



Cancer Patients Presenting to Emergency Departments with Acute Complications:

**Managing Risk and Ensuring Patient
Safety**

**Summary of Workshop
24th September 2010**

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1.0 WORKSHOP AIMS

The Acute Oncology Workshop held on the 24th September 2010, was with a view to;

- raising awareness within Northern Ireland of the need to develop Acute Oncology Services across the region
- clarify and explore the components of such a service
- identify the initial steps in the process.

The ultimate aim of an acute oncology service is to reduce morbidity and mortality in relation to cancer patients presenting with acute oncology needs.

2.0 WORKSHOP ATTENDEES

The workshop was attended by over 100 individuals with representation from the following stakeholder groups across Trusts:

- Patient Public Involvement Reps
- DHSSPS
- Patient Client Council
- General/Acute Physicians
- Surgeons
- Emergency Department
- Oncologists
- Haematologists
- Medical Directors
- Executive & Assistant Directors
- Service Managers
- Senior Cancer Nurses
- Chemotherapy Nurses
- Community Staff
- Regional HSC Board
- Public Health Agency
- PMSI
- Cancer Charities
- Commissioners
- Hospice
- General Practitioners
- Pharmacy Director / Managers
- Pharmacists
- Allied Health Professionals
- NICaN Team

See Appendix 2 (page 24) for a complete delegate list.

3.0 WORKSHOP PROGRAMME

Session One: National and Regional Context	
Welcome/Purpose of Workshop	Mr John Compton Chief Executive HSCB
National Guidance on Acute Oncology Services	Dr Martin Eatock Consultant Medical Oncologist/ Systemic Therapy Lead, Northern Ireland Cancer Centre
What is our Current Position?	Mr Charlie Martyn Medical Director, SEHSCT/ Chair of Acute Oncology Working Group
Sharing Experience:	
Cancer Centre ED Perspective	Dr Mark Bell Emergency Medicine Consultant, Belfast City Hospital, BHSCT
Cancer Unit ED Perspective	Dr Seamus O' Reilly Clinical Director of Emergency Medicine & Unscheduled Care, SHSCT
Medical Workforce Challenges	Dr Seamus McAleer Clinical Director/Consultant Clinical Oncologist, Northern Ireland Cancer Centre
Development of an Acute oncology Model	Dr Ernie Marshall Consultant Medical Oncologist, Clatterbridge Oncology Centre
Exploring the Issues and Identifying the Way Forward	
	Mrs Liz Henderson Nurse Director, NICaN
Feedback and Next Steps	All
Closing Remarks	Mr John Compton Chief Executive HSCB

4.0 SUMMARY MESSAGES FROM WORKSHOP SPEAKERS

Mr John Compton, Chief Executive Regional HSC Board, chaired the session. He emphasized the importance of this workshop and its role in improving the safety and quality of care for people receiving Systemic Anti Cancer Therapy (SACT). He acknowledged the need to develop a more coordinated and integrated service for patients with acute oncology (AO) needs. Given that the issues involved in this are complex, finding solutions would require all involved to work together and to be open to doing things differently.

Dr Martin Eatock, Medical Oncologist and SACT Lead, Cancer Centre, outlined the principle recommendations contained in recent national reports around the development of acute oncology services (AOS). This includes the identification of specified teams, systems and processes. He stressed the vital role of an integrated commissioning approach to planning, procuring and monitoring such services across NI. He presented the argument that short term investment would translate to cost savings in the longer term. He concluded that the development of such services is a necessity not an option.

Mr Charlie Martyn, Medical Director SET, NICaN Acute Oncology Group Chair, gave an overview of findings from the Regional Chemotherapy Service Review. Patient concerns included not knowing where to go for help, experiencing long waits in ED, and ambiguous pathways. Concerns of ED staff included competing clinical priorities, unsuitable environments for patients with neutropenic sepsis, and lack of available cancer clinical information. The review had also found variation in out of hours arrangements across the service. He concluded by stating the need to develop shared care pathways, improved access to clinical information, and improved training for ED and acute medical staff.

