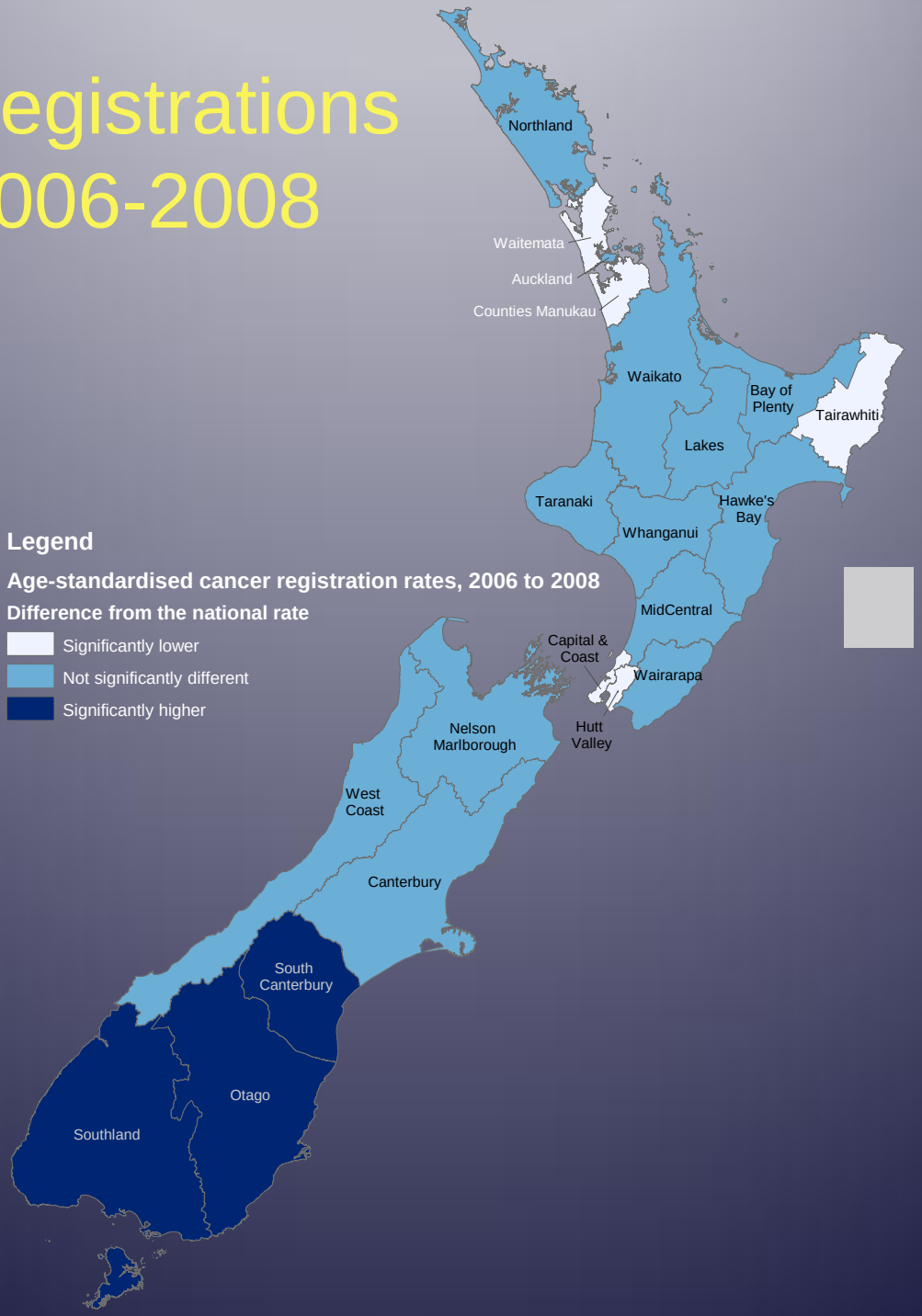
Whats new in cancer

The way we do business is changing

- Why?

