Improving Cancer Outcomes Project (ICOP)

Summary of findings and recommendations

Introduction: Improving Cancer Outcomes Project (ICOP) – Grampians region

The Improving Cancer Outcomes Project (ICOP) was initiated and funded by the Victorian Department of Health and Human Services (DHHS) to: examine pathways of treatment for people with cancer in the Grampians region; and to establish whether these pathways and treatment aligned well with best practice.

Colorectal cancer (CRC) was chosen as the first tumour stream to be investigated. This tumour stream was selected due to the:

- Apparent poorer outcomes for cancer in Grampians
- Possible over-utilisation of chemotherapy for colorectal cancer
- Possible under-utilisation of radiotherapy for colorectal cancer
- Other factors which might contribute to poor outcomes

Results:

The GICS' Lead Clinicians, GP Reference and Data Working Groups agreed 9 questions to be answered by the data gathering and analysis process. These were:

1. Did delays occur in diagnosis or treatment? And if so, reasons. (e.g. patient choice, excessive time on waiting list)
2. Did access to treatment impact choices? (e.g. transport issues, health literacy, social disadvantage)
3. Diagnosis and stage at diagnosis
4. Was there an MDM treatment plan and did this align with guidelines or existing evidence?
5. Did treatment received match the plan?
6. Did supportive care screening occur at 3 points of care? (Diagnosis, during active treatment and during the follow-up phase of care)
7. Did the patient receive supportive care interventions required?
8. Did the patient receive appropriate follow-up care in a timely way?
9. Did the patient experience recurrence and, if so, when?

Some of the questions were unable to be answered due to a lack of data.

(see following pages for recommendations relevant to General Practice)

**Recommendations relevant to General Practice:**

Area of work	Actions to be agreed
Multidisciplinary Meetings (MDMs)	
GICS to work with health services to ensure MDM treatment plans are communicated to all health services involved in delivery of care to the patient	1. Current GICS project commenced to automate this process
Clinical Service Improvement	
Dissemination of the Optimal Care Pathways to all relevant service providers and health services in the region to increase awareness of Victorian benchmarks and ensure they are embedded into clinical practice	1. Liaise with DHHS regarding regional launch of optimal care pathways, with keynote speakers. 2. Develop communication strategy for dissemination of optimal care pathways, with clinical champions identified as part of this process. 3. Access to optimal care pathways documents to be disseminated via the new website
GICS work with health services to improve access to colonoscopy services and comply with the Colorectal Cancer Optimal Care Pathway timeframes.	
There should be an emphasis on follow up of rectal cancer cases to capture local pelvic recurrences which are a marker of inadequate primary treatment	Liaison with surgical leads and medical directors at BHS, SJOG & Wimmera to provide services to capture colonoscopy or imaging recurrence – report to MDMOne
Consumer Focus	
Establishment of a community education program regarding early signs of possible colorectal cancer to reduce delay between symptom onset and initial GP presentation	1. Work with the GP Reference Group and PHN to identify existing programs (e.g. BowelScreen, encourage GPs to write to all patients over 50 in lead up to National BowelScreen week – via PHN) 2. In consultation with the GP Reference Group, develop a short communique of relevant audit outcomes for dissemination to General Practice
Supportive Care Screening	
GICS to work with health services to improve supportive care screening rates and comply with screening points throughout the patient journey.	1. Incorporate into current GICS project to reconfigure support care screening
Audit Methodology	
Improved access to alternative data points (eg, private clinician records, general practice records) to increase capture of relevant data	1. Coordinate approach with data WG
Resource provision for longitudinal patient record audits (e.g. tracking individual patients over a five year time period) including General Practice records	1. Coordinate approach with data WG

Question 1.

Did delays occur? And if so, reasons. (e.g. patient choice, excessive time on waiting list)

The Grampians Cancer Data Framework was modified to align with the new Optimal Care Pathway for colorectal cancer in order to enable comparison with best practice and ensure timeliness of care. This particularly relates to delays in the patient treatment pathway (see 'Optimal_cancer_care_for_people_with_colorectal_cancer.pdf').

