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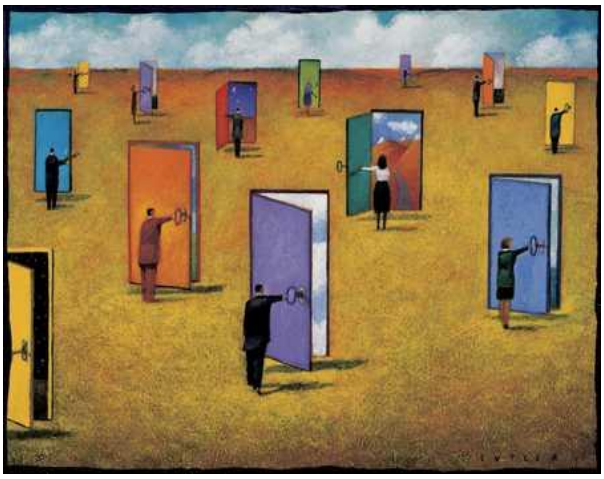
Opening doors to treatment

Exploring the impact of lung cancer specialist nurses on access to anti-cancer treatment: an exploratory case study



Project Summary

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Opening doors to treatment: Exploring the impact of lung cancer specialist nurses on access to anti-cancer treatment, an exploratory case study

Summary

Background

This exploratory study examined how different Lung Cancer Nurse Specialists (LCNS) worked within their Multi-disciplinary Teams (MDT) to have a positive impact on patient access to anti-cancer treatment. The study used a mix of qualitative methods including individual and group interviews, observation and documentary analysis.

The project was developed in response to the finding from the National Lung Cancer Audit (2010) that 64% of patients who saw a LCNS received anti-cancer treatment, compared to 30% of patients who did not see a LCNS. This project aims to generate insight to understand what it is the LCNS does that increases patient access to treatment.

Aim and scope

The aim of this study was to conduct an initial exploration to generate understanding of the role of the LCNS within the lung cancer multi-disciplinary team and identify factors that assist the LCNS in increasing treatment access for people with lung cancer and to generate recommendations for LCNS practice, MDT working and for future research.

Methods

Case study methods were adopted including individual interviews with the LCNS, clinical lead and up to four additional MDT members, observation of the MDT meeting and documentary analysis. NHS Research Ethics was not required as only staff were involved. NHS Research Governance and University Ethics approval was obtained.

Sample

The case was the LCNS. Four cases were purposively selected to include LCNSs working in sites with high and low treatment access as identified by the National Lung Cancer Audit (NLCA). The NLCA data was used to inform selection of sites with different treatment and LCNS access for patients. Individual interviews were conducted with up to six clinicians per case, comprising, the LCNS (n=4), the lead clinician for the MDT (n=4), plus three to five other MDT members (total for MDT members = 16). A total sample across staff groups was

24. One MDT meeting was observed for each case study site along with documentary analysis of a small sample of (n = 2-3) documents related to the LCNS role, for example job descriptions, patient pathways and protocols.
Two focus groups were held at the end of the study to expand and verify the findings amongst a broader sample of LCNSs (n=6) and wider MDT members (n=2).

Findings

The findings provide in-depth insight and understanding of the way the LCNS has an impact on treatment access, through their influence upon and work with patients, staff and organisational structures, processes and systems. The LCNS worked differently in the different sites according to local resources, geography and demographics. However, elements of the way they worked were similar and were seen to be instrumental to their impact to treatment access. The role was pervasive and had an influence across a range of people, places and structures. Unlike other MDT members, whose input was more episodic, the LCNS was the one MDT member who worked continuously with the patient across the pathway. The LCNS was referred to as the "hub", as being key to the delivery of care and the efficiency of the related systems and processes. Core themes that described this pivotal contribution were having a central role, continuity, co-ordination, and support and advice.