- Otago-Southland Colonoscopy review
- SCN Bowel cancer report
- SCN Lung Cancer report
- NCN Lung cancer report

New CRC Registrations by Region 2006-2008

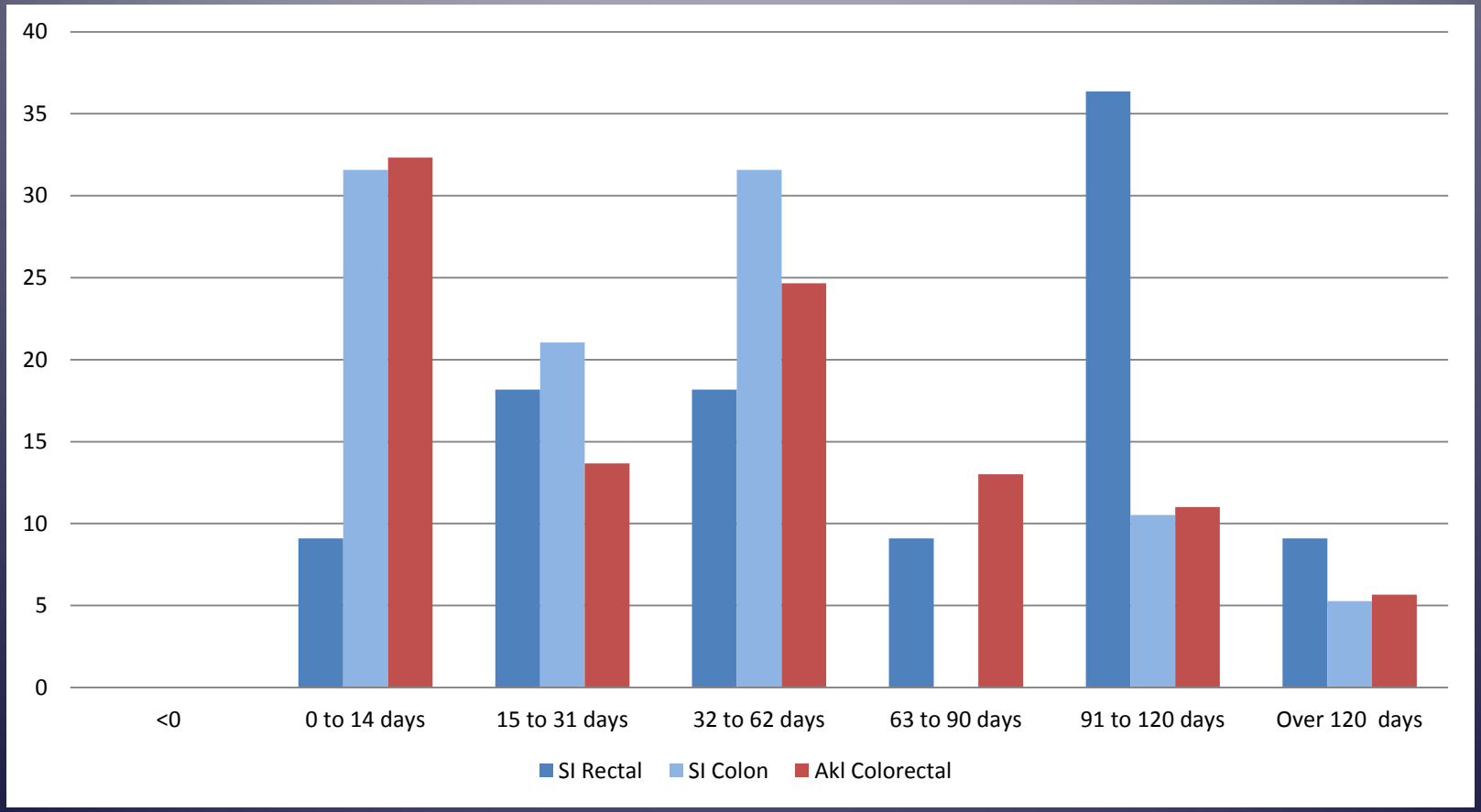


Diagnosis of Colon and Rectal Cancer

- 58% present to surgical service
- 10% acute presentation
- 19% gastroenterology or endoscopy

