Senior Haematology INtegrated CarE Service – University Hospital Southampton (UHS)

SHINE

Abstract

The Haematology team at UHS is looking to establish a novel multi-disciplinary team (MDT) approach for the management of elderly Non-Hodgkin's Lymphoma (NHL) patients. In conjunction with Roche Products Limited, a 18 month collaborative working was proposed [starting date mid April 2023] to facilitate a more holistic approach towards the management of this patient cohort post-diagnosis and in turn improve outcomes, reduce length of stay and improve patient experience.

Aims

The aim of the project was to design the MDT, ensure there is sufficient clinician capacity for implementation as well as develop accompanying pathways. The patient cohort was all patients with a diagnosis of NHL over the age of 65. Whilst all patients meeting these criteria would potentially be eligible to be reviewed by the MDT, the patients would first complete a comprehensive frailty assessment at the end of which the clinician will assign a clinical frailty score (CFS). Any patient scoring 4 or above with a clinical concern will be added to the MDT for review.

The MDT itself will aim to address all aspects of the patient's health care journey post diagnosis. To this end, the roles that have been defined as critical are: **Haematologist, Geriatrician, Pharmacist, Therapist (Physiotherapist or Occupational Therapist), Dietician, Clinical Nurse Specialist and Support Worker.**

Objectives

- Improve patient experience, outcomes and quality of life
- Access to consistent single point of contact
- Facilitation of shared decision making
- Delivery of more collaborative care pathways across services
- Reduction in variation of standards of care
- Reduced length of stay, non-elective admissions, AOS contacts

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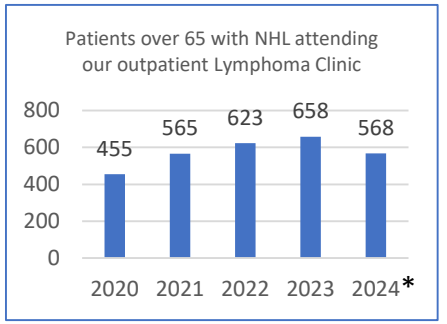
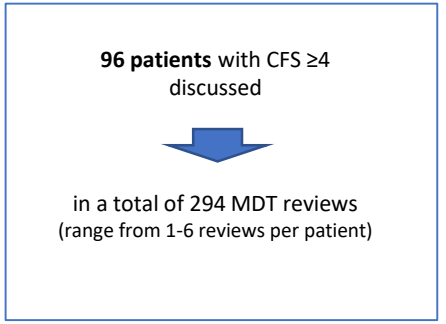
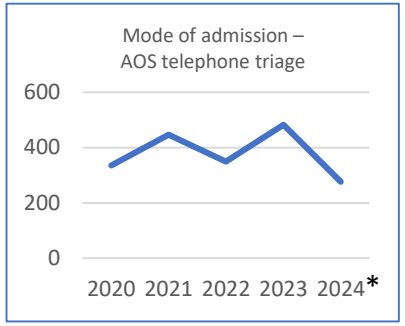
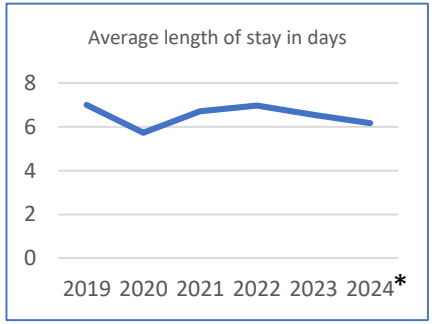
Results

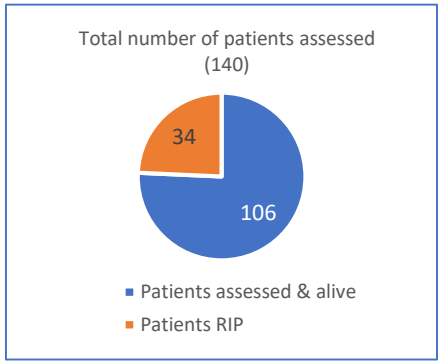
***All data for 2024 is up to 31st August 2024**

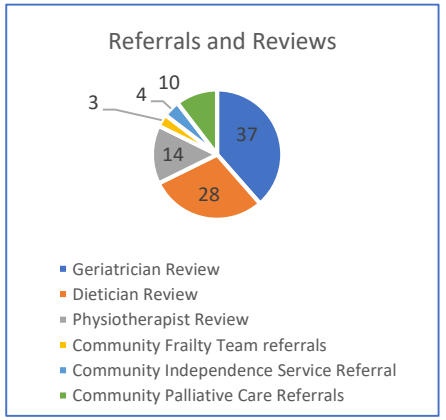


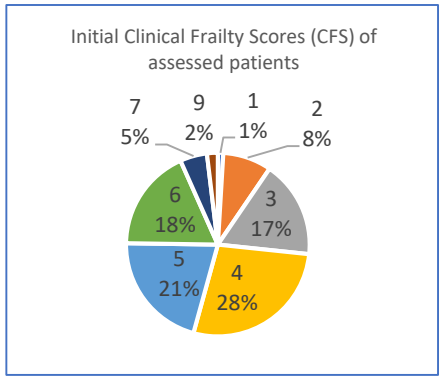


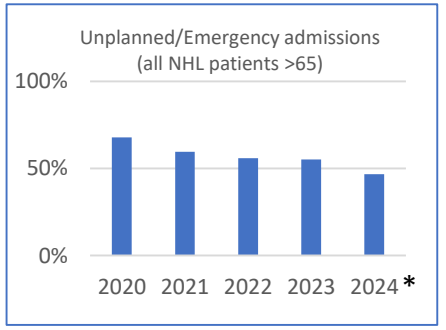












Case Study

Mrs C was 74 years old when diagnosed with DLBCL in 2022, fit and well, still working part time in a local nursing home. In 2024 she relapsed, on admission she had CFS of 6. She was immediately reviewed by SHINE and additional dietician input, therapy input and advanced care planning was commenced. One month after commencing treatment she presented with new sight loss and was found to have CNS disease. Discussions with SHINE and Mrs C led to a decision not to continue treatment and focus on best supportive care. She was discharged to the nursing home she previously worked at with community palliative care.
Mrs C was discussed at Frailty MDT 4 times during her relapse. She was given additional dietician support as well as psychological support and assistance with shared decision making. As someone with no close relatives Mrs C always expressed her gratitude to have those around her whom she could discuss options with. She was grateful for being able to put in place clear advanced care planning which was enabled through our SHINE service.

Conclusion

Currently at UHS there is limited provision of frailty services within Haematology. Some community teams run frailty support, but this is focused primarily on dementia support and assessment. Across Wessex (Hampshire & Dorset) there is no tailored assessment programme to identify those with additional needs due to comorbidities or other age related concerns. The unmet need in this patient population manifests as e.g. reduced rates of treatment completion or increased treatment modifications, increased length of stay for post treatment episodes, missed appointments and non-elective admissions. All of which all have a subsequent impact on the patient's prognosis and NHS resources.

Evidence from other centres who have initiated a geriatric oncology service or similar have seen increased success in completion of treatment for patients and a reduced length of stage of an average of 4 and a half days. Other centres have also found this 'one stop' approach avoided multiple specialty referrals which supported cost-effectiveness whilst also delivering more comprehensive care.

This pilot is enabling the Trust to collect data at local level with the hope that longer follow-up demonstrates improved patient experience, better outcomes and reduced length of stay.

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