Towards optimal care – ovarian cancer

Project report
Towards optimal care – ovarian cancer

Project report
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>6</td>
</tr>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Background to the project</td>
<td>7</td>
</tr>
<tr>
<td><strong>Overview of the project</strong></td>
<td>7</td>
</tr>
<tr>
<td>Objectives</td>
<td>7</td>
</tr>
<tr>
<td>Method</td>
<td>8</td>
</tr>
<tr>
<td>Governance</td>
<td>9</td>
</tr>
<tr>
<td>Observations related to processes and structure of the project</td>
<td>10</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>13</td>
</tr>
<tr>
<td>Potential future activities related to implementation</td>
<td>13</td>
</tr>
<tr>
<td>OCP implementation for low volume cancers</td>
<td>13</td>
</tr>
<tr>
<td><strong>Conclusions</strong></td>
<td>13</td>
</tr>
<tr>
<td><strong>Appendix 1</strong></td>
<td>15</td>
</tr>
<tr>
<td>Summary of learnings related to care of women with ovarian cancer</td>
<td>15</td>
</tr>
<tr>
<td><strong>Acknowledgements</strong></td>
<td>18</td>
</tr>
</tbody>
</table>
Executive summary

In 2016 the Cancer Strategy and Development section of the Department of Health and Human Services initiated a program of work to roll out the Optimal Care Pathways, which set out best practice and evidence-based care for people with cancer. With the concurrent focus on the two higher volume cancers in colorectal and lung cancer, a model for adoption of OCPs for low volume and complex model of care cancers was needed. The ovarian cancer OCP project took a state wide approach. The project has assessed the difficulties associated with low volume cancers as there are other OCPs that have similar characteristics.

The project objectives included the development of ways to measure and understand the current care for women with ovarian cancer and to identify priorities for improvement activities. This project also set out to undertake an improvement activity and produce a service map for Victoria.

An expert steering committee was able to review information about current care patterns. Qualitative, quantitative data and a literature review provided the basis for discussions at the steering committee level. A good level of engagement was achieved during the project. However, the steering committee was unable to identify a priority for improvement that was amenable to a service improvement activity within the scope of this project.

External factors, such as the state government’s acceptance of the recommendations of the Targeting Zero report and issues of sphere of influence and responsibility meant that progress towards the improvement activity in a priority was not achieved. The steering committee was concerned that some treatment was done by non-specialists in the private sector and that access to genetic testing was suboptimal.

Analysis of current care showed indication of a centralised model of care. Where measureable, treatment was seen to fall within timeliness measures set out in the OCP. Patient level data from the specialist multidisciplinary teams show that where women have treatment there are high rates of MDM treatment planning and follow up.

A service map that covers steps two to six of the OCP. Public and private metropolitan hospitals and the regional cancer centres contributed information for the map. The report also includes information on clinical trials and ovarian cancer specific support services such as fertility preservation and familial cancer centres. This report may strengthen the understanding of the system of care available for women with ovarian cancer and support the understanding of cancer care as a pathway for clinicians.

Recommendations for OCP implementation for low volume cancer types include ensuring the process of identifying priorities is done before OCP activities are planned. This aligns with the integration of the OCP adoption and tumour stream summits programs. Additional support for low volumes cancers is to group OCP activities that are common to more than one cancer type. An example of this is in ensuring the routine production of an end-of-treatment summary.
Introduction

In 2016 the Optimal Care Pathways (OCPs) for 15 cancer types were adopted nationally as a quality framework for describing evidence-based and best-practice cancer care. The Department of Health and Human Services (DHHS) in Victoria has initiated a program of work to roll out two to three OCPs each year. The intention of rolling out OCPs across Victoria’s health system is to improve outcomes and experience by supporting consistent, high quality, evidence based care for people with cancer.

The program to roll out OCPs is aimed at assessing current cancer care against the documents and addressing any gaps or areas of poor performance. This work is primarily being done by the Integrated Cancer Services and Primary Health Networks.

Coinciding with this work are activities aimed at promoting the use and understanding of the OCPs. Policy statements and the Victorian cancer plan 2016-2020 support adoption and application of the OCPs as a quality framework.

A set of criteria for prioritizing the OCPs for adoption has been implemented during the term of this nine-month project. The framework includes taking into account: incidence rate, poor survival, variation in outcomes across Victoria, clinician engagement and any external factors that would support addressing service issues connected to a particular tumour type.