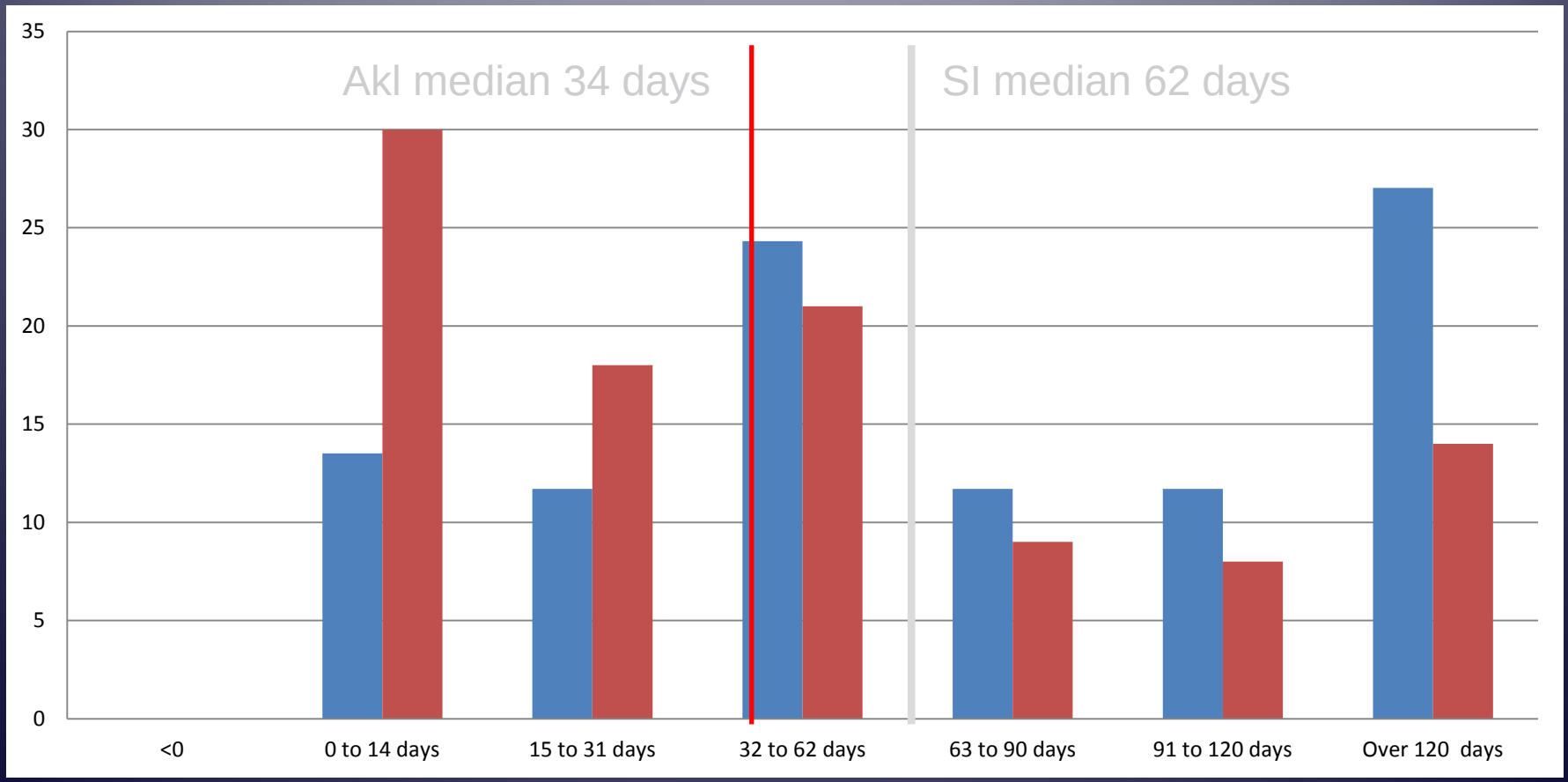
- Symptoms can be vague
- Abdominal pain, bleeding, bloating, anaemia, change in bowel habit
- Investigated with rectal examination, colonoscopy, CT colonography, sigmoidoscopy, (barium enema)

