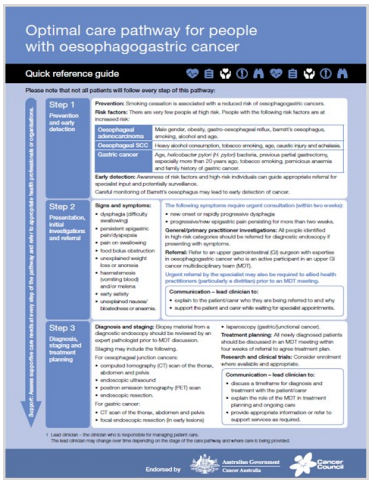
Oesophagogastric Cancer Summit Summary Report — September 2016

What was the Oesophagogastric Summit?

Improving outcomes for people with Oesophagogastric (OG) cancers is particularly challenging. Chances for early detection are slim and many present at a late stage of disease. Members of OG cancer multidisciplinary teams across Victoria gathered on the 26th of August this year to review variations in care and identify opportunities to improve the outcomes and experiences of care.

What happened at the Summit?

The scene was set by three senior UGI surgeons; Professor Robert Thomas, Chief Cancer Advisor to the Department of Health and Human Services; Mr Paul Cashin of Monash Health and Mr Ahmad Aly of Austin Health.



Oesophagogastric Cancer OCP

Professor Thomas opened the event sharing his own experience as a surgeon and highlighting the importance of the multidisciplinary team approach to cancer care. Professor Thomas introduced the optimal care pathway for people with OG cancer as an important document that sets a common understanding of what care to expect at different points in the cancer journey.

Mr Cashin welcomed the participants and set the task of identifying opportunities for improving outcomes and the organisation of care for Victorians diagnosed with OG cancer.

Mr Aly presented available data about the current state of OG cancer care and outcomes in Victoria. Data were used to highlight variations in OG cancer population, patterns of care and outcomes. This set the scene for discussion about the diagnosis and treatment steps in the care pathway.

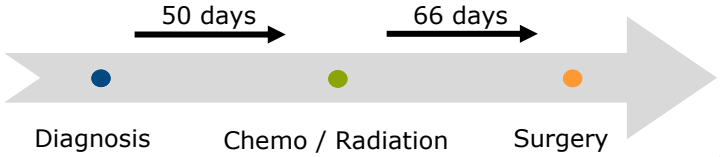
Observed variations in data

Trend for improving survival in both oesophageal and gastric cancers over the last 30 years with one-year relative survival increasing from around 35% to 55%

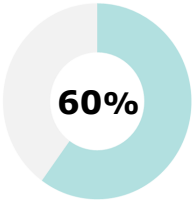
Regional variation in 5-year survival which seems to correlate with socio-economic status, higher rate of presentations with metastatic disease and utilisation of surgery and neoadjuvant therapy

Time to treatment: stomach cancer

Time to surgery and chemotherapy is longer than optimal timeframe of 28 days

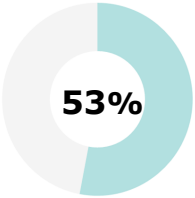


MDM discussions



60% of patients have treatment planned formally by an MDT

There are lower rates of MDM discussion for regional patients



The statewide percentage for recording staging at an MDM is 53%

Flow of patients across Integrated Cancer Services (ICS) of residence

Oesophageal cancer treated in ICS of residence

Oesophagectomy	Chemotherapy
63%	75%

Vs

Gastric cancer treated in ICS of residence

Gastrectomy	Chemotherapy
73%	81%

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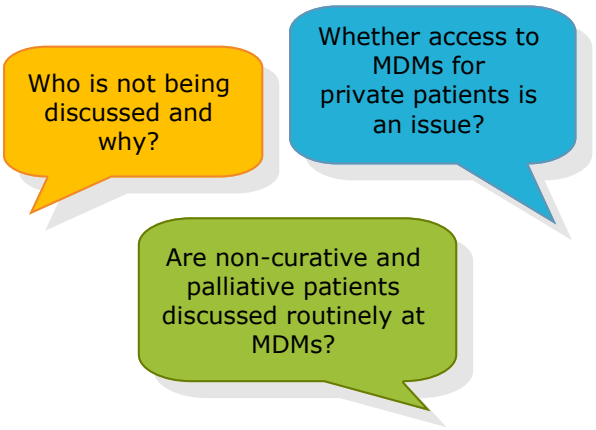
Where do we want to be and how to get there?