Consideration of what might be required for low incidence and/or a complex service model cancer types was also needed. A project that illustrated and tested the implications of OCP roll out for low volume and specialist model of care using a state wide approach would provide important information when it came to adjusting the OCP implementation program for other similarly situated cancer types.

The 2016 publication of the Cancer Australia, National Framework for Gynaecological Cancer Control provided a guide to priorities for gynaecological cancers, including centralisation of treatment planning. Ovarian cancer was also of interest because of the concerns about late diagnosis and poor survival rates. The adjusted overall 5-year survival is 42% but in some age groups can be as low as 18%. The majority of women are diagnosed with advanced cancer, with qualitative data supporting the perception that late diagnosis can contribute to poorer outcomes. A state wide approach, rather than an ICS level approach for the activities was chosen to support the need to evaluate how centralised and specialized model of care in Victoria affected OCP roll out.

Background to the project

In September 2016 the DHHS Cancer Strategy and Development unit began the work to implement the ovarian optimal care pathway as a state-wide project. A steering committee of clinical leaders, consumers, community based care organisations and health service improvement members was formed to assess the available data relating to care delivery. To support the project, a series of interviews was done to determine the highest priorities for improvement.

The strongest message from these consultations reflected the importance of the specialist, centralised model of treatment planning and surgical treatment. The most important factor in ensuring the best possible outcomes for women was appropriate referral to a specialist multidisciplinary team for treatment planning, and for surgery to be done by specialist gynaecological oncologists.

Overview of the project

Objectives

The key objectives of the project were:
Understand the current patterns of care for women with ovarian cancer in Victoria
Review the literature and current policy frameworks for known priorities for action.
Map the current services and capability for ovarian cancer care
Assess alignment of current care against the OCP to identify gaps and opportunities for improvement
Implement agreed activities to address identified gaps
Establish agreed metrics to monitor care against the OCP

Not all the objectives were achieved as will be described in the outcomes section.

**Method**

The process of assessing current care delivery included establishing an expert Steering Committee with representatives from the three public, specialist women’s hospitals multidisciplinary teams. The committee included clinical leaders, consumers, clinicians representing regional and central experience from various craft groups. One of the advocacy groups for ovarian cancer was present, as were primary health and cancer service improvement organisation representatives.

A series of key informant interviews was conducted to gather information about perceived priorities in the system from the clinical and consumer points of view in order to expand on the views provided by the Steering Committee.

Data analysis was commissioned from the Cancer Epidemiology Centre based at Cancer Council Victoria and Cancer Strategy and Development within DHHS. Additional data analysis was done using resources within the North Eastern Melbourne Integrated Cancer Service directorate team. Concurrently, a review of available literature with a focus on assessing quality care and possible indicators of quality care was done.

The process of developing clinical questions to guide data analysis, reviewing and refining the analysis was iterative. The optimal care pathway document was used as a point of reference for all data analysis.

Throughout the project term the Project Management Group met to provide advice on possible sources of data likely to assist the Steering Committee. This group also acted as a communication channel to the funders.

The Steering Committee met to review the data and to discuss possible priority areas. The Steering Committee was able to see from the administrative data set analysis that significant numbers of women had part of their treatment outside the specialist women’s hospitals. A systematic state wide assessment of the services available had not been done prior to this project. There were gaps in understanding the care provided in the private hospitals. Therefore, the services map, including private hospitals as much as possible, formed one of the agreed deliverables of the project. The Integrated Cancer Services provided patient-level data and facilitated the health services included in the services map to provide information.
Outcomes

A summary of the outcomes of the project against each of the objectives is set out below.

- Understand the current patterns of care for women with ovarian cancer in Victoria

The analysis of available data followed the steps of the OCP. Most of the analyses used the admissions data from health services and the Victorian Cancer Registry to identify the population. Treatment admission data and data indicating the referral pathways were able to show a centralised model of care. It was assumed that someone received specialist care when they were admitted to hospitals known to have a specialist gynaecological oncologist on appointment.

Multidisciplinary treatment planning information is not monitored centrally. Patients were identified and the records checked locally in order to ascertain a record of MDM treatment planning. The report included only patients admitted for treatment in a public hospital and resulted in a capture rate of approximately 92%.

Qualitative data derived from interview was obtained to understand issues and processes for referral to a second hospital for adjuvant treatment. Other issues of concern such as access to genetic testing were also obtained in this way.