Time to first treatment – advanced disease

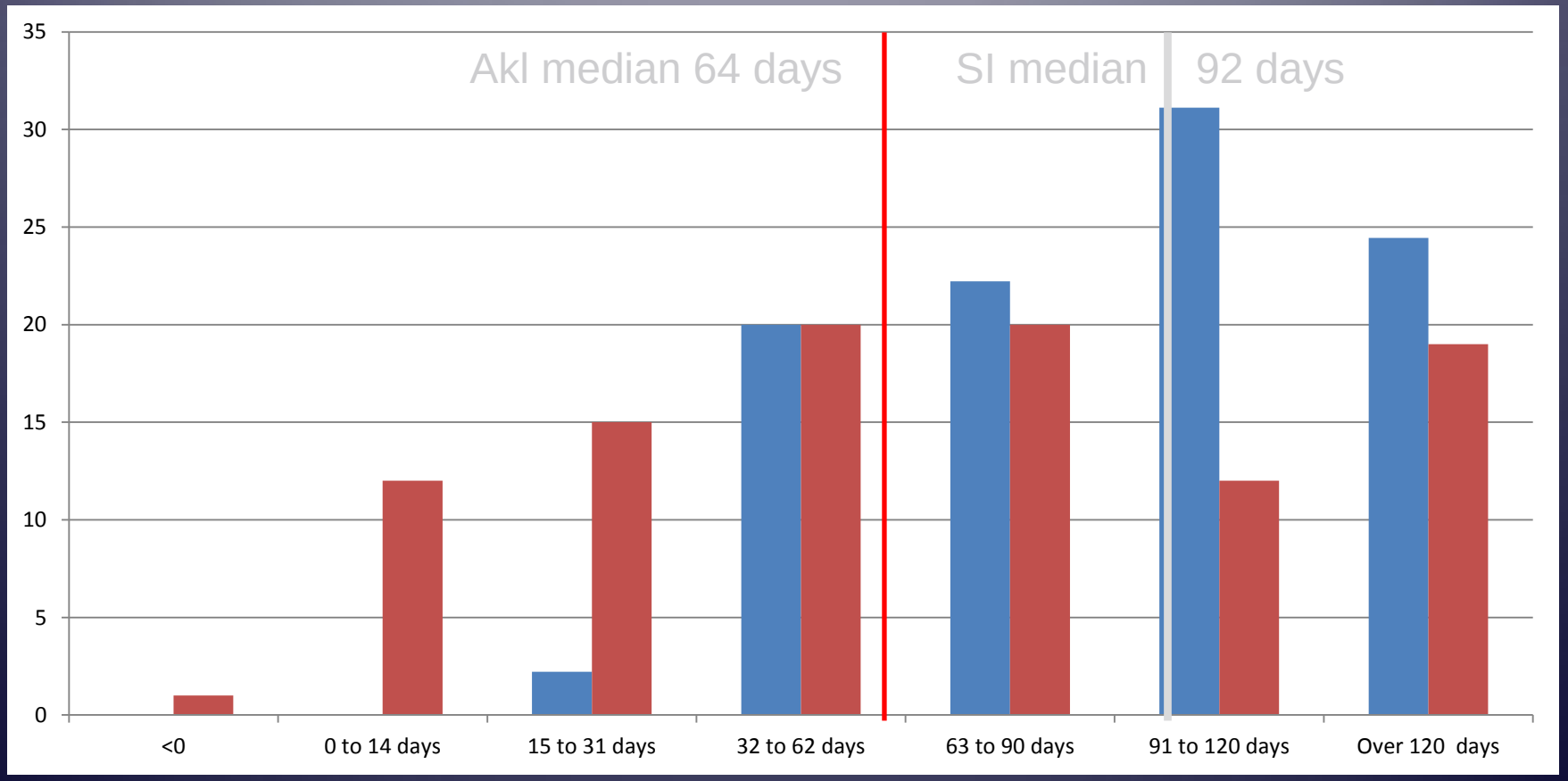


SI Colon n=19; rectal = 11

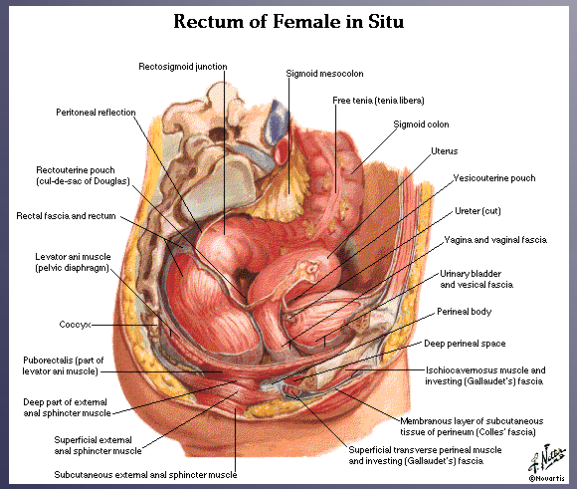
Time to first treatment – Early Colon Ca

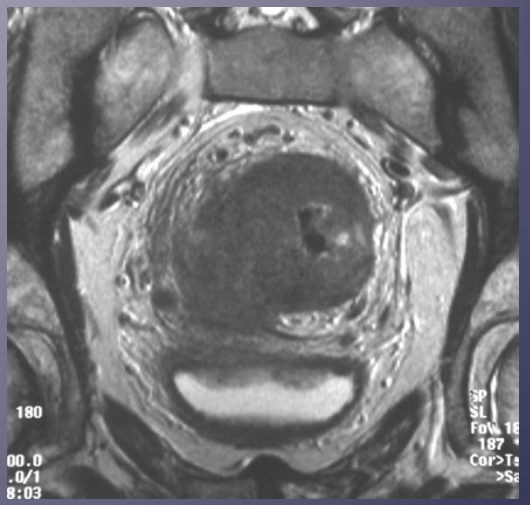


Time to first treatment – Early Rectal Ca



Rectal Cancer – multi-step process with multi-step waits





Service changes since 2009

