NEMICS health service profile: cancer support services

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Background:

The purpose of this programme of work is to collect cancer service data that will be used to help ensure fair access to effective, prompt and high quality care wherever a patient is treated in the NEMICS region.

This will be achieved through the following deliverables:

1. Deliverable 1. List of cancer services in the NEMICS region and their attributes (May – June 2013)
2. Deliverable 2. Service capability profiles
    a) Service capability profiles for day oncology and radiotherapy services in the region - Quality of service, capacity and access capabilities (May – September 2013)
    b) Service capability profile for surgical oncology services in the region - Quality of service, capacity and access capabilities (May – September 2013)
    c) Service capability profile for select cancer support services in the region - Quality of service, capacity and access capabilities (August – December 2013)
3. Deliverable 3. Work with Victorian Department of Health to pilot draft state wide service capability frameworks, sharing learning from local process (December – April 2014)

This paper addresses deliverable 2c – Service capability profile for select cancer support services.

An assessment of the following cancer support services are set out in this paper, based on clinical and management opinion as to whether further understanding of the regional service is required.

1. Hospital in the Home for oncology patients: Assess current provision and regional appetite to administer chemotherapy in the home.
2. Pathology: Assess the use of structured (synoptic) reporting across services and tumour streams.
3. Pharmacy: Clinical opinion of key gaps and issues.
4. Clinical trials: Assess regional gaps and issues, and scope of practice.
5. Tissue banking: Assess current provision including understanding of the Victorian state bio-bank.
6. Genetics and genetic counselling: Assess oncology patient flows and current service provision.
7. Lymphoedema services: Assess funding sources and service structure.
8. Oncology outpatient services: Assess current models for delivery and the use of multidisciplinary clinics, their rational and outcomes.
9. Pain management: Assess levels of service and identify any issues for outpatients.

Addendum 1 sets out the scope (including a list of cancer support services excluded from this assessment), rationale, and approach to assessing the services below.

1. Hospital in the home (HITH) for oncology patients

Key theme: Assess current provision and regional appetite to administer chemotherapy in the home.

Hospital in the Home (HITH) involves the provision of acute, sub-acute and post-acute treatments by health care professionals at a patient's usual place of residence as a substitute for inpatient care received at a hospital. In Victoria HITH patients are an inpatient admission and this is not so in all states. Victoria accounted for 75% of all HITH activity in Australia in 2009[1]. However, whilst there is a driver to administer chemotherapy in the home in other states due to growth in the demand of inpatient care, there is less of an economic driver in the NEMICS region as there has a been an estimated 25% increase in capacity in Day Oncology Units over the last four years with new builds and additional chairs. Current HITH provision for oncology patients is set out for each public health service below:

Austin Health: Austin Health has a full HITH service. In 2012 899 chemotherapy patients were seen by a HITH nurse (this excludes other oncology patients who required IV antibiotics and wound care or radiotherapy patients). Of the 899 patients:

- 13 patients were referred from the oncology ward and 886 from Day oncology
- 843 patients were seen for chemotherapy disconnections and 56 for long term care requirements (between 3-6 months).

Eastern Health: Eastern@Home provides a specialist HITH Oncology Service for Oncology and Haematology patients requiring:

- Some Chemotherapy treatments at home
- Central Line blood tests post admission for Chemotherapy
- Other intravenous treatments for cancer-related conditions

Mercy Hospital for Women: MHW have a HITH service but have very low service volumes for oncology patients. They estimate that less than 8 oncology patients per annum are seen by the HITH team, usually for wound management.

Northern Health: No service

HITH increases the capacity of day oncology units and therefore increases throughput, and thus workload. There will likely be an increase in the use of HITH to administer certain treatments in the future which will again, impact on training of nursing staff; and for pharmacy, has implications for drug packaging, storage, and cold chain (for example, as subcutaneous delivery of some monoclonals become available, these may well be administered through HITH).

Key discussion area: Should NEMICS provide trend and impact assessments (HITH and other) to health services to enable capacity planning?