Apart from referring to a recent survey reported by Ovarian Cancer Australia\(^1\), no patient experience data was able to be collected during the project

- Review the literature and current policy frameworks for known priorities for action

A range of Australian and international published articles related to ovarian cancer treatment and experience were reviewed for the project. An environmental scan included reviewing the Cancer Australia National Framework for Gynaecological Cancer Control and priorities established by Ovarian Cancer Australia.

- Map the current services and capability for ovarian cancer care

A state wide service map has been produced showing activity and service availability for the major metropolitan hospitals – specialist and non-specialist, and the regional cancer centres. This report is available as an attachment to this report.

- Assess alignment of current care against the OCP to identify gaps and opportunities for improvement

Analysis and review of data by the Steering Committee showed no clear gaps against the recommendations set out in the OCP that are currently amenable to improvement.

More than 80% of women have treatment in settings where a gynaecological oncologist is on appointment, both high volume and low volume. There are indications that more women have been receiving referrals to specialist hospitals with a reduction in the number of procedures being done in low volume settings where there is no access to specialist surgeons. Although the committee heard about cases of surgery undertaken by non-specialists, specific data are not available to clearly illustrate this problem.

For the public patients who have an admission for treatment, up to 92% are receiving MDM treatment planning. There are signs that patients in the private sector have multidisciplinary review of histopathology, although it is not known what proportion receive prospective treatment planning.

Timeliness measures were limited to time to chemotherapy only (20 days’ median) and time to adjuvant chemotherapy (32 days median).

More detail related to findings against the current practice of care can be found in appendix. 1.

---

\(^{1}\) Ovarian Cancer Australia: A report summarising findings on a family history and genetic testing survey. 2015
• Implement agreed activities to address identified gaps

As noted above, the committee was unable to identify a priority from the data presented during the meetings.

Steering committee priorities included supporting and strengthening the referral pathways into the specialist hospitals. Referral tools\(^2\) to assist GPs are in place, as are guidelines published by Cancer Australia. Despite these, there were concerns expressed by some committee members that inappropriate referrals still occur. The absence of a Service Capability Framework and role designation was noted by the committee. Work in this area is within the responsibility of Safer Care Victoria.

A second area of concern from the committee was related to access to genetic testing for appropriate patients. It has been estimated that approximately 50% of eligible women have been referred over the last four years\(^3\). The issue of supporting access for women diagnosed in earlier years and the consequential backlog was also of concern. Work in this area is thought to be outside the scope of the Victorian Integrated Cancer Services.

This importance of the private hospitals in providing treatment services to this population was noted, and the committee expressed concern about the lack of information about the standard care and services available to private patients. The service map produced through this project has been able to provide information for the largest private hospitals, although not a comprehensive picture.

• Establish agreed metrics to monitor care against the OCP

Significant progress has been made in determining available ways to measure the quality of ovarian cancer care in Victoria. Further development and testing of some of the metrics used in this project are recommended.

Observations related to processes and structure of the project

The following observations are the result of reflections on the progress of the project:

A high level of engagement and good will were developed within Steering Committee related to this project. The committee met on four occasions, engaging in reviewing and discussing the data findings. There seemed a willingness to participate in a state wide process of potential service improvement amongst the members of the committee.

Data was available to assess approximately half of the pathway. Clinical questions related to the specialised, centralised model of care meant attempting to show referral pathways in the data. Novel analysis methodologies were developed to provide indicative data about referrals. Opportunities to further build capacity and test these analysis methodologies were noted during the project.

The process of expert clinician review of the data analyses may have been limited by the distance between the Steering Committee and the biostatistician. Opportunities to share insights into the clinical characteristics to help shape sampling and analysis were fewer than optimal. Additionally, the committee members would have benefited with some support through explanation of the possible interpretation of the analyses. The speed and complexity of the DHHS’s adoption of using administrative data to inform service improvement opportunities may mean that clinicians who involve themselves in projects like Towards Optimal Care are in need of more support than was available in this project.

This project commenced prior to the alignment of the OCP roll out with the tumour stream summits program. The alignment of these major pieces of work ensures support for engaging with clinical experts

\(^2\) HealthPathways
\(^3\) Personal communication with Dr. Allison Trainer, Clinical Geneticist Familial Cancer Centre, Victorian Comprehensive Cancer Centre
and the development of a data report for each cancer type, reflecting the clinical questions posed by the expert working group. This process has now been used successfully for five cancer types and should play a role in OCP adoption activities for all cancer types.