Snapshots:
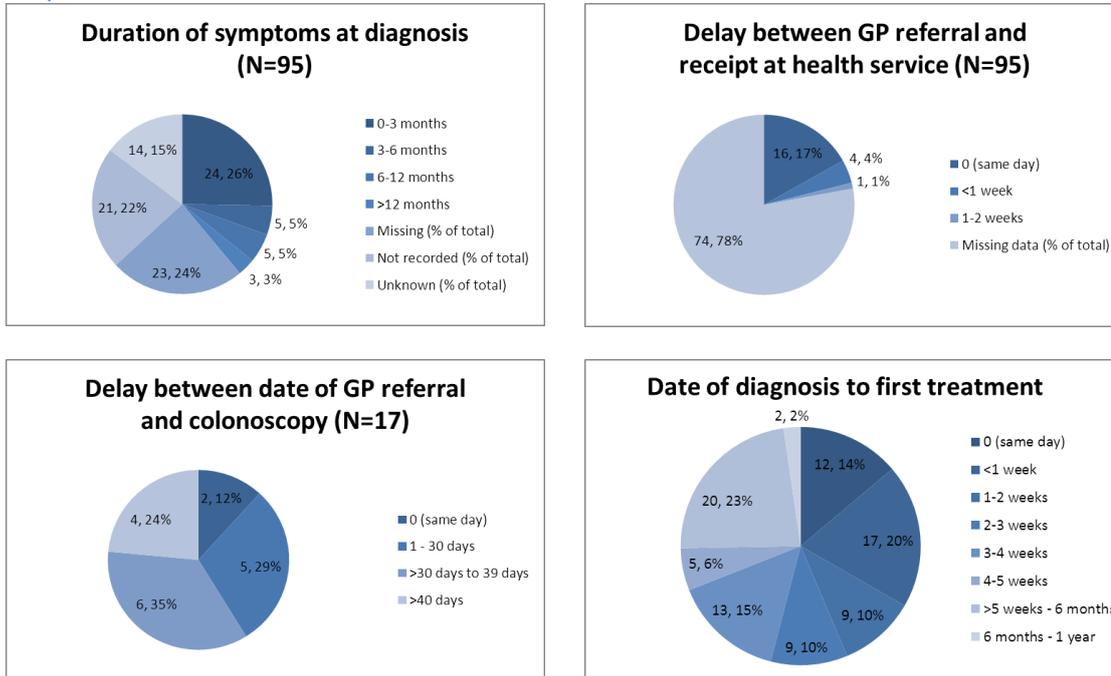
('Missing' = data item not completed by the auditor; 'Not recorded' = Data not found in history; 'Unknown' = recorded as Unknown in the history)

Discussion:

41 percent of patient records with a GP referral letter in the history met the Optimal Care Pathway prescribed timeframe to colonoscopy of four weeks

From the available data, 35% of patients who presented to a GP and were referred had symptom duration of more than 3 months. This could have been due to patient delay in presenting to or following up with a GP, or GP delay in referring patients with symptoms. GP referrals were often received on the day they were written. There was no trend identified showing that location of residence impacted duration of symptoms at diagnosis. Anecdotally, stoic farmers in remote areas are reluctant to present to a GP, however, this was not borne out in the data.

Seven people (10%) were known to have waited more than four weeks for their diagnostic procedure from their first appointment in a specialist setting.

For 21 patients with known GP referral date, 17 went on to have a colonoscopy. 59% of those patients who had a colonoscopy following GP referral waited more than 30 days to undergo this procedure. 90% of patients underwent some form of treatment for their colorectal cancer after diagnosis. Of these, 1 patient waited more than 6 months to receive post diagnostic treatment for their cancer. (Note: 11 patients were diagnosed at excisional surgery)

Recommendations:
- Establish a community education program regarding early signs of possible colorectal cancer to reduce delay between symptom duration and initial GP presentation.
- GICS work with health services to improve access to colonoscopy services and comply with the Colorectal Cancer Optimal Care Pathway timeframes.
- GICS establish a set of key performance indicators aligned to the Colorectal Cancer Optimal Care Pathway benchmarks and monitor health service compliance on a six monthly basis.

Question 2.

Did access to treatment impact choices? (e.g. transport issues, health literacy, social disadvantage)

Unfortunately, there was no evidence to support or refute the theory that health literacy or social disadvantage impacted access to treatment. Patients either had treatment or did not, and reasons for particular patterns of care were not well documented. However, location of services did seem to play a role in whether patients received investigations and radiotherapy in particular.

Only 2 patients of the 95 were documented to have refused treatment. The reasons given were: 'patient did not want surgery due to age'; and 'Patient stopped chemo because of side effects'.

Not all institutions have the full complement of radiology services available. Wimmera Health Care Group made MRI available in December of 2013, so lack of local access to this investigation during the audit timeframe may have contributed to the lack of MRI seen in this audit.