- Greater use of direct access endoscopy / CTC
- Increase in MDM discussion for rectal cancer
- Reduction in use of barium enema
- Increased number of colonoscopies in Southern
- Electronic referrals
- Radiation therapy targets

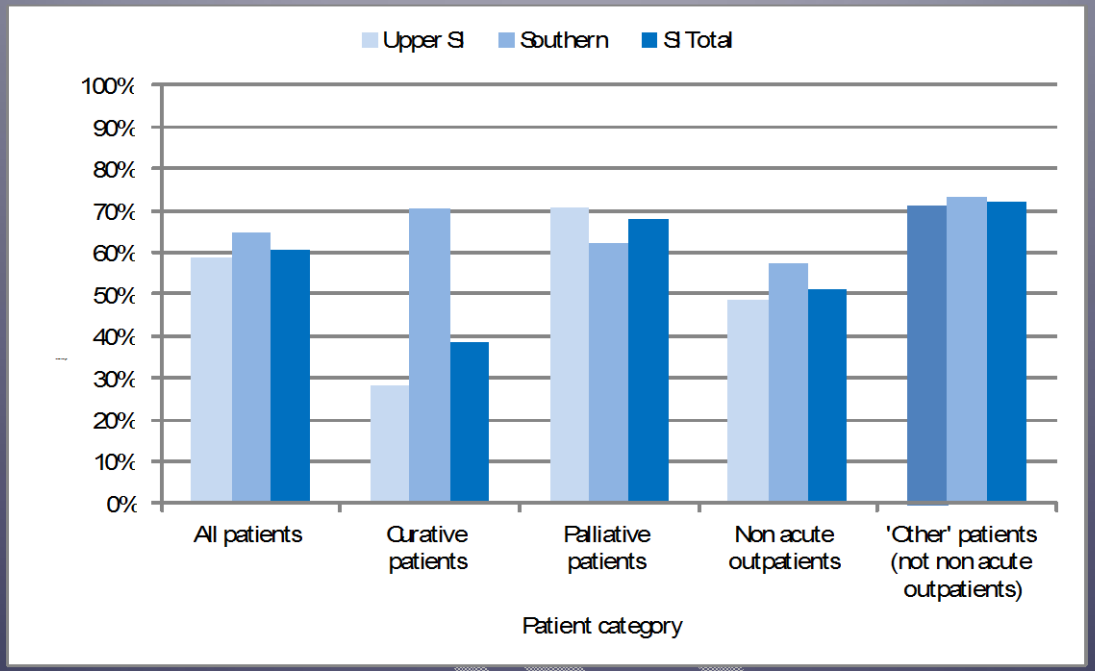
- CHCH MEDIAN time to treatment from DIAGNOSIS for rectal cancer still > 40 days (unpublished data)