[1] Deloitte access economics, Economic analysis of Hospital in the Home (HITH): Hospital in the Home Society of Australasia, 2011

2. Pathology

Key theme: Assess the use of structured (synoptic) reporting across services and tumour streams.

Use of the structured reporting protocol (cancer datasets) is not mandated in Australia. It is being considered by the National Pathology Accreditation Advisory Council (NPAAC) and is included as a recommendation in their proposed document "Requirements for Medical Pathology Services".

Within NEMICS, representatives from each public health services have reported that synoptic reporting is routinely done. At Austin Health, CNS and lymphoma MDMs use a different reporting format.

The Royal College of Pathologists of Australasia (RCPA) have advised they do not currently have any means to monitor the use of structured reporting on an ongoing basis, though a pilot project was run last year to set a baseline and establish a process to do this. The pilot assessed 400 pathology reports supplied by the Cancer Council Victoria. Two elements of structured reporting were assessed against RCPA guidelines for colorectal cancer: (1) Report completeness – are all required content included in the narrative? (2) Is content set out in a structured format? Unpublished findings showed low completeness with fields of data missing and fewer than 60% of the 400 reports used a structured reporting layout.

The College advised of the following limitations to the pilot, and to monitoring the use of structured reporting in health services:

- Pathologist input was required to interpret content to determine equivalency against minimum guidelines (and was not able to be recruited within the pilot timescales).
- Reports had to be assessed and manipulated so only those in an electronic format were usable. This substantially restricted sample size and geographic spread so the pilot was considered not sufficiently representative.
- Some best practice indicators only apply in some circumstances and therefore best practice is not always listed as a minimum requirement in the RCPA guidelines
- Access to electronic versions of pathology reports (as many reports are still sent via fax and paper to the registries).

The RCPA is working with their counterparts in the United States of America and the United Kingdom to agree internationally uniform guidelines. Four tumour streams are near finalised (melanoma, lung, radical prostatectomies, and endometrial cancers).

Table 2 shows pathology providers for each health service across NEMICS. Given the mix of in-house and contracted out pathology providers, it would be useful to assess whether synoptic reporting varies by type of provider.

Table 2. Anatomical pathology provider for each NEMICS health service

Key
Full service on-site
Limited service / sessional appointments / service located within 0.5km of hospital site
Service (not patient) moves between sites within same provider / virtual service across NEMICs providers
No service

Service provider - public					Service provider - private				
Austin Health - Austin Hospital	Eastern Health	Northern Health	Mercy Hospital for Women	Peter MacCallum Cancer Centre - Box Hill	Knox Private Hospital (Healthscope)	Ringwood Private Hospital (Healthscope)	John Fawkner (Healthscope) - WCMICS	Warringal Private Hospital (Ramsay Health)	Epworth Eastern Hospital (Epworth Healthcare)
Austin	EH	healthscope	Austin			Healthscope or melbourne pathology		Dorevitch and Melbourne Pathology	Melbourne Pathology

There is clinical consensus that synoptic reporting of cancer cases in anatomical pathology and haematology is likely to contribute to better cancer control through improvements in clinical management and treatment planning. There is literature to support that pathology reporting deficiencies have been shown to be common in Victoria, with deviations from the suggested minimum dataset. These deficiencies have been shown to be correctable with the uniform introduction of synoptic reporting[2].

Key discussion areas: Is there a clinical view that synoptic reporting varies by type of provider or by tumour stream?

Is there a role for NEMICS to facilitate early adoption of international reporting guidelines currently being developed?

Is NEMICS well placed to monitor the use of synoptic reporting locally?

3. Pharmacy

Key theme: Clinical opinion of key gaps and issues

A regional meeting with representative oncology pharmacists across NEMICS health services was convened in November 2014. The areas they identified that would deliver the most significant improvements to oncology pharmacy services across the region are set out below.

