Bevan Commission Exemplar Project

Specialist Neuro-oncology community therapy services: addressing inequalities and gaps in service provision

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Why this project

Neuro-oncology is a specialised field of medicine focused on the diagnosis and treatment of brain and spinal cord tumours. It involves a multidisciplinary approach, combining the expertise of various specialists to provide comprehensive care.

One of the worst survival rates when compared to other cancers (Brain Research UK)

Devastatingly short life expectancy of 12-18 months from diagnosis

Multiple supportive care needs

Disease progression can be rapid and unpredictable (Pompili et al 2014).

Identifying a Case for Change

CURRENT PROVISION

- Does not allow for outreach or community services from specialist neuro oncology therapists
- Leaves vulnerable patients in communities with little support, impacts on QoL and can lead to crisis management and hospital admission

IDENTIFYING A GAP / UNMET NEEDS

- Current service limited to outpatients
- “Postcode lottery” when it comes to what community services are available.
- Lack of specialist knowledge in community services
- Waiting times
- Crisis Management

Pre Pilot Data Collection

of patients required community occupational therapy

30% required community physiotherapy input

of patients required hospital admission*

* Data taken from audit of WCP notes for neuro oncology patients from April 2023 – March 2024

Existing neuro oncology service

Patient offered outpatient apt with OT/PT

PROS	CONS
Patient seen in timely manner	Patient not seen in home environment
Access to specialist skills set of OT/PT	Unable to ax for or facilitate home adaptations
Consistency of care	Requirement for Patient to travel to VCC – inconvenience & cost

Patient referred to Community Service dependent on needs

PROS	CONS
Community teams able to see in home environment	Long waits for services
Less travel cost for patient	Lack of specialist NO skills within community teams
	Experience of inappropriate interventions / advice
	Lack of consistency of care
	Lack of efficiencies as repetition in ax / rx
	Increased burden for community service

Pilot Design

Scope (What)

Solution (How)

Delivery (Who)

Implementation (When)

Funding (Who Pays)

Evidencing the Impact

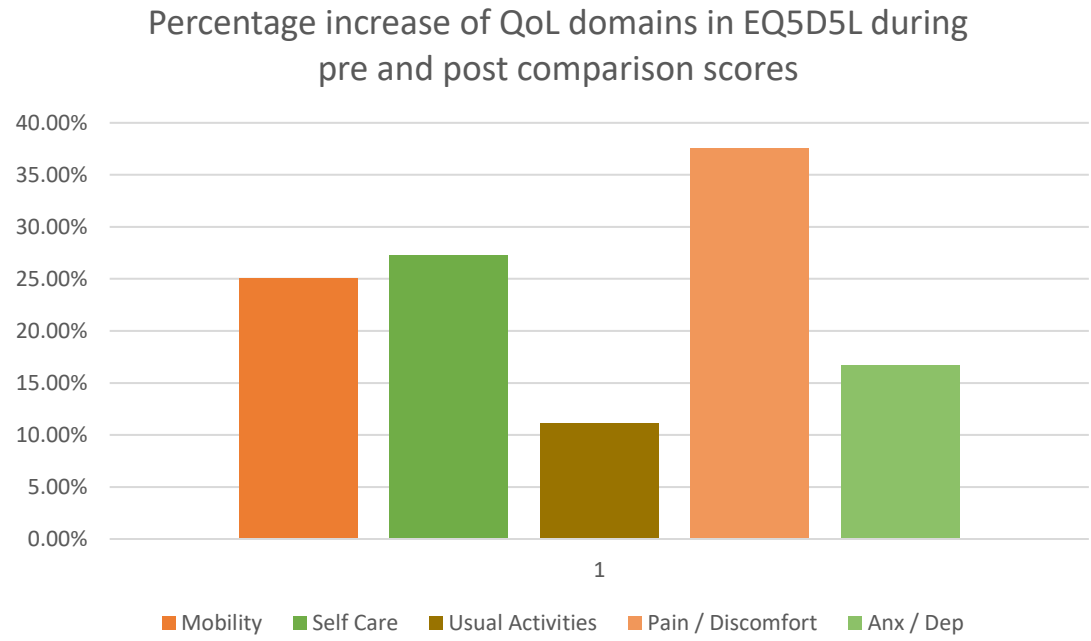
Pilot Completion

- Received total of 12 referrals
- Of which 8 met the criteria
- 1 was hospitalised prior to being seen
- 6 patients were able to give outcomes over a 4-week period

Outcomes

Quality of Life data demonstrated improvements in:

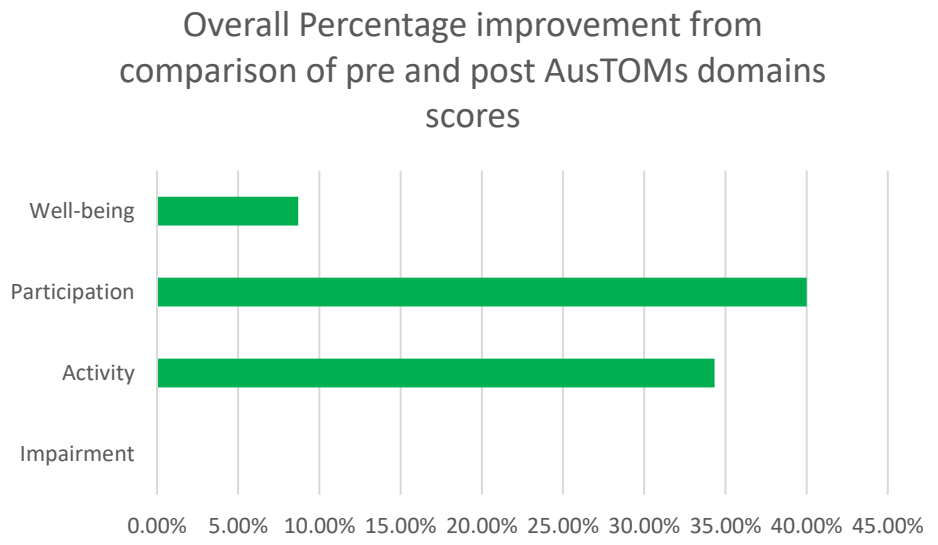
- Mobility
- Self care
- Usual Activities
- Pain
- Anxiety / Depression

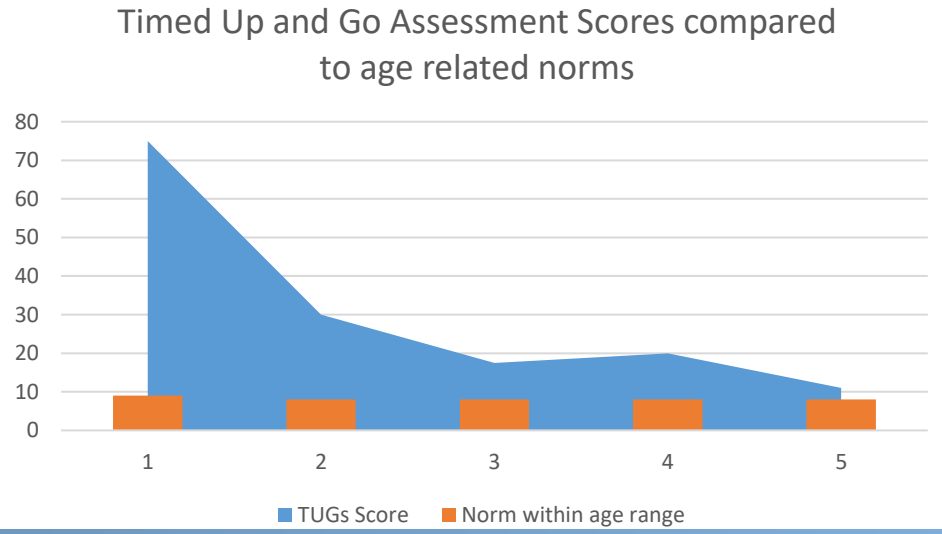


Outcomes

All patient required functional mobility interventions.

- Overall percentage improvements seen in the domains of activity, participation and patient well-being from AusTOMs
- TUGS demonstrated a higher score than expected baseline data from population norms, showing a significant risk of falls within this patient cohort





Patient quotes

"You have it down to a T – professional, friendly, marvellous."

"Really useful in own environment as [patient] can put on a bit of a show when in hospital"

"I found the experience to be quite emotional in how well I was supported."

"taking the time to come to our home was very good. It was brilliant, really good and you have to continue."

" You must carry on with it."

Key Conclusions

Majority of referrals were needed at a later stage of disease than anticipated indicating the need for a review of current service provision.

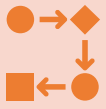
Clear evidence of risks of falls and the impact of dual tasking.

All patients within pilot had unmet allied health professional needs, including speech and language therapy and dietetics.

All patients required onward referrals for equipment and services that would otherwise have been missed.

Next Steps:

Collect longitudinal data to compare hospital admission rates from pre pilot cohort.



Follow up with 6 week falls review to establish if further input needed.

Feed into business case for a 2-year extension to pilot for ongoing data collection and feasibility of permanent service.

Huge thanks for the support of this project

All the patients involved for inviting us into your homes and lives at such a difficult time

- Bevan Commission
- VCS Neuro Oncology Team
- Data Analysis Support
- VCS Therapies Team
- Innovation Team at Velindre Service
- My family