Lung

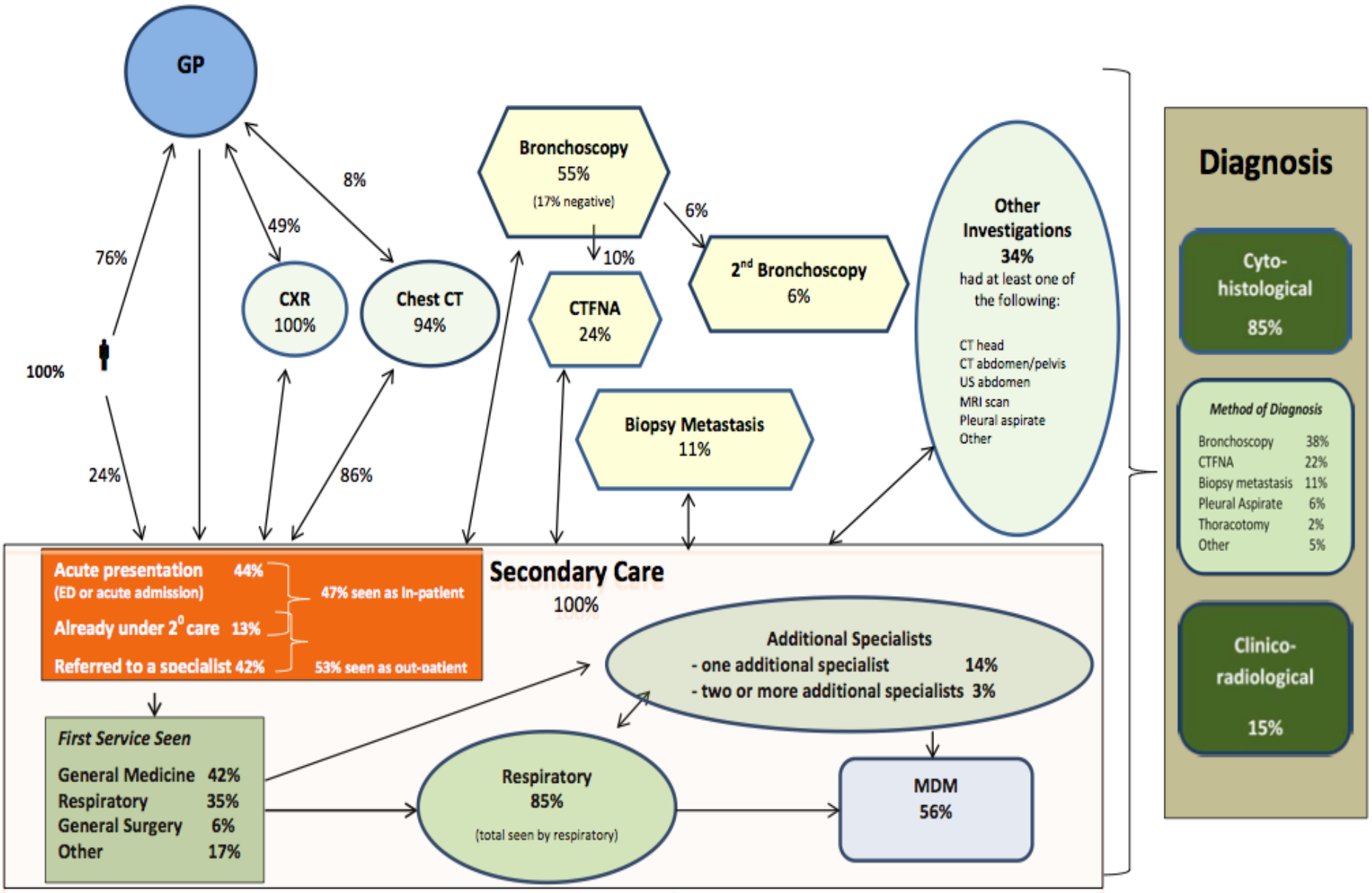
SOUTHERN CANCER NETWORK SOUTH ISLAND COMPARATIVE LUNG AUDIT (2008-2010)