Dr Mark Bell, Consultant in Emergency Medicine, BCH, presented the findings of an audit of unscheduled cancer patients presenting to ED in a 7 week period. This equates to approximately 750 presentations per year, with a 73% admission rate for ED cancer related presentations compared to 25% admission rate for non cancer related patients. Of those admitted, 40% had general deterioration, 12% neutropenic sepsis and 9% other SACT related complications. He stated that patients had raised expectations about their management because the Cancer Centre was on site, yet there was a lack of specialist bed availability and ownership of patients who fall outside 6 weeks of chemotherapy. This is

hugely problematic. On a positive note, he outlined the establishment of good working relationships through the process of developing a robust network neutropenic sepsis policy.

Dr Seamus O'Reilly, Consultant in Emergency Medicine, CAH, presented a patient journey through Craigavon ED. This illustrated the difficulties of managing AO patients in a pressurized environment with competing clinical priorities. These patients are often assessed by junior medical staff who have limited experience or appreciation of the potential clinical risks of such patients. He outlined the actions taken locally to address some of the identified challenges.

Dr Seamus McAleer, Consultant Clinical Oncologist, Clinical Director, Cancer Centre, presented the oncology and haematology medical workforce challenges. He highlighted the difficulty of implementing the NCAG recommendation which stipulates a minimum of Monday to Friday oncology service at hospitals with EDs. The current locations of services on five sites would require 6PAs of clinical work per venue. His key point was that currently the service is not resourced appropriately (in terms of medical staff) for a resilient service. There are still 3.5 posts required to provide resilience to the current pattern of activity and current service. The development of AOS would be additional to this and he estimated that another 3-5 posts would be required. He acknowledged that an overview approach from commissioners is required.

Dr Ernie Marshall, Consultant Medical Oncologist, Clatterbridge Centre for Oncology (Merseyside and Cheshire Network) gave an overview of how they had implemented AOS. The service problems triggering the change were very similar to those outlined above. He stressed the vital clinical input and coordinating role that the Oncology Nurse (as a key AO team member) played in managing the patient across boundaries and between teams. One of the key elements was the development of an OncoAlert system so that the AO team knew when someone with cancer presented at ED. The AO team meets weekly to review cases and processes. In establishing their team, they submitted a business case and were pump prime funded for 6 oncologists with a view to offsetting this with anticipated savings from reducing hospital admissions, length of stay etc.

To view a copy of all workshop presentations please follow this link:

www.cancerni.net/networkservices/regionalprojects/chemotherapyreview

5.0 WORKSHOP

In introducing the workshop, Mrs Liz Henderson, Network Nurse Director (NICaN) summarized the key messages from the presentations as:

- There is a need to develop acute oncology service across NI
- The challenges in achieving this include, current financial pressures, limited numbers of oncologists, and competing priorities. However, all acknowledged that patient safety is paramount, national reports need to be taken account of as these are a benchmark for effective practice, and the findings of the NI Chemotherapy Review all indicate that NI Acute Oncology Services must be developed.

She noted the striking difference in the type of service outlined by Dr Marshall compared to the current NI service. The variation included:

- An increase in nurse led chemotherapy
- The use of pre-prescribing to reduce patient waiting
- Reduction in Consultant led follow up

Process

Round table discussions were held with each table being asked to consider a number of questions relating to a specific Acute Oncology Measure, as outlined in the Manual for Cancer Services draft document. Delegates were given a briefing paper relating to the relevant measure to help inform discussions. Each table had an identified facilitator and note taker. Proformas were completed to reflect group discussions and were collated at the end of the workshop.

The following measures were discussed:

1. Establishing a Hospital Acute Oncology Group & Acute Oncology Team
2. Network Role re Acute Oncology
3. Training Staff involved in the provision of an Acute Oncology Service
4. Protocols, Guidelines & Policies for the Management of Acute Oncology Patients
5. Provision of a 24/7 Acute Oncology Advice Service
6. Fast track clinics with slots for Acute Oncology patients
7. Patient Flagging System

A record of the workshop discussions is attached (Appendix 1).