Snapshots:
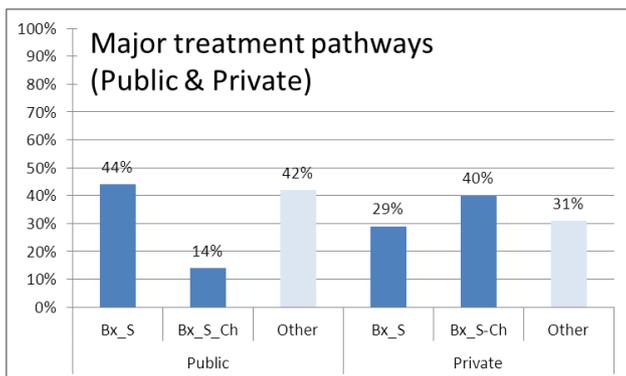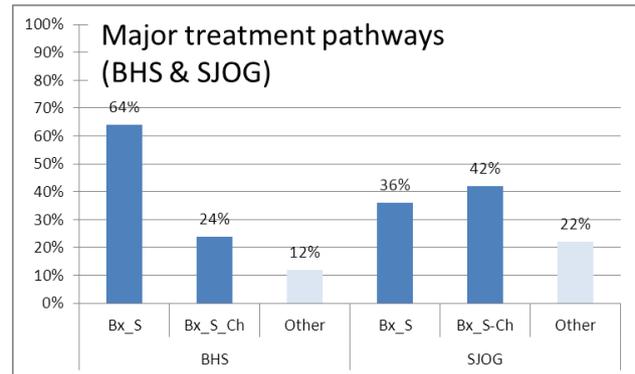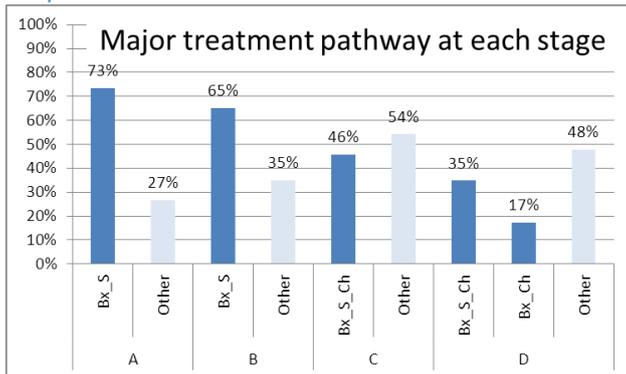
Pathway Legend:
Pathways are set out in chronological order of treatment received:

- Bx Biopsy
- S surgery (major excisional)
- Ch chemotherapy
- R radiotherapy
- CCR concurrent chemo-radiotherapy

Discussion:

Of interest are the referral pathways into health services and treatment pathways by stage of disease at diagnosis: 11 of 15 patients (73%) and 13 of 20 (65%) who had stage A or B colorectal cancer respectively underwent a pathway of biopsy followed by surgery. This appeared to be irrespective of where they lived. By contrast, approximately 46% of those with stage C colorectal cancer underwent adjuvant chemotherapy, but there was more diversity of pathway in this group. The most diversity occurred for people with stage D colorectal cancer, with 35% of this group undergoing biopsy and excisional surgery followed by chemotherapy, and 4 of 23 (17%) who had only biopsy and chemotherapy without major surgery for their cancer.

It appears that patients treated publicly are more likely to undergo biopsy followed by surgery (without chemotherapy) (44%), than those treated as private patients (29%) irrespective of which type of health service provides the surgical care.

Access to radiotherapy: As radiotherapy is only available in Ballarat (within the Grampians), and treatment usually involves five days per week for up to six weeks, anecdotal evidence suggests that lack of radiotherapy for patients in this cohort may be due to travel and accommodation issues, although this information was not documented in the patient records.

Recommendations:
- Future audits to examine:
  - treatment pathway variation by location of residence
  - if there are real differences in pathway based on stage of cancer and treatment intent at diagnosis.

Question 6.

Did supportive care screening occur at three points of care? (Diagnosis, during active treatment and during the follow up phase of care):

Definitions:
A) Diagnosis Phase (Defined by period between Date of Diagnosis and First Treatment Date)
B) Active Treatment Phase (Defined by period between First treatment and final treatment of initial cancer – not treatment of recurrence)
C) Follow-up Phase (Defined by period after final treatment date of initial cancer)

Supportive care screening is associated with improved outcomes for people with cancer. (NICE 2004)

Snapshot:
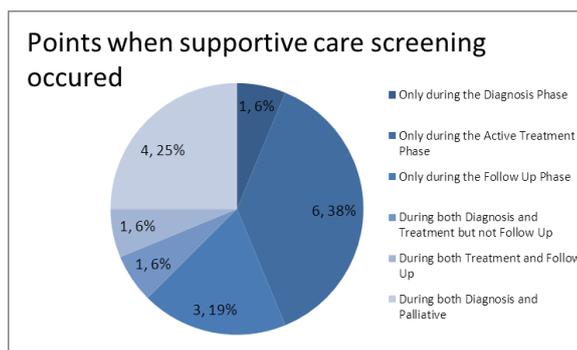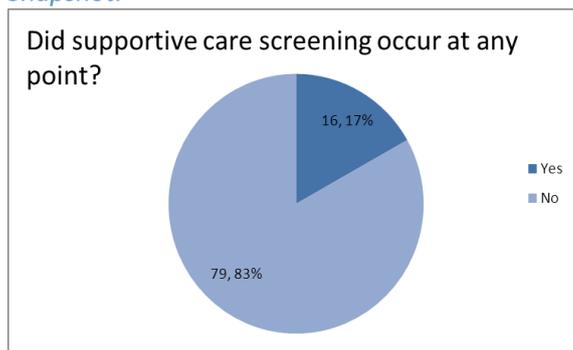
The six most self-identified supportive care issues from supportive care screening.

