison as part of an evaluation cycle (Fig 1). The team included KPIs, including rate of readmission and reason for readmission for non-acute oncology issues, such as poor symptom control. (Admission to the acute centre should only be for an acute problem or if the centre is a designated preferred place of care for end-of-life care.)

Patients were also given contact details of the specialist nursing team, so could trigger a call to the team if they came to the emergency department.

**Results**

Audit results before and after proactive