Percentage of patients meeting 62 day indicator (referral receipt to earliest treatment) by patient category, 2010

Figure 4: Percentage of patients meeting 62 day indicator (referral receipt to earliest treatment) by patient category, 2010



Lung Cancer Clinical Pathway to Diagnosis



% = % of the total lung cancer cases

Identification of barriers to the early diagnosis of people with lung cancer and description of best practice solutions" (W. Stevens et. al.)

Patients felt that most of the delays in the lung cancer pathway occurred within primary care. Often patients presented on numerous occasions, however sometimes this was to different GPs.

The median time from presentation to referral was 3 weeks however 25% of lung cancer patients took longer than 2.5 months to be referred (IQR2 6; 73).

Regional Cancer Networks	Northern				Midland			Central								Southern					
DHBs	Northland	Auckland	Waitemata	Counties/Manukau	Bay of Plenty	Lakes	Waikato	Capital & Coast	Mid Central	Hawke's Bay	Tairawhiti	Wairarapa	Hutt Valley	Whanganui	Taranaki	Canterbury	South Canterbury	West Coast	Nelson/Marlborough	Southern - Dunedin hospital	Southern - Southland hospital
Standards																					
Timely access to services																					
1. Patients requiring active treatment should start treatment within 62 calendar days of secondary care receiving a referral.	59%	39%	55%	39%	31%	41%	43%	46%	Not available	76%	46%	33%	69%	40%	47%	55%	31%	63%	23%	60%	53%
2. Patients with clinical and/or radiological signs and symptoms suggestive of lung cancer should be seen by a specialist with an interest in respiratory medicine within 14 calendar days of secondary care receiving a referral.	14%	30%	61%	12%	26%	56%	63%	52%	Not available	61%	39%	50%	75%	33%	40%	90%	67%	56%	45%	76%	61%
3. Chest X-rays should be performed for all patients with symptoms suggestive of lung cancer and should be reported back to the referrer within seven calendar days of the radiology service provider receiving a referral.	100%	60%	60%	Not available	29%	71%	44%	Not available	55%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Communication and referral																					
4. The formal referral pathway and required information should be agreed between primary, secondary and tertiary care. Communications between health care providers should include the patient's name, date of birth and National Health Index (NHI) number, and ideally should be electronic.																					
Data Collection																					
5. All patients with lung cancer should be entered into a lung cancer database.																					
Investigations																					
6. Computed tomography (CT) should be performed before a bronchoscopy.																					
7. All cancer centres should have timely access to endobronchial ultrasound (EBUS).				♦				♦													
8. Staging positron emission tomography and computed tomography (PET-CT) should be performed in patients with suspected or confirmed non-small-cell lung cancer suitable for potentially radical treatment, with the exception of peripheral T1aN0 tumours.												Not available			Not available						
Multidisciplinary care																					
9. All patients with lung cancer should be discussed at a multidisciplinary meeting.	70%	75%	75%	70%	51%	62%	71%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	77%	59%	74%	Not available	88%	73%
Smoking cessation																					
10. All current smokers and their family/whānau should be offered smoking cessation advice and support to quit, where appropriate.										Not available											
Care co-ordination																					
11. All patients with suspected lung cancer should have a nominated single point of contact, ideally a nurse who specialises in cancer care, to provide psychosocial support, information and co-ordination of a patient's cancer journey. Contact will be made with the patient within seven calendar days of the initial assessment with a specialist.																					
Palliative care																					
12. Patients who cannot be offered curative treatment, as well as those with a significant symptom burden, should be offered early access to palliative care services.	Not possible to gauge DHB performance against this standard from available information																				
Active anti-cancer treatment																					
There is no specific standard for active anti-cancer treatment. However timely active anti-cancer treatment is important and is incorporated in the 62 calendar day wait time target between receiving a referral and start of treatment (see Standard 1).	See Standard 1																				
Follow-up																					
13. All patients and their general practitioners should be given written information regarding a follow-up plan (including frequency of visits, tests required, and with which designated service), together with a nominated point of contact if there is a clinical concern																					

