The testing showed the effectiveness of managing patients’ symptoms in the community. However, the method of implementation was difficult to sustain and has highlighted a need for a more integrated approach between primary and acute care in supporting patients with breathlessness.

Evaluation of the patient alert has demonstrated the need for an automated system that is triggered when a known cancer patient is admitted to hospital. The trust is exploring how this could be linked with the Gold Standards Framework.

The testing indicates that focusing on reasons for admitting cancer patients can highlight specific needs.
BACKGROUND

- Lung cancer is one of the most common cancers in the UK, with around 35,000 new cases diagnosed each year (Registrar General, 2004).
- The lack of early presenting symptoms results in patients often being diagnosed with advanced disease, where the emphasis is on palliative treatment and supportive care (Claxton, 1999).
- Moving quickly through an illness trajectory presents a major challenge for patients, families and health professionals. As the disease progresses, patients have to contend with worsening symptoms.

The project focused on lung cancer stages 3b and 4, according to the TNM classification for non-small-cell lung cancer (Mountain, 1997). Stage 3b means locally advanced disease and stage 4 denotes metastatic spread.

It was hoped that the teams could offer patients self-management techniques for breathlessness and enough support to avoid them hitting a crisis point at home. Key workers would act as the lead in primary care, supporting patients and families and referring to other professionals as needed, including the palliative care team.

In order to assess whether a potential admission had been averted, the key worker used a validated assessment tool. This was developed by Northampton PCT and is used across the PCT to identify when an intervention by primary care practitioners has prevented an admission.

Emergency admission alert system

To reduce the length of patient stay, an alert system from the EAU to the lung cancer CNS was initiated.

This involved staff on the EAU alerting the CNS when known lung cancer patients were admitted. The CNS would see patients within 24 hours of the alert, with the exception of referrals over the weekend, and acted as the hospital key worker, supporting patients and families throughout the inpatient stay.

RESULTS

From June 2006 to January 2007, 65 patients were assessed for breathlessness, of whom 39 had symptoms of shortness of breath. Of these, 28 took part in testing and were referred for additional community support. The results showed that:
- Patients’ breathlessness experience was improved by individual interventions offered by the community key worker. However, there was no significant improvement in the amount of breathlessness they experienced;
- The admission rate fell from the baseline study. At baseline, there were 10 patients with 18 admissions, compared with 28 patients with nine admissions at the end of the third phase of the project. Six admissions were reported as having been avoided, although this was difficult to measure because of the subjective nature of the assessment tool and the trajectory of the disease;
- The key-worker role provided continuity of care for patients following discharge and before they needed specialist palliative care. It enabled patients to be cared for in a proactive way, and difficulties experienced by patients and carers were acted on before they became unmanageable;
- This key-worker role enabled the CNS to discuss and manage admissions to hospital and there was liaison between patients’ GPs and the specialist nurse. However, not all patients wanted the support of a key worker in primary care, such as younger patients who declined to take part in the project;
- The average length of hospital stay at baseline was 12.5 days. At the end of the second phase of the project, this had fallen to 8.8 days. It now stands at 7.1 days.

Other findings

In the baseline audit, no discussions about place of care were documented in the hospital notes. At the end of the first phase, there were eight patients with a place-of-care discussion documented because of the CNS’ input. Seven of these had died, with five having had their place of care met. This was seen as a positive development and in line with national recommendations.

There was, however, a feeling that care had been duplicated in some cases, with several healthcare staff visiting patients at home for breathlessness interventions.

Since February 2007, the alert system has been extended to all patients with a known cancer diagnosis admitted via EAU.

Feedback from the specialist nurses indicates that the system has enabled them to be aware of patients earlier and support them through their inpatient experience. Symptoms have been dealt with promptly and place-of-care discussions have been instigated. However, the system has not been successful across all tumour groups, particularly for patients with prostate cancer, who tend to be admitted for symptoms unrelated to the cancer.

CONCLUSION

The three strategies tested the following: managing symptoms in the community; integrating the key-worker role between primary and acute care; and an effective alert system from emergency admission. The combination of the strategies has had a significant impact on the lung cancer pathway. This has enabled patients to be cared for at home, has improved confidence in managing symptoms and, where patients are admitted to hospital, has reduced length of stay.

REFERENCES


NICE (2004) Improving Supportive and Palliative Care for Adults with Cancer. London: NICE.