E-prescribing: Only 2 of the 10 NEMICs day oncology units have electronic prescribing for chemotherapy. There is online medication prescribing systems at some campuses but the software is not always extended to chemotherapy prescribing. A paper based model is in place at some large acute hospitals due to cost pressures, leading to frequent transcription issues and therefore safety issues. E-prescribed administration of drugs is restrictively safer.

Workforce – Pharmacists: There are no national or state wide competency frameworks to assess pharmacist skill / allow to benchmark professional development although the Society of Hospital Pharmacists of Australia (SHPA), and at a state wide level, VIC TAG (Victorian Therapeutic Advisory Group) is currently developing competencies due to be finalised over 2014.

[2] Winn RD, Robinson DR, Farmer KC, Bell SW. *Deficiencies in pathological reporting of colorectal cancer in Victoria.* Department of Surgery, University of Wollongong, New South Wales

Workforce – cytosuite: There are issues with recruitment of appropriately skilled staff and retaining staff to work in the unit. This is partly due to the high pressure nature of the work, isolation, health and safety issues (and misinterpretations of these) and skill mix requirements. Technical staff require training and there is a shortage of approved courses for technicians / manufacturing skills. Training often falls onto the pharmacy department and the only state wide course offered is at Peter McCallum Cancer Centre. Consequently, there are resource pressures and limited available spaces on the Peter MacCallum course. Box Hill TAFE have recently developed a level 4 certificate in health services pharmacy support for pharmacy technicians which will help alleviate this, and has been government accredited.

Access to agents: Several issues were raised at the Victorian chemotherapy service redesign project (VCSRP) community of practice events:

a. PBS billing - the system encourages patients to be treated on the same day in the day oncology unit and not as an inpatient if the hospital wants to avoid bearing the cost of treatment. There is a driver to maximise revenue and minimise prescribing drugs to inpatients.
b. Each institution has guidelines on what can be used within their institution and this varies between hospitals. As such, some agents are restricted in some hospitals and not in others. This is particularly restrictive for longstanding patients at any one health service reluctant to go elsewhere for access to drugs and for patients who are not well informed of the options to do so. For example, Peter Macmillan Cancer Centre may allow access to drug A whilst drug A may not be readily available at Austin Health.
c. Any patient (public or private) admitted to a public hospital and wanting to bear the cost for access to a particular medication cannot do so as per the Medicare agreement. Again, this restricts patient choice further in regards to both access to drugs and location of treatment.

Benchmarking services: There is no established benchmarking tool to establish staff resource requirements for day oncology units and cytosuite manufacturing services. The society of hospital pharmacists (SHPA) updated their Standards of practice[3] for clinical pharmacy services in 2013 but the standards are not specific to oncology. There is detail on recommended staffing levels for clinical services and day oncology units and cancer inpatients are mentioned but the standards do not cover production.

Oral chemotherapy: There is an upward trend for prescribing of oral chemotherapy as a treatment option. Often oral chemotherapy prescriptions are not reviewed by the oncology pharmacist. As such, competency requirements and documented processes should be established to ensure oral chemotherapy is being safely prescribed and dispensed. COSA have developed guidelines on safe dispensing of oral chemotherapy and individual services have protocols in place but there is a voiced concern among pharmacists that this is not always endorsed. One example is administering cyclical prescriptions where full quantities are dispensed by community pharmacists without adequate instruction, and patients risk not taking the correct dose or understanding “rest” periods when no medication should be taken between cycles. Hospital review should be encouraged.

[3] Journal of pharmacy practice and research volume 43, 2, June 2013 – supplement: SHPA Standards of Practice for Clinical Pharmacy Services

Monoclonal antibodies: There is an upward trend toward use of monoclonal antibodies as a treatment option. This will impact on service provision. Given the high cost of monoclonal antibodies, again there are resource and access issues that will arise over time. COSA is likely to release a position statement by the end of 2013 on the preparation and safe dispensing of monoclonal antibodies. A mixed model of pharmacy and nursing is usually employed to dispense these agents which again, will impact pharmacy resource. WCMICS have established a working party to develop a guidance document.

