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Introduction

Cancer incidence is rising, recent figures suggesting 1 in 2 will be diagnosed with a malignancy in their lifetime. Advances in treatments, particularly systemic therapies, have led to over 50% of patients being 'cured' of their cancer. However, a significant number of patients are living with metastatic disease, frequently in the bone, leading to increasing demands for palliative radiotherapy (PRT). The clinical oncology workforce has not expanded in relation to the increased demands, requiring alternative measures to manage the workload. A Macmillan consultant radiographer specialising in PRT was appointed in our cancer centre to alleviate the workload. A training programme commenced, culminating in the radiographer becoming competent in planning palliative bone and brain radiotherapy. Once the competencies were achieved, the clinical oncologists could authorise and delegate the treatment planning by indication on the PRT booking form. If no authorisation was given, the radiographer may undertake initial planning but would not sign off the plan ready for treatment. The impact of this appointment was audited, using bone radiotherapy as a point of reference.

Aims

The aim of the patient audit was to ascertain;

- Patients numbers seen requiring PRT for bone metastases
- The details of the treatment required by the individual patients
- The timescale over which the patients' treatments were administered from referral to commencement of treatment
- Proportion of planning by different professions (Consultant clinical oncologists, Specialist registrars (SpR's) or consultant radiographer)

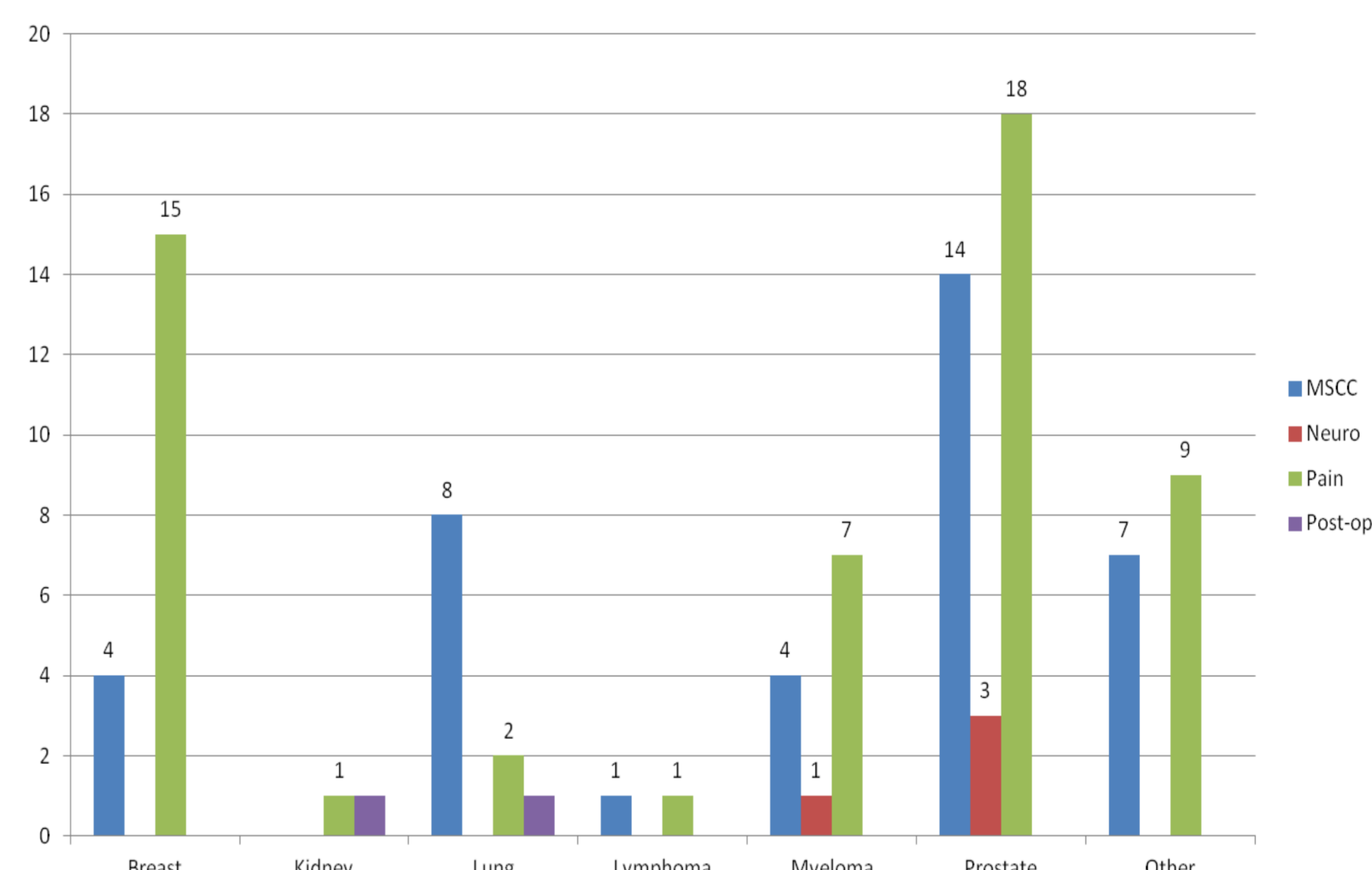
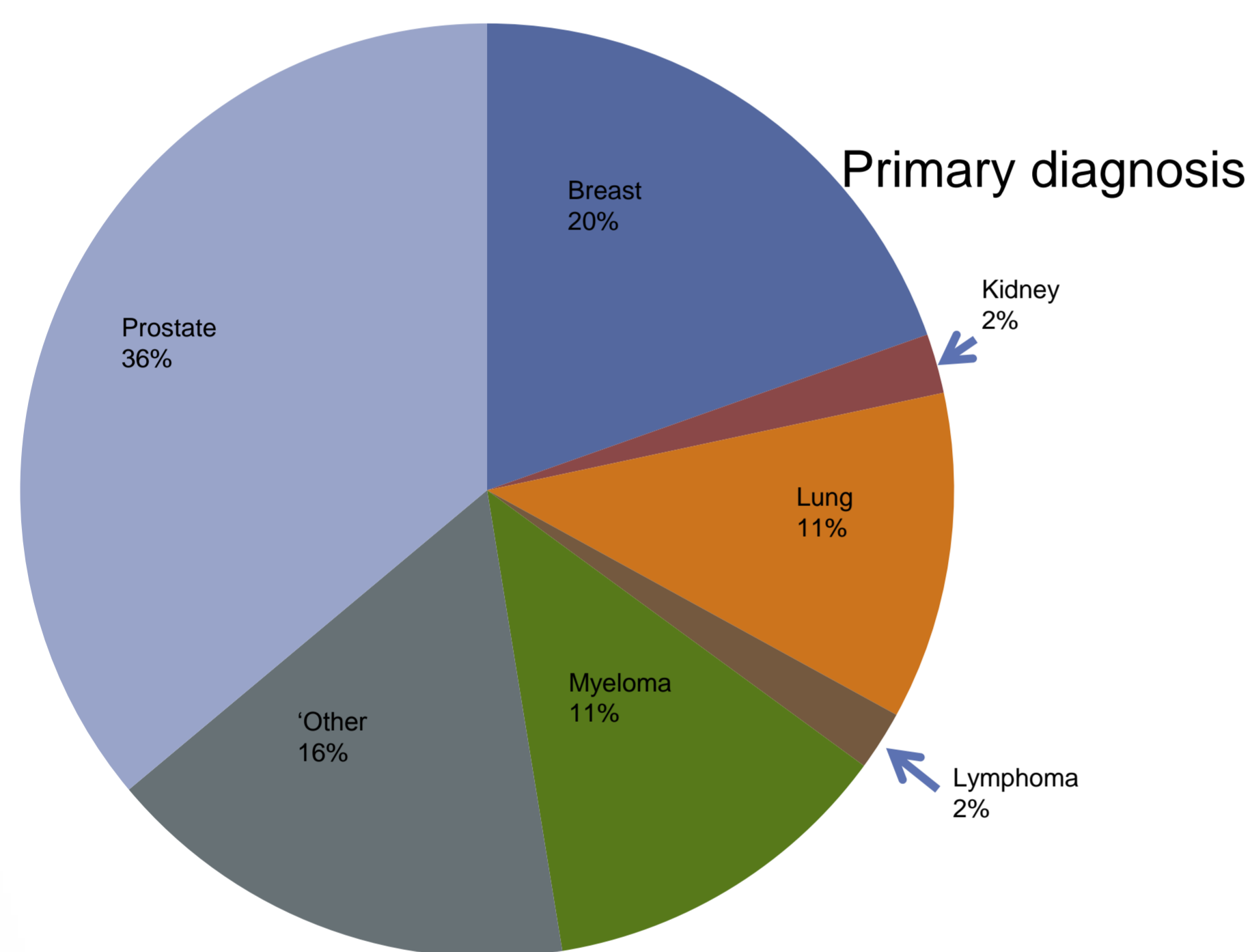
Method

- 3 month retrospective audit Bone mets PRT patients identified from Radiotherapy Management system (Mosaiq)
- Reviewed using Mosaiq, Prosoma (Virtual simulation package), Trust electronic notes.
- Data collected: patient demographics, treatment site, indication and dose, details of the patient pathway (decision to treat to 1st appointment, subsequently subdivided into individual aspects of the pathway), profession of the member of staff planning the treatment.