6.0 SUMMARY OF WORKSHOP KEY MESSAGES

- There is a clear consensus that Acute Oncology **Services** must be commissioned and developed across NI. The evidence and experience is already in the public domain via NCEPOD, NCAG and Acute Oncology Measures (draft) as outlined in the Manual of Cancer Services. These services need to have executive buy in and a structure for management support. Trusts should review their existing AO service to identify current provision and measures required to address gaps. The development of AOS will require a stepped approach.
- There is a need to develop Acute Oncology **Teams** within each Trust which have identified membership as outlined in NCAG. If teams with clear leadership were in place then the development of AOSs would happen. Sessions need to be included in job plans for doctors. Specialist nurse outreach should be part of the team with clinical support from oncologists and palliative care. There is a minimum requirement to have oncology presence M-F at cancer units. Greater use needs to be made of oncology nurses with an increase in nurse led practice. There is a need to cost the NCAG suggestion of putting 0.5 Oncology per day and 1wte Acute Oncology Nurse in the 5 Trusts.
- The current **configuration of ED** adds a significant level of difficulty in designing AOS. While there is an assumption that the number of EDs will reduce, in the meantime those located outwith cancer units need to be proactively linked to Trust's AOS. Therefore there is a need to have effective teamwork, robust protocols, triggers, triage, pathways and strong communication mechanisms (including IT) across the entire Trust.
- There needs to be better **joined up working** and collaboration between ED, medicine, surgery, oncology, primary care, and palliative care across the patient journey.
- AO awareness raising and **training programmes** should be delivered to relevant staff across the Network. These need to take account of the local context and utilise various methods to address prioritized need.
- There is a need to establish a **Network Acute Oncology Group** which will also include NIAS / Commissioners / PHA / Primary Care & GPs / Senior Management as outlined in the AO measures. The pathways, alerts, protocols will naturally flow once the teams

are established. All of this requires Network coordination to ensure max efficiency, equity and standardization. There are clear Peer review measures for the Network regarding this.

- The Network group should develop a range of **guidelines and protocols** which can then be adopted locally, for example, ED and medical initial management protocols, robust alert systems.
- There is a need to further develop **24/7 patient advice** line/s. This could either be a regional advice line, or an advice line at each treating unit. There needs to be dedicated staff handling 24/7 advice line/s calls, who have the relevant level of knowledge, skill and expertise. To facilitate staff handling calls, there needs to be:
 - regional agreement on patient pathways (where patient should be admitted/treated)
 - regional agreement on who will have responsibility for these patients
 - identified regional and local leads taking a multiprofessional team approach that includes interfaces
 - a regional consistent service providing consistent advice that is reviewed and audited regularly
- There is a need for an integrated regional **flagging system** that alerts the Acute Oncology Team to the fact that patients are in ED or admitted to medical wards. For example, an Acute Oncology Nurse could support EDs in decision making and timeliness of interventions, give direct link to oncologists and highlights patients with high needs and priorities.
- **Fast track clinics** should be developed with agreed criteria and referral mechanisms to ensure patients that need a quicker than routine appointment get one, without having to be admitted to hospital.
- The most important next step is the need for formal agreement with key stakeholders (Centre/Units/ Commissioners/ Network etc.).
- The steering Group should agree on pump priming to create the necessary momentum and that ultimately Units accept this as future efficiency savings.

7.0 NEXT STEPS

- A typed up summary of the workshop will be produced and circulated to workshop participants and to the Acute Oncology Service (AOS) Working Group.
- The workshop findings will be discussed at the next AOS Working Group meeting on 22nd October.
- The Acute Oncology Services Group should use the information gleaned at the workshop to pull together key recommendations to go to the NICaN Chemotherapy Steering Group, with a view to including these in the final report. This report will be submitted to the NICaN Board for approval and onward submission to RHSCB.
- The workshop summary will be submitted as an agenda item at the next Medical Directors Informal Forum meeting, with a view to identifying Trusts responsibilities towards implementation.

Appendix 1: Summary of the Workshop Discussions

Measure 1: Protocols, Guidelines & Policies for the Management of Acute Oncology Patients

1. What guidance/protocols must be in place for an Acute Oncology Service?

- Neutropenia
- Protocol for the management of chemotherapy complications;
 - SVCO
 - MSCC
 - ↑ Ca
 - ↓ Na
 - Bowel obstruction
 - Complications of cancer
- Guidelines advising to which hospital a patient is referred, especially post chemotherapy
- Protocols for arrival to ED for post chemotherapy patients
- Medical / ED staff initial management protocol (pre being seen by oncology)
- Fast track services for oncology notes ED
- Information given to patients having chemo (patient expectation) (patient held record)
- Development of nurse assessment on day of admission and oncologist 24 hours
- Robust alert systems if patient attends ED / admitted
- Need criteria / system to let oncology know when 'old' patient admitted
- Oncology assessment unit
- Central 24 hour telephone advice service – immediate response / staff appropriate / experience and training
- GP guidance
- Training / Education
- Other methods of delivery of AOS - acute team - community (for 6/52 chemo patients)
- Take best practice from other areas