Development of the OCP adoption program has meant that tumour stream summit process is now used to identify the priorities to focus service improvements. It is difficult to know if a summit meeting would have identified different improvement opportunities than the Towards Optimal Care project. It does appear that the process of expert clinical review of data and iterative clinical questions is a necessary preparation to any OCP adoption activity at the health service level.

The project was also affected by the publication of the Targeting Zero report produced by Dr Stephen Duckett. The release of the report increases high level focus on quality and safety in health care. Recommendations relating to the establishment of Safer Care Victoria and the review of the clinical network model will affect questions of responsibility and priority in addressing issues relating to high complexity, low volume cancer care, including for women with ovarian cancer.

What was learned during this project about working with low volume or centralised model of care cancers may have an impact on other cancer types in relation to the relevant OCP adoption work. In the case of ovarian cancer, unless an opportunity was noted in one of the high volume specialist hospitals, low patient numbers and the distribution of services meant that a focused service improvement project, would only impact very few women.

Health services providing information for the services map were variable in their ability to contribute validated data for the state wide services map. Access to a health service nominee, who could provide information about all oncology services, especially in smaller hospitals, was difficult to gain. Therefore the quality of the data is hard to assure.

The combination of factors related to scope of the project and gaps in data availability meant that the Steering Committee was unable to identify a priority despite good engagement. Part of the difficulty may be due to the fact that the measurable parts of the pathway occur in the acute hospitals. The proportion of women referred to specialists for treatment planning and treatment were high, although committee members expressed frustration at cases where treatment was deliberately undertaken outside of best-practice guidelines. Timeliness to adjuvant treatment and access to MDM treatment planning were found to be acceptable. Overall, the data showed that care within the specialist hospitals was high quality where it is measurable.

Gaps noted in the care system related to access to genetic testing for suitable patients and in improving the structural supports for the centralised model of care. Support for genetic testing is the responsibility of Genetics and Health Technology unit of DHHS. Determining the priority of a service capability framework and role designation is within the remit of Safer Care Victoria.

This project took place in the context of other work being done by Ovarian Cancer Australia in relation to improved data collection, by government in the funding approval of a new treatment modality and by the research organisations.

Activities associated with OCP implementation that were not included in this project relate to directly promoting the OCP to clinicians and consumers. One of the recommendations in the following section refers to a system level approach to this activity.
Recommendations

Potential future activities related to implementation

The service map produced during this project sets out the main providers of cancer care and support services from a state wide perspective. This may be the first time that an ovarian cancer system has been described.

Leveraging on the service map, activities to promote the use and understanding of the OCP within the health services could include the establishment of a Victorian Ovarian Cancer Network. This would use marketing and key message development included in a communication strategy to effectively “brand” ovarian cancer care providers as a part of a network. All aspects of the system – public and private hospitals, non-government organisations such as support groups and peak bodies and Primary Health Network organisations – could be included. All communications would include the OCP as key message.

This work could pave the way for the implementation of a service capability framework by engaging in providers through a system lens with ways of reinforcing evidence base for system approach including specialist centres / clinicians. It will also support the implementation by monitoring activity and providing opportunity to assess how well it is working.

OCP implementation for low volume cancers

Characteristics that mark out ovarian cancer as different from lung and colorectal cancers can be summarised in that ovarian cancer has relatively low volumes of cases in any one year and the fact that many women travel out of their ICS for at least part of their treatment.

The alignment of the tumour stream summits with the OCP roll out can help to identify the presence and size of a problem before OCP roll out activities are planned. Preliminary work to define the problem will ensure that it is cancer-type specific and within the control of the health services, and that organisational readiness will facilitate successful change projects.

Another approach is in grouping cancer types to natural clinical units e.g. address both endometrial and cervical OCPs (when appropriate) at the same time.

There are likely to be many elements of cancer care along the pathway that have an impact on several (if not all) cancer types covered by the OCPs. Examples of this could include access to effective palliative care services and timely access to consultant medical oncologists in smaller hospitals covered by oncology outreach service arrangements. Addressing these issues more broadly and mapped to the OCP implementation program may provide a critical mass for improvement projects for low volume cancer OCPs.