Key discussion areas: Given the current mix of provision and various systems in place, it is not feasible to integrate these across NEMICS service providers. As such, is a role for NEMICS to endorse uptake of electronic prescribing and support a defined number of systems across the region?

How might NEMICS go about facilitating the develop a region wide staffing model for both clinical and manufacturing oncology pharmacists and technicians to enable resource planning and account for incremental growth over time?

What is the timeline for working with our WCMICS colleagues to review and apply the monoclonal antibodies guidance document currently being developed in their region to NEMICS providers?

4. Clinical trials

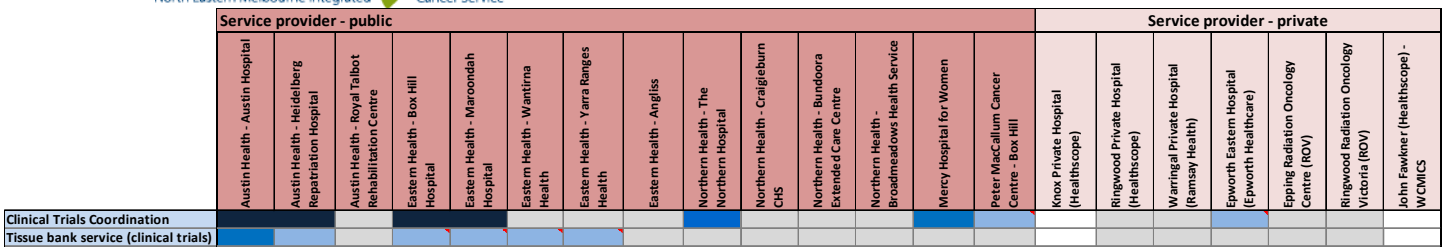
Key theme: Assess regional gaps and issues, and scope of practice

Clinical trials are run by a combination of pharmaceutical companies, collaborative groups (such as AGITG), and local investigating clinicians. Clinical trials not only involve testing new drugs but also implementation of new devices, new infrastructure or test evaluation techniques. NEMICS hospital clinical trials units are self funded and their main source of funding is generated by meeting recruitment quotas, which often occurs under tight timelines. To remain attractive as a trial site to the pharmaceutical industry and collaborative groups, and hence maintain this source of funding, recruitment quotas must continue to be met (however research staff are not paid per patient and thus units often operate at a loss or use any excess provided by pharma companies to cover shortfalls in collaborative studies or investigator led studies).

The location of the clinical trials units in the NEMICS region are set out below.

Key

- Full service on-site
- Limited service / sessional appointments / service located within 0.5km of hospital site
- Service (not patient) moves between sites within same provider / virtual service across NEMICs providers
- No service



With clinician and service management input, the following regional gaps and opportunities were identified:

There is a perceived role for NEMICS to facilitate a more collaborative culture to encourage cross referrals for studies particularly where the incidence of the disease under study is low. There is a trend toward the study of targeted therapies where a “whole of Melbourne” population is required to achieve an adequate patient accrual. The rationalisation of the number of hospital sites partaking in these studies has the obvious benefits of containing setup costs and maintenance costs and creating efficiencies (for example, by minimising duplication from multiple submissions to ethics committees). Also, it is not cost efficient to set up these trials at multiple sites if few patients are likely to be recruited at each individual site.

There is scope for collaboration between the NEMICS tertiary centres, and between the metropolitan health services and regional counterparts. There is scope to identify and cross refer a much larger cohort of patients to clinical trials from regional Victoria.

Furthermore, developing tumour stream registries providing robust information about outpatient populations would facilitate appropriate referrals and targeted rationalisation of trial sites. This would enable patient accrual targets to be more accurately projected.

Clinical Trials Australia (CTA) administers a proportion of studies for Austin Health (a foundation member). Other NEMICS hospitals are not members but there are a number of large tertiary institutions outside of the NEMICS region who are also founding members (for example, Peter McCallum Cancer Centre, Monash Health, and The Royal Melbourne). There is a view that the CTA should decentralise their offices and have staff located at each member site to improve coordination and study time lines.