2. Identify which should be developed at: Network level / Trust level

- All to be done at Network level then 'localise' to each Trust
- Helpline - central advice line
- Management protocols - ? central

- Which hospitals – Network and Trust – need options for care delivered locally
- Expand red flag service for ED to include oncology clinics as well as site specific services (with protocols) – Regional
- Fast track for ED – avoid ED – Trust (avoidance of ED i.e. Altnagelvin)
- Assessment nurse day of admission and oncologist 24 hours - Regional

3. In terms of implementation, which of these can be delivered in the short term?

- Neutropenic sepsis
- Oncology emergencies – Education / protocols / implementation
- Developing interface / better communication between Oncology / ED / Medicine
- Patient Ownership
- Consultant of the week
- Need better communication from helpline to Consultant teams
- Improve communication
- Helpline - 1 phone number including (referral pathway to hospital / IT systems / local services knowledge)
- Management protocols – work done to date
- Contact nurse assessment

4. What are the difficulties regarding the others?

- Commissioners / Money
- Time / Consultant clinic WTE
- Ageing population therefore more cancers
- Increasing expectation
- Education and training

Key Actions

- Identify key stakeholders and educate
- Improve chemotherapy complication and cancer protocols
- Skillmix – structure oncology service to manage patient appropriately
- Communication – interface – IT/ Protocols / Helpline
- Access to training
- Audit and feedback
- Avoid waiting time in ED
- Some perception that some units are better than others so, share local good practice
- Consider red flag slots for ED

Measure 2: Establishing a Hospital Acute Oncology Group & Acute Oncology Team

1. What must we have in place?

- Review what is happening / know current situation i.e. oncology chemo service etc.
- Acute hospital reorganization / need a reduction of EDs
- Need to tailor to NI ED provision – assume we will have 5 ED acute hospital services, 1 central and 4 units (12 not possible/sustainable for oncology) Must be based in units, one for each area, needs joined up with ED units
- Concentrate acute oncology where there is oncology – not in every ED
- Job plans for doctors
- Find other models that work
- Clear point of entry
- Continuity of care and advice – common protocols and pathways / Patient routes of flow
- Getting the right information
- Must have an equitable service for NI
- Transparency re how decisions made e.g. resources
- An Oncologist presence - part of unit / hospital team (can be visiting from centre but on site 5 days per week)
- Good leadership and direction from all key parties – commissioners / oncologists / Trust managers / CE / Directors etc. - necessity in acute hospitals
- Ownership of management – groups – lead oncologist / lead ED / lead medicine / palliative care / relevant managers / admin
- Medical team integrated
- Clerical support for team
- Systems of trauma, key unit (level 1 ED) – regional transfer / sign posts
- In level 1 ED there should be triggers / triage - pathways / IT
- Develop oncology nurses / nurse led practice - Onc x 2 & Haem nurse to provide cover
- Specialist nurse out reach should be part of the team with clinical support from oncologist and palliative care
- Important to have time allocated
- Need oncology time to drive it and buy in – oncologists/nurses
- Palliative care in units (already in all units)
- Training of staff – training programmes
- Capture feedback from users

2. What will prevent/hinder this from happening?

- Lack of resources – time / personnel / money
- Provision of adequate oncologist cover - workload in units for oncologists
- Job planning
- Lack of oncology / haematology nurses
- Lack of leadership / Commissioner leadership / direction / will / ownership
- Culture change
- Lack of time to release staff for training
- Tension between specialist, general and acute
- Need to recognize pressure on centre & units - current not sustainable within resources