Conclusions

This report summarises the activities and findings of the adoption and application of the ovarian cancer optimal care pathway in Victoria. For the large part the analysis of the current system of care showed a high standard of care provided in the specialist hospitals.

The Steering Committee was not able to identify a clear priority for service improvement that was within the sphere of influence of the ICS and would have a significant impact on the ovarian cancer population. Reasons contributing to this outcome include low volume incidence and the mixed centralised and disseminated care model for treatment.
This combination of characteristics is likely to arise with other cancer optimal care pathways. Recognising the risks that were uncovered during this project could aid in increasing the effectiveness of the OCP adoption program.
Appendix 1

Summary of learnings related to care of women with ovarian cancer

One of the outcomes expected from the meetings of the Steering Committee was an identified agreed priority for improvement. This agreement was not reached. The following section summarises the results of discussions and data analysis presented to the committee over the four occasions that they met.

Step 1 Prevention an early detection

There is no screening test for ovarian cancer. Increasing awareness of symptoms and the need to rule out ovarian cancer early are the focus of organisations such as Ovarian Cancer Australia and Cancer Australia. This project did not undertake any activities in this area

Step 2. Presentation, initial investigations and referral

It is known that the majority of women are diagnosed with advanced cancer; however, there is no collection of data relating to stage at diagnosis at a state wide level. This project proceeded with the assumption that Victoria’s pattern of stage at diagnosis is similar to that found through the national Australian Ovarian Cancer Study. However, data from a study at the Women’s showed a stage distribution that varied from the expected stage distribution. In this study showed a higher proportion of early stage disease.

Proxy markers for referral pathways involved using an admission that included appropriate ICD codes and surgical or chemotherapy procedure codes in the VAED. See the data report for more details.

A high level finding relating to the functional shape of the care system: more than 80% of women who receive surgical or chemotherapy treatment for their cancer within one year of diagnosis are admitted to a hospital with at least one gynaecological oncologist as a staff specialist or visiting medical officer and a routine linkage with an MDT.

There is no available information about initial investigations.

Step 3. Diagnosis, assessment and treatment planning

The time to treatment from presentation was not able to be measured during this project. There are no data as to the time interval between women presenting to a GP with symptoms and a referral to a specialist. VINAH data, capturing the date of referral into the public hospitals was not linked at the time of data analysis for this project. In timeliness analysis the surgery date and the tissue diagnosis date are the same.

The finding showed that for women receiving treatment in the public hospitals, close to 90% had a record of multidisciplinary (MDM) treatment planning. The focus for an MDM capture study centered on the metropolitan ICS and Grampians as the sites where initial treatment was provided. The ICS were asked to produce a list of patients with a diagnosis notification. The dates of treatment admissions and MDMs were collected.

The dates of admissions and MDM records showed that 57% of the discussions occurred prior to the initial treatment.

The private hospitals were not included in this study. Service mapping shows that Epworth Freemasons has a weekly MDT that meets for treatment planning. Cabrini does not have a gynaecological oncology MDM.

Each of the ICS has a connection with one of the regular MDMs. Some linkages are supported by well developed procedures including sharing of diagnostic images. Grampians is an example of this. Other
linkages occur as needed and a supported by teleconference only. Barwon South West and Hume are examples of that model.

**Step 4. Treatment**

**Access**

Seventy-two percent of women with a diagnosis had surgery within one year of diagnosis. Analysis supports that women from regional Victoria a slightly less likely to have surgery but not less likely to have chemotherapy. A clear explanation for this has not emerged, but one possibility is that these women are referred to a medical oncologist instead of a gynaecological oncologist. Low volumes of women involved and the possibility that this could be occurring anywhere in Victoria, in both public and private settings, mean that identifying this as an opportunity for improvement would require further analysis, and possibly, a ‘patterns of care’ study.

Analysis showed that 12% of women diagnosed with OC don’t have an admission for chemotherapy or surgery related to the cancer. These women were associated with older age and higher co-morbidity scores. Death was recorded in 82% of these women during the first year after diagnosis.

Analysis suggested that women with no treatment related admissions were more likely to have an emergency department presentation after diagnosis during the study period (70% vs. 47%, $p = 0.0001$). Although further analysis is needed, the experience of women who have no treatment admissions is poorly understood.

**Timeliness**

Timeliness of adjuvant treatment was found to be at a median of 32 days for the whole population. Discussion from the Steering Committee showed that the practices between the three public specialist centres varied around adherence to the 28-day recommendation for commencement of adjuvant chemotherapy. The phrase, “evidence-free zone” used during Steering Committee discussions revealed the different response.