Clinical trials impact other cancer services workload. There are more clinical trials requiring access to beds and allowing access to newer drugs. There are complexities around ring fencing pharmacy staff to undertake manufacturing for clinical trials at each institution, which are technically self-funded.

Key discussion areas: Clinical trials administration is a state wide issue. There may be opportunities for NEMICS to facilitate a more collaborative culture to encourage cross referrals for studies across their metropolitan and regional health services.

Should all NEMICS health services be members of Clinical Trials Australia and what are the cost barriers for health services?

5. Tissue banking

Key theme: Assess current provision including understanding of the Victorian state bio-bank

The Victorian Cancer Bio-bank (VCBB) is a collaborative consortium of the four major teaching hospitals housing tissue banks in Victoria. The VCBB collects oncology samples and distributes these to researchers. It has instituted standardised operating and collection procedures. Within NEMICs, the VCBBs are located at Austin Health and Box Hill Hospital and participating sites include Epworth Eastern, and Mercy Hospital for Women. CVBB are imbedded within service units and at the Austin Hospital are developing a joint service agreement to provide a collection service on behalf of the clinical trials unit. This provides reprieve to clinical trials nurses who are in under supply. The VCBB covers all tumour types and is the only non-tumour stream specific oncology bio-bank in Australia. The other largest bio-banks are K-confab (a familial breast cancer population study) and an ovarian cancer study of genetic markers.

Routine tissue banking is not undertaken in private hospitals within NEMICS as there are no pre-admission clinics. The service relies on the treating clinician to identify private patients suitable for banking on a case by case basis.

Key discussion areas: What measures would encourage increased uptake of tissue banking of private patients across NEMICS providers?

6. Genetics and genetic counselling services

Key theme: Assess oncology patient flows and current service provision

Oncology genetics is a relatively new discipline (circa 1995). About 80% of a cancer geneticists work load is breast cancer, 10-15% bowel cancer, and the remainder, rarer disease.

Within Melbourne, there are four familial cancer centres. These are based at Monash, The Royal Melbourne, Peter McCallum Cancer Centre, and Austin Health. The latter two are government funded genetics services operating across NEMICS health campuses:

The service based at Austin Hospital covers Austin Health, Northern Health, Ballarat, Shepparton, and Albury Wodonga. An outreach service is provided to The Northern Hospital (one clinic once a month where two oncology geneticists and one general geneticist provide a service and take referrals in the interim period. The clinic is increasing to twice monthly). The service also takes some referrals from the gynae-oncologist at Mercy Hospital for Women. The service is in the process of establishing a monthly high risk clinic for breast cancer (opening in early 2014). The service provides multidisciplinary input from oncology, surgery, gynaecology, geneticists, and genetic counsellors.

The other government funded genetics service based at Peter McCallum Cancer Centre provides an outreach service at Box Hill Hospital and takes some referrals from Mercy Hospital for Women.

A regional gap identified is that given centralised service provision, there is no clinical capability to determine whether all patients that should be referred, are being referred.

An identified referral gap from the Austin based service is that a large proportion of Mercy Hospital for Women patients are referred to the Peter McCallum genetics service, due to historical relationships when it would improve the patient experience to refer in to the Austin service.

Key discussion areas: How might referral pathways to genetics services be improved so that the all patients who require the service are referred, and are referred to the service closest to their home?

7. Lymphoedema service

Key theme: Assess funding sources and service structure

Current provision of lymphoedema services is set out for each public health service below:

Eastern Health: A hub and spoke service is provided, with Yarra Ranges Health as the hub and satellite clinics at Angliss Hospital and Box Hill Hospital. Yarra Ranges Health funding is through VACS, whilst Box Hill Hospital and Angliss Hospital are funded through SACS (community funding). Self management techniques, specialised assessment (Yarra Ranges Health only), lymphatic drainage, and education are provided.