3. How do we get started?

- Cancer services regional therefore regional solution required – uniformity / clarity
- Review and describe current oncology provision / situation in each unit & centre including what is available and what is gap
- Commissioners to give direction – agree to support establishing team in each unit: AOT essential (not just chemo provision)
- 5 units need adequate staff in place, oncologist on site / onc & haem CNS / admin etc.
- Establish management groups
- Team redesign
- ? NCAG cost as starting point
- Work to see how implementation will release resources to help fund
- Learn from other models across the UK
- Develop the oncology nurse specialist role - unit based
- Training for staff, especially ED re:
 - Oncology patients/service
 - Medical staff – i.e. Consultants / nursing / juniors
 - Surgical staff
- Dedicated urgent slots at clinics
- Review of cancer services oncology waiting patterns
- Identify current resources in place, where is it being spent, already work ongoing regionally
- Minimum identified resource e.g. nurse specialist
- Work in partnership across all units & centre - equity approach, protocols, guidelines, provision

- Capture user perspective
- Remodel the sceptics

Key Actions

1. Regional / systematic change
2. Ownership of patient / system
3. Clear lead for change
4. Minimum identified resource

Measure 3: Training Staff involved in the provision of an Acute Oncology Service

1. What are the training needs of the staff involved in the provision of an AOS?

- Simple standardized information across the region
- Knowledge of the services available and opening times – local configuration e.g. acute admissions ward in the cancer centre
- Need to involve AHP and social workers etc. involved with cancer patients elsewhere
- Baseline level of training on effects of chemo / XRT i.e. most common 5 acute presenting conditions and the remaining general deterioration cases, tailored to individual need
- Recognition of early stage prioritization
- Communication skills at all levels
- Familiarization with chemo drugs

2. How can this be addressed?

- Context specific training – e.g. delivered specific to issues encountered in each context
- Prioritise staff for training and areas – first priority neutropenic sepsis
- Use of online training sessions and accredited testing - but only relevant to role e.g. ED
- Rolling programme – requirement to complete training over a defined period of time
- Development time to teach and learn
- Under graduate to develop the workforce of the future
- Continuous learning for junior doctors based on the aspects relevant to the areas they are working in - building up knowledge
- Challenge - how does this training compete with other mandatory training especially for short hour contracts

Key Actions

- Identify any existing resources and build on them
- Set aside time in job plans
- Use accredited trainers
- Include patient experience within training
- Learn from other programmes such as right patient right blood – positive and negative experience of this

Measure 4: Provision of a 24/7 Acute Oncology Advice Service

1. What elements of an Acute Oncology Advice Service must we have in place to ensure patient safety?

- Regional protocols
 - pathways for admission
 - who gives advice
- Establishment of clear & consistent pathways with:
 - Robust sieving processes
 - Robust 2 way communication linked with key services, i.e. inpatients / ED / Comm
 - Robust locally and regional governance arrangements
 - Everyone must know about it
- Dedicated staff with training and expertise
- Single point of access at each treating unit
- Access to up to date patient information at all points of access for patients – ED / MAU
- There is a need for access to two types of timely advice 7 days per week
 - 24/7 for emergencies
 - 7/7 for urgent i.e. next day advice

2. What will prevent/hinder this from happening?

- Lack of access to oncologists advice 24/7
- Lack of ongoing coordinated approach to education and training
- Differences in practices across cancer units i.e.
 - access to beds
 - access to dedicated triage nurses
 - access to identified medical teams responsible for pts with oncology complications

Key Actions

There is a need for:

1. Regional agreement on patient pathways i.e. where patient should be admitted/treated
2. Regional agreement on who will have responsibility for these patients
3. An identified regional & local lead, taking a MPT approach that includes interfaces
4. A regional consistent service providing consistent advice that is reviewed & audited regularly

Measure 5: Fast Track Clinics with slots for Acute Oncology Patients

1. Please describe the ideal system for fast tracking Acute Oncology Patients

- From ED perspective:
 - Equity about outcomes rather than access
 - More of same won't work
 - Right to keep CC investigations out of hospital
 - For unknown primary
 - Need set of criteria for who to refer to each specialist clinic i.e. Resp / H&N / GI
 - Which clinics need slots
 - Identify where you make referrals
 - How can clinic get slots
 - Need to be seen by senior clinician in ED
- Central point of referral for oncology pts who need a quicker than routine appointment
- Pathway for pts for areas with ED and no cancer unit on site - communication process
- How do slots be made available

2. What difficulties does the group envisage in achieving this?

- Getting slots made available when there is already a waiting list for routine
- Urgent diagnostics is a limiting factor on some sites
- Training and implementation
- Could be a victim of its own success i.e. GPs may refer in instead of routine OP
- Open access could harm functionality if inappropriate people are referred
- Reassuring service providers that filters will be adequate
- GP awareness
- Inadequate resources
- Who are referrers? - ED / GP
- Appropriately timed specialist opinion
- Remodeling existing or new?