Faster Cancer Treatment

Reporting against the 3 FCT indicators
based on four data points

SCN
Southern Cancer Network

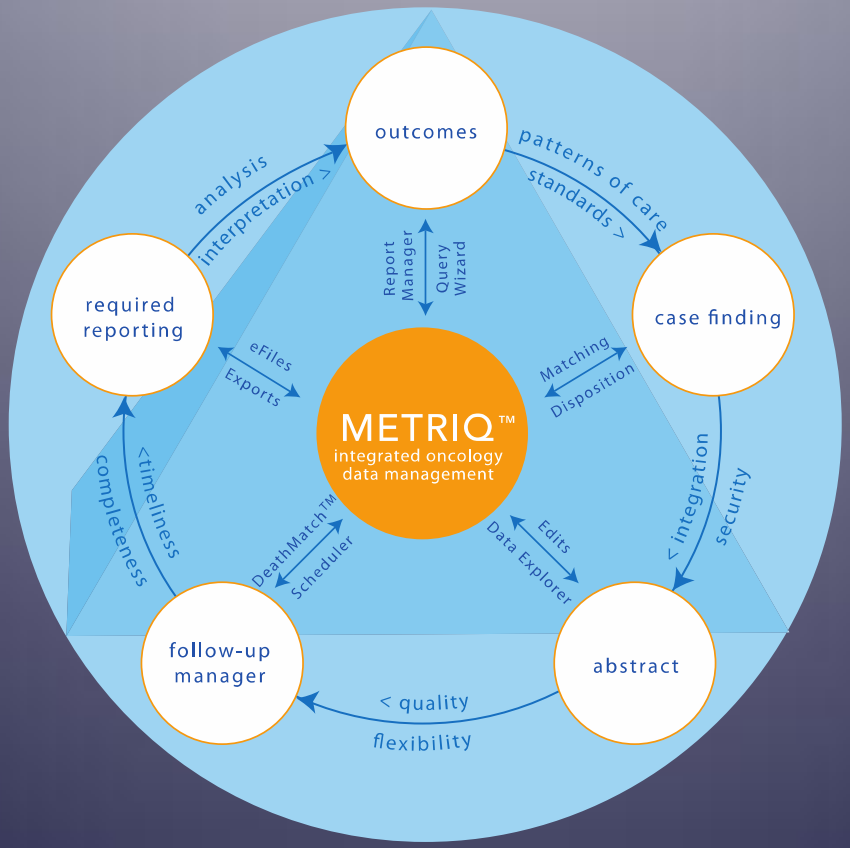
Achieving best practice cancer care: Guidance for implementing quality multidisciplinary meetings

- improved treatment planning through consideration of the full range of therapeutic options resulting in improved outcomes
- improved equality of outcomes for patients with cancer
  more patients being offered the opportunity to enter into relevant clinical trials improved continuity of care and less service duplication
- improved coordination of services
- improved communication between care providers with the development of clear lines of responsibility between members of the multidisciplinary meeting
- optimisation of resources, with effective MDMs resulting in more efficient use of time and resources.

Cancer Care Coordination

- first point of call for patients and their families
- providing patient centered care including determining each patient's
- areas of need
- acting as an information and education resource to patients and their
- families, and providing patients with supporting information on their
- diagnosis treatment and possible side effects
- coordinating patients' care including tracking patients as they transfer
- between services and maintaining communication links to ensure that a
- patients care is ordered according to best practice
- providing expert management and advice on common symptoms like
- pain, nausea and treatment,
- providing emotional support and guidance,
- helping with a self-care plan after treatment such as access to psycho
- social or supportive care

Metriq – regional cancer database

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