Issue identified	Domain	Number N=328	%
Fatigue	Physical	188	57
Worry	Emotional	155	47
Sleep	Physical	152	46
Memory/concentration	Physical	114	38
Pain	Physical	108	33
Fears	Emotional	96	29
Grampians region supportive care screens completed over a 12 month period (Oct 2013 – Sept 2014) *299 individuals completed the screen* *(Source: GICS MDMOne Database)*			

Audit 2: Colorectal Pathways (n=21)

(Chart showing horizontal bar graph with categories from bottom to top:)
- Surg only: 7 (No Support Care Screen - blue)
- Surg with stoma: 5 (No Support Care Screen - blue)
- Surg + Chemo: 3 (With Support Care Screen - red)
- Surg + Chemo + Stoma: 1 (With Support Care Screen - red)
- Surg + Chemorad+stoma: 3 (With Support Care Screen - red)
- Surg + Oral Tx: 2 (No Support Care Screen - blue)

X-axis: 0 to 8

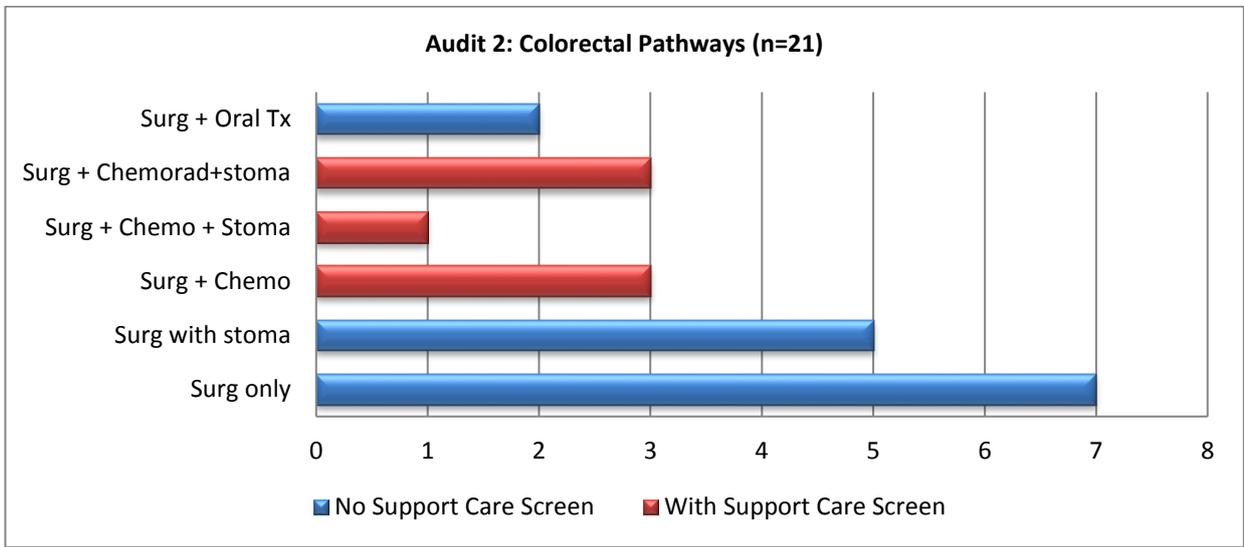Legend: ■ No Support Care Screen ■ With Support Care Screen

Chart 3: Provisional Grampians data analysis from statewide Audit Round 2 2014-15.

Points to note from Audit 2, chart 3:
- There was evidence of supportive care screening in 33% of cases (7 of 21)
- All of these were treated in chemotherapy day unit

Discussion:
There was an overall lack of supportive care screening of patients in the audited colorectal cancer patient cohort, with only 16 of the 95 patients (17%) with invasive colorectal cancer recorded as having a supportive care screen. This is consistent with the DHHS Cancer Service Performance Indicator audit findings which show sub-optimal levels of supportive care screening in the region as demonstrated in Audit 2 results in chart 3.

Recommendations:
- GICS to work with health services to improve supportive care screening rates and comply with screening points throughout the patient journey.
- GICS establish key performance indicators aligned to the Colorectal Cancer Optimal Care Pathway benchmarks regarding supportive care screening points and monitor health service compliance on a six monthly basis.