3. What key steps are required?

- Scope numbers
- Set criteria
- Agree affected clinics
- Agree steps in pathway
- Electronic system

- Training
- Audit system in place to ensure system isn't abused (Protect lung & H&N)

Key Actions

1. Scope which site specific clinics – Resp / H&N / UGI / rapid disease progression
2. Get buy in from service providers to agree criteria and method of referral

Measure 6: Patient Flagging System

1. What are the current issues with regards to identifying Acute Oncology patients?

- Issues with COIS
 - Maintained by Cancer Centre secretary and could be 6-8 weeks out of date
 - Level of information is insufficient
 - IT system which is text heavy database
 - Needs to go peripherally
 - Integration – prescribing system not available everywhere
- Training issues for access to system
- How do we interface COIS & PAS / H&S Care Number

2. What needs to happen to address these issues?

- There is a need for a regional approach
- Regional & complete stakeholder engagement & accountability to new flagging system
- Aware that a new system being developed over 3-5 years (Regional Haematology Oncology Information System). We need to know where we are regionally before we move forward
- Need time lines for delivering on system
- Are we going to patch COIS up?
- LOIS – Currently working on in BHSC until RHOIS established
- Electronic Records Management System (ERM) currently being trialed in UHD, this would result in one overarching system
- Do we run with ERM System for the future?
- Possible use of a Unique Identifier Number or use H&S care number
- Want one system to suit all
 - New electronic IT system would enable all patients including onc/haem patients
- Timely data input
- ? Quick fix to flag patients 'now' until regional systems are developed (quick look ups) flagging systems
- Need to be able to flag up information on a patient
- Patient flagging from ED to Oncology / AOT
- Need to flag up to oncology that a patient has sought help
- Need to include NIAS in flagging system, particularly around Neutropenic Sepsis
- ? e-mail site with oncology - Text / e-mail helpline

- Time lined interventions linked to telephone advice line
- System needs to interface with OOHs systems throughout NI with one unique identifier
- Possible systems - Give patient card prior to leaving system – passport / put in hands of patient, internet access to record / patient responsibility for providing passwords to access intranet

3. What are the first steps that could be taken?

- Regional overview
- What systems have we now?
- Decide on ERM system or COIS update
- COIS replacement will need to factor AOS needs into system development
- Standardize role out of chemotherapy side effects / linked to system
- Change of design, modify new systems
- All stakeholders should be involved in new systems i.e. oncology /general /GPs / NIAS
- Specialist nurses who could be called to ED
- Follow other models - Chest Pain Nurse - support ED decision making & timeliness of interventions. Gives direct line to oncology opinion / highlight patients with high needs & priorities
- Decision report tool

Key Actions

1. Integrated to all systems – NIAS / GP / OOHs / ED staff / In-patient teams
2. Up to date, emergency records system, user friendly and accessible
3. Stakeholder engagement
2. Make a system to pilot

Measure 7: Network Role re Acute Oncology

1. What is NICaN's role in relation to developing Acute Oncology Services?

- As outlined in Manual of Cancer Services, NICaN should host a Network Acute Oncology Group
- Will require some expert opinion to scope out problems

Key Actions

1. Make proposal to Board that NICaN facilitate an Network Acute Oncology Group
2. Enlarge proposed membership to include:
 - Senior Management
 - Commissioners
 - NIAS
 - Primary Care / GPs
 - Public Health
3. Act in an advisory capacity
4. Undertake regional audits: Neutropenic Sepsis & Cancer of Unknown Primary as benchmarks
5. NICaN to develop patient pathways, CMGs, disseminate & monitor practice
6. Develop performance indicators

Dr Ernie Marshall's Summary of Workshop Discussions

- There appeared to be a consensus recognising the value and importance of AO within the audience.
- The most important next step is agreeing this formally with key stakeholders (Centre, Units, Commissioners, Network).
- The evidence and experience is already in the public domain via NCAG / NCEPOD and PEER review is coming.
- There is a need to cost the NCAG suggestion of putting 0.5 Oncology per day and 1wte AO Nurse in the 5 trusts.
- The steering Group should agree on pump priming to create the necessary momentum and that ultimately Units accept this as future efficiency saving.
- The pathways, alerts, protocols will naturally flow once Acute Oncology Teams are established. All of this requires Network coordination to ensure maximum efficiency, equity and standardization. There are clear Peer Review Measures for the Network regarding this.