Participants worked in small groups to turn observed variations into opportunities for state or local action...

MDM Processes

Variation in the MDM practice certainly grabbed the attention of participants. MDMs are a pivotal point in the care pathway for many reasons including their impact on the effectiveness of care, timely treatment planning, referrals and professional development. The participants recognised MDMs as an opportunity to document key data variables crucial in evaluating short and long term outcomes of care. Consistent with the optimal care pathway there was a strong agreement at the summit that all OG cases should be presented at a specialist MDM.

Participants asked….



What can we do to improve?

- Common MDM software (QOOL project)
- Better mechanism for calculating the MDM capture rate
- Better documentation of staging, ECOG, tumour type, treatment pathway and nutritional status
- Regional access to MDMs via teleconference into a specialist MDM

Timeliness of care

Timeliness of treatment resonated with the participants. The optimal care pathway states that treatment should occur within 28 days of diagnosis. High on a wish list was care-coordinator role specific for OG cancers. Many clinicians shared stories about overworked staff chasing results, waiting for decisions and re-doing actions in a poorly coordinated system. Applying re-design methods could be useful for local teams to identify gaps in coordination of care.

What can we do to improve?

- Investigate timeliness along the entire pathway (GP to diagnostics, staging diagnostics, triaging)
- Enable access to dietitians and diagnostics especially for regional patients
- Better engagement with gastroenterologists
- Investigate gaps in coordination of care across multiple professions and settings

Utilisation of treatment and late presentations

Variation in 5-year survival for regional Victorians raised questions of access to treatment, utilisation of different treatment modalities and why residents of regional ICS present later. Unpacking this further at a local ICS level would provide data to understand issues and design interventions to optimise systems.

What can we do to improve?

- Public awareness campaigns
- Professional education
- Screening programs
- A shift in paradigm for treatment options for older patients
- Better understand reasons for variation

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What did attendees think of the Summit?

47 attendees completed the summit evaluation (59%)

Respondents rated the summit **8/10**

85% Would recommend their colleagues to attend

"This is an excellent forum for sharing ideas about improving timeliness of care. Informative and inspiring."

100% Found the presentation '*Oesophagogastric Cancer Care in Victoria'* useful

"The data presented was of very high quality and simulated good discussion"

3/4 respondents thought there was appropriate representation to identify opportunities, actions and maintain ongoing engagement to improve OG cancer care. However some suggested more representation from gastroenterology and allied health

The majority of participants thought the summit:

- ✓ Raised relevant and interesting issues related to improving OG cancer care
- ✓ Provided an opportunity for participants to contribute ideas and opinions
- ✓ Enabled discussion groups to identify actions that will help improve OG cancer care

What next?

Generating tangible action that will impact on patient outcomes is not easy. Agreement on important issues is only the first step towards collective action to change practice and improve outcomes. This summit was an invitation to engage in dialogue and change what is in the clinical sphere of influence to change.

The OG Summit Working Party will reconvene in October to prioritise actions and agree on a short-term plan for state-wide and local implementation. You will receive quarterly updates on the progress of post-summit actions.

Contact your local ICS about your role in these activities.

Have a question? Please contact Amy Sutherland

List of ICS and e-mail contacts below

Integrated Cancer Services	Contact
Barwon South Western Regional Integrated Cancer Service (BSRWICS)	(03) 4215 0459 bswricsadmin@barwonhealth.org.au
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Loddon Mallee Integrated Cancer Service (LMICS)	(03) 5454 8380 sbarri@bendigohealth.org.au
Southern Melbourne Integrated Cancer Service (SMICS)	(03) 9928 8541 info@smics.org.au
Gippsland Regional Integrated Cancer Service (GRICS)	(03) 5128 0138 gricswebsite@lrh.com.au
Hume Regional Integrated Cancer Service (HumeRICS)	(03) 5832 8301 info@humerics.humehealth.org.au
Western Central Melbourne Integrated Cancer Service (WCMICS)	(03) 8344 9158 contactus@wcmics.org
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