The specialist nurses worked flexibly and in an entrepreneurial manner in order to enhance their impact on patient care and outcomes, such as treatment access. The findings describe how the LCNS is able to enhance delivery of the whole service and function of the MDT. However, this means it is difficult to extract any one particular element which is discrete to the LCNS impact on treatment access. The picture is much more complex and the LCNS impact is symbiotic and synergistic to the working of the MDT. What is clear is that the LCNS role is crucial and at times the catalyst to patient eligibility for treatment. Some participants did not appreciate the extent of this impact until they reflected on practice due to participation in the study. The impact on treatment access is described here in terms of the tasks identified that the LCNS undertakes, for example assessment, managing symptoms and early and appropriate referral.

The co-ordination and communication aspects of the LCNS role are essential in realising the impact in increasing treatment access. The findings illustrate how the LCNS is described as the hub, the oil on the wheels, the central cog, and in this way makes things happen. Without a LCNS the MDT members highlight how continuity and advocacy is absent, and how that void can obstruct treatment access.

The LCNSs in this study clearly worked to an advanced level of clinical decision making. Whilst co-ordination, linking and liaising were crucial dimensions of the role it is important to realise that this aspect of the role isn't just administrative but involved high levels of clinical decision making e.g. ordering, interpreting and acting on tests and investigations, referrals and prescribing. The expertise the LCNS brings to the service is evident in the study in terms of knowledge of the patient population, the disease trajectory, how relevant services work and how to get the best out of those services. The LCNS could often anticipate and deal with problems that could obstruct treatment access. These problems could be patient focused, such as fear and denial or organisational, such as the need to improve tracking systems. If the LCNS did not pre-empt these issues and deal with them it is difficult to see who else would be in a position to do so.

Aspects of the LCNS role were challenging for the cases because of lack of funding and an increasing workload. Another constraint that was identified relates to reliance on the LCNS to undertake administrative tasks which hindered their ability to work efficiently and maximise patient outcomes.

In financially constrained environments it would be tempting to see the LCNS as an expensive resource, and therefore vulnerable to cuts. However, this study demonstrates how integral the role is to efficient and cost-effective care, as well as increasing treatment access. The results also indicate how the LCNS role is enhanced when the organisational structure is stable, relationships with MDT members is harmonious; they have support and supervision and information systems that are efficient and not cumbersome.

As this study emerged from an observed association from the National Lung Cancer Audit, data was extracted and analysed that provided insight into how the LCNS worked with and valued the NLCA database (sometimes referred to as LUCADA). There were mixed experiences and views regarding the Audit and database. Where there was good knowledge of the Audit and related processes, regular well-informed administrative and data entry support, and local reliable IT expertise, LCNS views were more positive. Where such resource was lacking, there was concern about the completeness and confidence in the audit findings.

Measures suggested that would improve audit data accuracy and capture included trained administrative support for LCNS and others responsible for entering data for the NLCA, clarity over who should enter data at all stages of the patient's journey and contemporaneous data entry by people trained not only in the information system but also in medical terminology.

Future research

Future research could test and evaluate the impact of factors identified here as influencing the LCNS impact on treatment access across multiple sites. Future multi-centre studies could seek to identify what aspects are most important in terms of patient outcomes. The thematic framework from the study provides the beginnings of a typology to explain the practice or impact of the LCNS on treatment access. This framework could be developed, implemented and evaluated in future multi-centre research.

There is an urgent need for an economic evaluation of the impact of the LCNS roles. Robust cost benefit and cost effectiveness studies would be a challenge but are essential.

Finally, more analysis is required of the database. Currently the NLCA only analyse two of the five fields that relate to the LCNS input to the patient pathway and outcome. It is necessary to consider if all five are necessary, if more resource is required if the NLCA is to realise its potential and if there are better fields that could be developed to evaluate the impact of the LCNS role and that of other professionals and service components.

Conclusion

This study generated clear and in-depth insight to demonstrate why and how the LCNS has an impact in access to treatment. The study reveals the centrality of the LCNS role to the MDT and continuity in relation to the patient and their journey across the pathway. This study provides the first step in understanding and evidencing the contribution this advanced practice role makes to a tangible and vital patient outcome.