Appendix 2: List of Delegates

Name	Job Title	Organisation
Willie Barron	Assistant Director of Cancer & Clinical Support Services	South Eastern HSC Trust
Fiona Beattie	Asst Director for Diagnostics & Clinical Support	Western HSC Trust
Kathleen Beck	24 Hour Care Team	Belfast HSC Trust
Mark Bell	Consultant in Emergency Medicine	Belfast HSC Trust
Rema Borland	Macmillan Oncology & Palliative Care Facilitator	Belfast HSC Trust
Wilma Boyd-Carson	Clinical Manager for Cancer Services	South Eastern HSC Trust
Dr Una Bradley	Consultant Physician	Southern HSC Trust
Therese Brown	Head of Clinical Quality and Safety	Western HSC Trust
Geraldine Byers	Lead Nurse, Acute Services	Belfast HSC Trust
Sally Campalani	Senior Nurse Cancer Services	Belfast HSC Trust
Jackie Campbell	Acting Service Manager in Older People	Belfast HSC Trust
Una Cardin	Cheotherapy Unit Manager	Western HSC Trust
Jackie Clarke	Consultant Clinical Oncologist	Belfast HSC Trust
Niall Collum	Consultant Emergency Medicine	South Eastern HSC Trust
John Compton	Chief Executive	HSC Board
Fidelma Connor	Oncology Liaison Nurse	Belfast HSC Trust
Rory Convery	SHSCT CD for Cancer Services	Southern HSC Trust
Dr Bernie Corcoran	Macmillan Cons and Clinical Lead in Palliative Medicine	Belfast HSC Trust
Dr Elaine Corrigan	SpR Public Health Medicine	Public Health Agency
Dr Vicky Coyle	Consultant Medical Oncologist	Belfast HSC Trust
Brenda Creaney	Director of Nursing and User Experience	Belfast HSC Trust
Dr Gerard Daly	Respiratory Physician	Western HSC Trust
Eileen Deery	Lead Nurse, Cancer Services & Outpatients	Northern HSC Trust
Matthew Dolan	Regional A & E Pharmacist Team Leader	Belfast HSC Trust
Dr Martin Eatock	Consultant Medical Oncologist	Belfast HSC Trust
Ray Elder	Strategic Lead, Palliative Care Reform	South Eastern HSC Trust
Elizabeth England	Macmillan Lead Nurse/Oncology Manager Cancer Services	Western HSC Trust
Nicola Evans	Lead Occupational Therapist, Cancer Centre	Belfast HSC Trust
Audrey Fenton	Medical Oncology SpR	Belfast HSC Trust
Damian Finnegan	Consultant Haematologist	Western HSC Trust
Dr Stephen Garvin	Patient Representative	PPI
Veronica Gillen	Regional Commissioning Team	HSC Board
Audrey Given	Ward Manager, Medical Assessment Unit	Northern HSC Trust
Siobhan Glenn	Ward Manager	Western HSC Trust
John Gray	Consultant - Emergency Medicine	Belfast HSC Trust
Mal Gribbon	Clinical Pharmacist	Belfast HSC Trust
Dr Stephen Hall	Associate Medical Director, Cancer and Clinical Services	Southern HSC Trust
Liz Henderson	Nurse Director	NICaN
Dr Dermot Hughes	Network Medical Director	NICaN