Mercy Hospital for Women: The Mercy Health Lymphoedema Services (MHLS) team is based in East Melbourne and comprises medical practitioners, lymphoedema therapists (physiotherapists, occupational therapists or nurses) social workers, dieticians, and allied health assistants. The outpatient service is a public health service and a medical referral is required for assessment at the clinic. Patients with either primary or secondary lymphoedema are treated in the clinic or referred to more local services. An outreach service is provided at Mercy Hospital for Women.

Austin Health: There is no on-site lymphoedema service. Mercy Health provides an off-site service for Austin Health patients upon written medical referral from clinicians. There are also private lymphoedema practitioners in the community that Austin Health patients are offered the details for. In addition, the Olivia Newton-John Cancer & Wellness Centre (ONJCWC) offers oncology massage for lymphatic drainage (outpatients can self refer and an inpatient service is provided on the wards). The ONJCWC also offers an acupuncture service for breast cancer patients who require a written referral from their treating clinician.

Northern Health: There is no service. Northern Health patients are referred to the Mercy Health service.

Key discussion areas: Is there a service gap for Northern Health patients who are referred in to Mercy Health for lymphoedema services?

8. Oncology outpatient clinics

Key theme: Assess current models for delivery and the use of multidisciplinary clinics, their rational and outcomes

Current models of delivery for oncology outpatient services are set out for each public health service:

Northern Health: The Northern Hospital has a multidisciplinary breast outpatients' clinic and colorectal outpatients' clinic with surgeons and VMO oncologists in attendance. There are early plans to have gynaecologists present at the Breast clinic also.

Eastern Health: Only the uro-oncology outpatients' clinic held weekly on Thursday afternoon at Box Hill Hospital is multidisciplinary in the sense that both surgeons and medical oncologists are present.

Mercy Hospital for Women: MHW is partially multidisciplinary in that outpatient appointment days are the same as Day Oncology Unit opening days. Medical oncology, surgical oncology, pastoral care, and social work are therefore all onsite.

Austin Health: All of Austin Health's oncology outpatient clinics are multidisciplinary.

Key discussion areas: Should all oncology outpatients clinics be multidisciplinary? How might this be mandated and monitored?

9. Pain management

Key theme: Assess levels of service and identify any issues for outpatients.

Current levels of service and perceived service gaps are set out for each public health service below:

Eastern Health: Clinical and managerial colleagues report no perceived service gaps in pain management services at Eastern Health. The Ambulatory Pain Management Service offers specialist medical and allied health services for the assessment and treatment of persistent pain. The service is offered at Yarra Ranges Health, Angliss Hospital, and Peter James centre. Within the service are: a medical rehabilitation clinic; an opiate dependence and pain assessment clinic; and an 8 week / 16 session allied health program. In addition, palliative care physicians offer a pain management service to inpatients. Medical oncologists and the Eastern Palliative Care Service offer pain management to outpatients.

Mercy Hospital for Women: Outpatients will see a clinician for ongoing pain management if required and can present via emergency or outpatients clinic. In addition, there is an inpatient pain team.

Northern Health: Pain management is undertaken by oncologists and palliative care consultants. There are pain clinics at Broadmeadows health service and Bundoora Extended Care Centre but this service is not oncology specific.

Austin Health: There is an acute pain service that predominantly sees post surgical patients and a small number of oncology patients. The outpatient's pain service primarily sees patients with chronic pain issues. Referrals are triaged and prioritised. There can be up to a two year wait for an appointment. For oncology patients, pain is predominantly managed by their oncology clinician with a palliative care review if required. Often oncology patients are managed collaboratively between pain services and pall care. Palliative care takes over pain management as disease progresses.

Key discussion areas: How can variation in access to pain services for oncology patients be reduced across NEMICS providers?

10.Next steps

This paper provides further detail on select cancer support services where there was a lack of understanding regarding regional service availability, or a perceived regional gap or issue in the provision of services.