Results

97 patients were identified (compared to 63 in the same period 10 years ago)

Sites – 61% of patients were planned for spine RT (64% of these MSCC). The next most common treatment sites were Pelvis (19%) and Hip (5%). Other sites included Humerus, base of skull, shoulder, ribs, femur, etc.

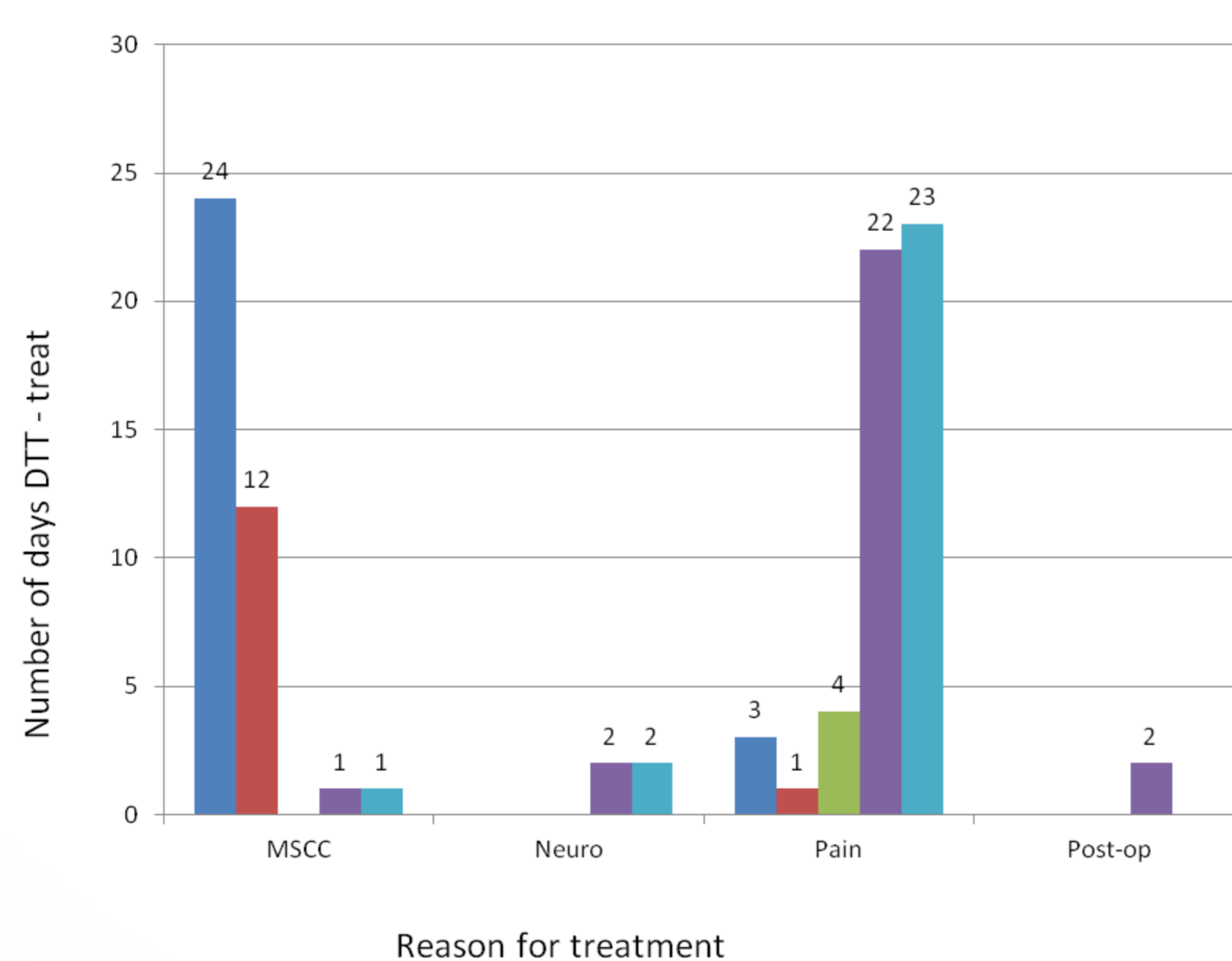


Primary/Indication for treatment

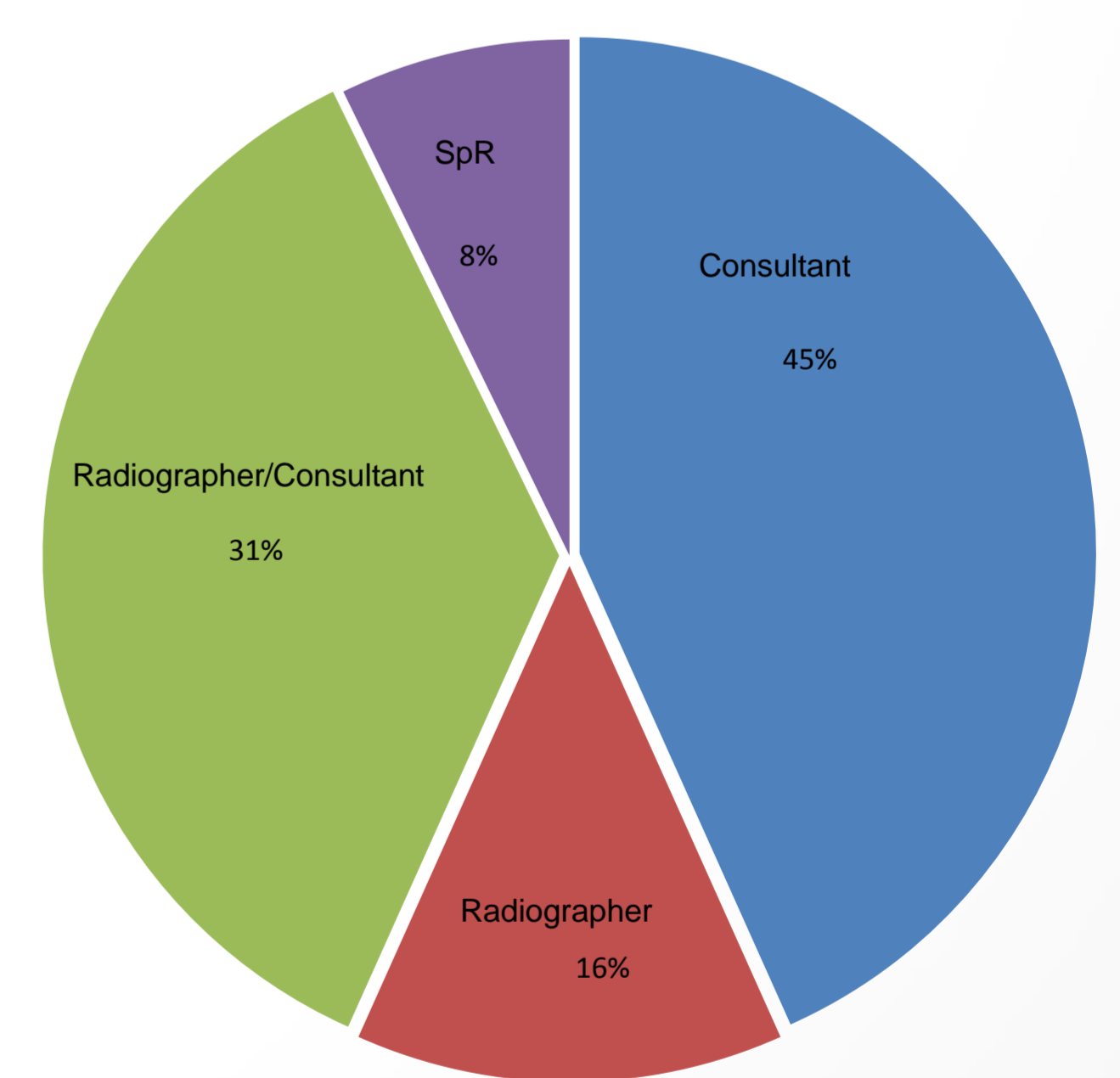
55% treated for pain relief
39% for MSCC

Patient pathway (Decision to treat – Treat)

91% MSCC treated within 2 days
57% pain treated within 2 weeks of referral.



Profession



Discussion/conclusions

- ❖ Successful implementation of the consultant radiographer into the PRT service, involved in nearly 50% of PRT cases
- ❖ Early days of localisation competencies, initially all planning checked by clinicians, independent planning increased during audit period
- ❖ Involvement expected to increase \implies reduced clinician PRT workload, allowing increased focus on complex planning, etc.
- ❖ Reason for patient pathway delays –
 - large clinician workload?
 - communication between CT and clinician?
 - CT/treatment Unit capacity?
- ❖ Small % SpR planning –? typical ? due to appointment of consultant radiographer
- ❖ Impact on SpR training and education. Consider PRT planning meetings/discussion groups to increase exposure and education
- ❖ A prospective audit will be undertaken for the equivalent 3 month period to ascertain if these theories are supported.