Angela Jackson	Senior Sister	Belfast HSC Trust
Jackie Kayes	Community Inreach	Belfast HSC Trust
Dr Breffni Keegan	Consultant in Care of the Elderly	Western HSC Trust
Rosemary Lavery	DVT Sister	Belfast HSC Trust
Michelle Laverty	Programme Manager for Unscheduled Care	PMSID
Linda Linford	Service Manager A&E and OOH	Belfast HSC Trust
Dr Janet Little	Assistant Director	Public Health Agency
Joe Magee	Head of Cancer Services, Diagnostics and Specialist Drugs	DHSSPSNI
Gail Malmo	Service Improvement Lead	NICaN
Dr Ernie Marshall	Consultant Medical Oncologist	Clatterbridge Centre
Charlie Martyn	Medical Director	South Eastern HSC Trust
Gillian McAleer	Acting Manager 24hour Nursing Team	Belfast HSC Trust
Dr Seamus McAleer	Clinical Director/Consultant Medical Oncologist	Belfast HSC Trust
Jonathan McAleese	Consultant Clinical Oncologist	Belfast HSC Trust
Kevin McCallion	Colorectal Surgeon	South Eastern HSC Trust
Pat McClelland	General Manager, Cancer Services	Northern HSC Trust
Isobel McClintock	Department Manager in A&E	Western HSC Trust
Janice McCulla	PPI Coordinator	NICaN
Lisa McCullough	Str/Staff & Clinical Development	Belfast HSC Trust
Seamus McGoran	Director of Hospital Services	South Eastern HSC Trust
Sean McGovern	Consultant in Emergency Medicine	South Eastern HSC Trust
M McKeown	Hospice	Marie Curie
Laura McMullan	Speech & Language Therapist	Belfast HSC Trust
Siobhan McMullan	Sister in A&E Department	Western HSC Trust
Catherine McNicholl	Director of Performance and Service Delivery	Belfast HSC Trust
Dympna McParlan	Chemotherapy Service Development Manager	NICaN
Joanne Millar	Consultant Medical Oncologists	Belfast HSC Trust
Anne Mills	Nursing Officer	DHSSPSNI
Heather Monteverde	General Manager, NI	Macmillan Cancer Support
Sharon Morgan	GP Macmillan Facilitator	South & East Belfast
Helen Morrow	A&E Pharmacist	South Eastern HSC Trust
Lorraine Mullan	Cancer Services Pharmacist	Western HSC Trust
Dr Hilda Nicholl	Consultant in Emergency Medicine	Southern HSC Trust
Brenda Nugent	Clinical Specialist Oncology Dietitian	Belfast HSC Trust
Dr Brendan O'Brien	SpR Public Health Medicine	Public Health Agency
Bernie O'Neill	Chemotherapy Unit Team Leader	Northern HSC Trust
Maggie O'Reilly	Acute Oncology Nurse	Belfast HSC Trust
Dr Seamus O'Reilly	Emergency Medicine Consultant	Southern HSC Trust
Dr Conor O'Toole	Consultant Emergency Medicine	Southern HSC Trust
Alison Porter	Head of Cancer Services	Southern HSC Trust
Dr Gillian Porter	Emergency Medicine Consultant	Belfast HSC Trust
Deirdre Quinn	Pharmaceutical Services Lead	Regional HSC Board

Jane Rankin	Lead Cancer Physiotherapist	Belfast HSC Trust
Fiona Reddick	Oncology Nurse Specialist	Southern HSC Trust
Joan Regan	Consultant in Palliative Medicine	Marie Curie
Michael Reilly	Lead Cancer Clinician	Western HSC Trust
Eleanor Ross	Assistant Director Unscheduled Care	PMSID
Dr Paula Scullin	Consultant Medical Oncologist	Belfast HSC Trust
Peter Shortt	Consultant in Emergency Medicine	Belfast HSC Trust
Louise Skelly	Head of Operations	Patient and Client Council
Paul Smith	Lead Nurse Emergency care	Southern HSC Trust
Tony Stevens	Medical Director	Belfast HSC Trust
Leeanne Stewart	Senior Clinical Pharmacist	Belfast HSC Trust
Kevin Stoker	Laboratory Service Manager, Haematology	Northern HSC Trust
Gillian Traub	Service Manager	Belfast HSC Trust
Michael Trimble	Consultant Physician in Acute Medicine	Belfast HSC Trust
Jennifer Welsh	Director of Cancer and Specialist Services	Belfast HSC Trust
Sarah Williamson	General Manager, Cancer Services	Belfast HSC Trust