Further to this, there is a state wide move to encourage linkages between regional facilities and connected to metropolitan services. The spread or concentration of cancer support services, general services, and staff will impact workload, capacity, and access. A greater understanding of service boundaries and planned referral pathways would enable better resource planning. NEMICS is well placed to advise health services of the Victorian Department of Health plans regarding pathway and system changes for cancer services and support services in regional Victoria.

In February 2014 the proposed number and location of cancer services in the NEMICS region, and best practice referral pathways for these services and key support services, will be presented at the annual NEMICs planning workshop to support decision making on regional service planning priorities.

The work will also feed in to the Department of Health's service capability profiles being developed for cancer support services (including pharmacy).

Addendum 1. Scope of review cancer support services:

Cancer service	Detail / scope	Key focus areas
HITH (oncology)	All oncology service users of HITH	Further detail as to what is currently delivered. Check no economic driver to administer chemotherapy in the home (on assumption no capacity constraints in NEMICS region / 25% increase in capacity over last period)
Pathology	Anatomical / genetics	Assess use of synoptic reporting across services and tumour streams
Pharmacy	With / without cytosuites	Convene NEMICs regional meeting of pharmacy representatives to discuss key issues – access to agents; workforce; cytosuite training
Diagnostic procedures	EBUS + EUS	Map current service provision (documented on regional service map)
Nuclear medicine		Map current service provision (documented on regional service map)
Clinical trials	Clinical trial coordination	Assessment of gaps and issues: Are trials services affiliated with CTA? Other affiliations? Scope of practice? Disease scope? Beds available for clinical trials in oncology?
Tissue banking		More detail on current service / no. and proportion / VIC state bio-bank
Genetics / genetic counselling service	Oncology patients	Assessment of oncology patient flows and current service provision
Lymphoedema service	Education and services	Assessment of funding sources and structures in place
Continence services		Map current service provision (documented on regional service map)
Oncology outpatient clinics		Assess models for delivery – use of multidisciplinary clinics, their rational and outcomes.
Pain management	Inpatient and outpatient	Access issues for outpatients. Assess levels of service.
Day oncology units	Public and private providers	Service capability profile produced in phase 1 of this project
Radiation oncology	Public and private providers	Service capability profile produced in phase 1 of this project
Surgical oncology	All	Service capability profile produced in phase 1 of this project
Emergency departments	All	Determine collocation requirements with core cancer services / include in decision making criteria for any cancer service relocation proposal
Day surgery	All	Diagnostic vs therapeutic interventions. No immediate requirements.
Coronary care	Out of scope	General service

Anaesthetics	Out of scope (pain management listed separately)	General service
Oncology outpatient clinics	Out of scope	NEMICs does not have a service delivery role
MDM meetings	Out of scope	Separate NEMICs project (CV)
Prosthetics and orthotics	Out of scope	General service
Supportive care screening	Out of scope	Separate NEMICs project (MS)
Rehabilitation	Out of scope	Established structures
Allied Health services: Occupational therapy, speech pathology, social work, dietetics	Out of scope	Workforce issue / service mobile
Psychology	Out of scope	Workforce issue / service mobile
Psychiatry	Out of scope	Workforce issue / service mobile
Physiotherapy	Out of scope	Workforce issue / service mobile
Pastoral care unit	Out of scope	Workforce issue / service mobile
Dental services	Out of scope	General service / established structures
Interpreting services	Out of scope	Workforce issue / service mobile
Post acute care programme	Out of scope	Separate managed project
GP Liaison units	Out of scope	Replaced by medicare locals
Advanced care planning	Out of scope	Separate managed project
Palliative care team / beds	Out of scope	General service
Health information / IT	Out of scope	Separate managed project / general service
Radiology	Inc. Interventional radiology and nuclear medicine. Excl. Diagnostic imaging (covered above)	Out of scope
Medical physics		Out of scope
Diagnostic Imaging	General / CT / MRI / PET / Nuclear medicine	Out of scope
Infectious diseases unit	All	Addressed in 1-1s with NUMs. No further requirements.
Wellness services	External visiting services, therapy, education courses	DOUs perceived service gap – coordination and access to these services and information. Covered in another NEMICS project