There was also a study published after the release of the ovarian OCP that supported a broader interval for adjuvant effectiveness. This prompted some discussion about the need for timely review of the OCP in light of emerging evidence.

It was also noted that when women were referred to a hospital other than the surgical hospital for adjuvant chemotherapy, there was a time to care difference. Discussions with clinicians assisted in suggesting some of the factors that contribute to the delay. Possibilities include access to medical oncology consultants in smaller hospitals and the time needed to receive mail. Australia Post packages can now take up to one week to arrive at a destination in Victoria.

As mentioned above, the low volumes and the possibility that the referral could be made to one of a large number of non-specialist hospitals meant that this area was not likely to develop into an opportunity for improvement.

**Specialist model of care**

The centralisation of the surgical services and support for the specialist care model for ovarian cancer was apparent. Slightly more than 80% of surgical admissions happened in one of four public and four private hospitals. The list of low volume, non-specialist sites where women received surgery associated with ovarian cancer was long and may include cases on incidental findings.

Changes in referral patterns were also suggested in the data. Women in the Grampians ICS are routinely having surgery locally, but other regional ICS as referring more women to metropolitan ICS for surgery. Other changes observed by the project is a suggested loosening of the centralised model. Recently one of the gynaecological oncologist has made arrangements to perform surgery in Gippsland ICS.
The current policy settings and clinical leadership have shaped the current care setting, but the Steering Committee voiced frustrations over the limits to influence to further improve the specialist care model.

Gynaecological oncologist access in the regions is managed through ad hoc outreach arrangements. Regular clinics are held in regional cancer centres by a member of one of three specialist MDTs. These arrangements differ in both the structure of the arrangement and the level of services provided. For example, MHW provides an ambulatory clinic consultancy service only to Bendigo Health; the Moorabbin Hospital provides a service that includes surgical privileges to Ballarat Health.

**Step 5. Care after initial treatment and recovery**

The Steering Committee raised the importance of an ongoing relationship between the specialist MDT and the clinicians providing adjuvant treatment and follow up care. This relationship supports access to clinical trials and the possibility of referral for genetic testing. The MDM capture study showed many cases where there were repeated discussions for many of the patients. There is no data collection that can show how many women are referred back to the treating team at recurrence as recommended in the OCP.

**Step 6. Managing recurrent, residual or metastatic disease**

Qualitative data, collected through interviews with clinicians showed some variation with managing advance disease complications such as ascetic fluid collections in different hospitals. However, this was not explored using the linked data sets as the appropriate procedure codes were not identified.

Palliative care admission codes were assessed and were found to be low. This was expected as codes relating to palliative care and advance care planning have only recently been included in the VAED.

One of the palliative care issues for women with advanced and recurrent cancer is ascites accumulation. Palliative interventions for this condition need skills and equipment found in acute hospitals. Anecdotally, access to services to manage ascites accumulation were not thought to be problematic. An investigation of the VAED codes that may show the distribution and scale of this need was not successful.

**Step 7. End-of-life care**

No activities were undertaken by this project relating to end-of-life measures. No ovarian cancer specific services exist.
Acknowledgements

The DHHS gratefully acknowledges the contribution of members of the project Steering Committee:

Dr Mahesh Iddawela (Chair), Latrobe Regional Hospital and Monash University
Nadia Addobbo, consumer
Emma Burt, consumer
Associate Professor Peter Grant, Mercy Hospital for Women
Professor Orla McNally, Royal Women’s Hospital
Dr Jane McNeillage, Monash Health
Mr David Deutscher, Grampians Integrated Cancer Service, Ballarat Health
Sue Hegarty, Ovarian Cancer Australia
Sue Merritt, Victorian Primary Health Network Alliance
Danielle Carpenter, Peter MacCallum Cancer Centre
Ilana Solo, Loddon Mallee Integrated Cancer Service
Heather Davis, Southern Melbourne Integrated Cancer Service
Marita Reed, Cancer Strategy and Development unit, DHHS

Grateful acknowledgement also goes to Luc te Marvelde, Ella Stuart and Charmaine Smith for statistical support.

The project team also expresses gratitude for the assistance of Victoria’s Integrated Cancer Services in collecting data for the MDM capture audit and facilitating the health service’s contribution to the project.