Herceptin® at Home Pilot – Trust Cancer Managers Evaluation November 2010

Responses were received from the 3 Cancer Managers and 1 Lead Cancer Services Pharmacist most closely linked to the pilot

1. ***Have the Healthcare at Home staff supported the unit(s) to ensure the pilot has run effectively?***

   Yes x 4

   Comments

   - More input would have been beneficial however, as I know the staff on the unit have spent a long time sorting out the process and supporting the patients

2. ***Do you feel the service is safe? Please consider the entire patient process from selection, to handover and referral back to NHS as appropriate.***

   Yes x 3

   Not completed x 1

   Comments

   - Yes – within the boundaries that any chemotherapy service can ever be safe, so selecting suitable and stable patients is key to making this work safely. There are many more information governance issues with transferring information to a non-NHS body and treating patients in the community, however, I am happy that these are all suitably guarded against
   - Yes – it took a while to get the governance issues sorted with H@H but we got there eventually. I haven't seen any patient feedback so would be interested to see this?
   - We have not had large volumes to really compare the whole process of return back to the NHS. We had a recent incident regarding deferred patient and the prescriptions which does not reassure me that its water tight based on low numbers
   - Numbers who have gone through the whole process are still low and the range of possible complications of the process has yet to become apparent. Some local issues would suggest the process isn't watertight as yet, to ensure total security and communication between H@H and trust especially when the patient journey can fail. Also numbers of concurrent patients is also low so difficulties managing and organising large numbers have also not shown themselves yet.

3. ***What have been the main challenges encountered with the pilot?***

   - The main issues were with regard to the set up of the project – ensuring safe selection of suitable patients and making sure that correct information governance was in place. It was quite clear that this had either been ignored during the commissioning set up phase or assumptions made around what could be done. Had the infrastructure been in place, the Trust would have been concerned with delivering the service for commissioners, as it happened the Trust were required to arrange governance issues that could have been more effectively addressed at a regional level before the project was rolled out.

- Knowledge of the targets and what working towards. Not knowing the patient population response regarding uptake versus decline rates. Patient views regarding support from the units are difficult to change as its choice but yet you are penalized for this. Time and effort from all parties to keep a focus, design the pathway and keep open communication. Time taken within the Trust on the pilot with other competing work, difficult to quantify with each specialist. Two units with differing environments and therefore the process does not match in full.
- The main challenge for us was getting everyone on board and sustaining momentum. I don't feel the way the information was communicated initially back in March was entirely appropriate. We then had to get all nursing and medical staff on board.
- Unrealistic initial target and loss of moral when criticised for underperformance despite a lot of effort and commitment. It felt like the trust was being penalised for offering patients choice. On a day to day basis getting prescriptions signed and available and LVEF tests carried out and reported and assessed all to marry up and occur within the timescales requires considerable discipline from all concerned which can be difficult when they all have other jobs and commitments pulling their attention away.

4. Are there any further resources needed to support the pilot?

- Provided the pilot remains within its current focus (i.e. Herceptin® delivered to clinically suitable patients) then this can be delivered within the current resource. Were any expansion to be made this would need to be funded, and may also push up costs for other treatments should this begin to destabilise the overall service.
- Additional nurses would be helpful as initially stated to support the process in the day units and the discussions with patients around what is going to happen, what will happen when they return to hospital for investigations and so on.
- Admin support to ensure timely data entry, filing information from Healthcare at Home and chasing results. As more patients come on line more time for checks of results and ensuring prescriptions are ready etc.
- Admin support to ensure timely data entry, filing information from healthcare at home and chasing results. As more patients are entering into the scheme and therefore more going along at the same time the link nurse activity will need more resource to keep abreast of the chasing and checking of results and co-ordinating loading doses and new prescriptions etc.

5. How could the process be improved?

- The involvement of the Cancer Network has been helpful in smoothing the process between commissioners and providers and collating information. Possibly the implementation may have been smoother had they been involved at the outset.
- At the start a steering group. Lessons learnt from other Trusts would have helped in the set up – so we would have been aware of the issues. Inf Gov issues to be worked through across three Trusts at the start as not aware of the changes of guidance etc. pathway in each Trust would have generic aspects and therefore could have been developed as a group then put the local tweaks in – saving time and energy.
- Improvement would have been better communication with commissioners from the outset. A greater understanding as to how the pilot commenced, ie, why H@H, how long the trial is running for, what will be the evaluation period and when, what will the tendering process be, why and when.

- The gathering of all involved trusts to share experience was too late in the process and would have been better at the beginning of the process rather than when everyone had already struggled on their own. It would have been better to start with a working group to look at generic issues which would b applicable to all rather than each having to work it out for themselves and potentially missing issues others had found.

6. Are there any other comments you would like to make?

- SIFT helped focused process and provided lessons learned from other oganisations.
- I am still insure as to how the trajectory was set as I was not involved in the discussions – why not?
- Healthcare at Home have been very easy to work with as an organisation and have been a good partner in this process. They have worked well to build relationships with staff in the unit and this has been appreciated and has made the process run much more smoothly and effectively.

  From a provider point of view, it seems that this was rushed through the commissioning process without proper forethought or research, and then Trusts were held to account for the poor implementation.

7. Overall how would you rate your experience of the pilot?

(use a score of 5 for excellent though to 1 for poor)