Lung cancer summit 14th November 2014 - morning session summary report

Opportunities for improvement identified by the participants

In small discussion groups the participants were asked to identify opportunities for improvement based on either variations in care and outcomes highlighted in the data presentation or based on their own experience. Below is a summary of opportunities reported to plenary and discussion points. The participants prioritised seven opportunities as most important (highlighted in red) which were further discussed in the afternoon session of the summit.

Prevention and early detection

1. Screening for lung cancer – management of small nodule pick up.

Presentation, initial investigations and referral

2. **Better access to lung specialists**
   - Only clinicians attending lung MDMs to be called specialists.
   - MDM membership to be used as proxy for specialist access.
   - Promoting fast-track lung diagnostic clinics.

3. **Better engagement with GPs:**
   - communication with GPs from MDMs
   - GP education (lung cancer symptom recognition investigation guide promoting early referral – Cancer Australia)

Diagnosis, staging and treatment planning

4. Further investigate low rates of lung cancer tissue diagnosis in some regions
   - Is this a situation of seeing the specialist but not necessarily getting histological diagnosis?
   - Is this more a regional / rural issue?
   - Perhaps an issue of philosophical difference to treatment: proactive vs nihilism.

5. Formalise links between regional and metropolitan centres (including for access to PET and EBUS and difficult tissue diagnosis cases).

6. Reduce time from referral to diagnosis and treatment
   - Measuring timeliness is a good mechanism to identify potential blockages.
   - Currently there is no consensus on timelines measures.
   - Suggestion that date of scan to date of treatment could be a measure for timeliness of treatment.

7. **Decrease EGFR testing turnaround times**
   - EGFR testing important for personalised treatment.
   - Uncertain as to pathologists' understanding of sub-typing of adenocarcinomas.
   - Change in MBS billing enables the practice of reflexive molecular testing in lung cancer.

8. **No consensus on best practice for lung MDM**
   - Variations in who should be discussed and who gets discussed.

- Suggestion to use of decision support tools at MDMs.
- Current evidence of lung MDM discussion as an independent factor for increase in survival
- Concern about the sustainability of MDM administration.
- Need to implement state-wide lung MDT software – regional state-wide MDT software project in development.

9. Improve rates of TNM staging documentation

- MDMs opportune moment to agree on cTNM.
- Important to document for its value for data adjustment.
- Issue of different interpretations of TNM guidelines.
- Recommendation to make this a mandatory field.

Treatment

10. **Significant variation in the utilisation of adjuvant chemotherapy across metropolitan ICSs**
11. Major lung surgeries – what do we do centrally?
12. Generally low rate of radiotherapy uptake (explore best practice)
13. **Improve recruitment to lung cancer clinical trials in Victoria**

Supportive care and palliative care

14. Increase rates of supportive care screening

15. Improve equitable access to allied health

- Which patients need it?
- How to access it when needed?
- Best utilisation of resources.
- Institutional variation in allied health resources.

16. Better and earlier referral to palliative care

17. Clarify the role of cancer care coordinators in particular for metro regional transfer of patients.

Quality and measures

18. Introduce patient reported outcomes
    - Currently using supportive care screening as a surrogate measure.

19. Better ways to measure outcomes and care processes
    - Analyse outcomes for surgeries performed at health services with less than 20 major lung surgery operations per annum.
    - Transparent reporting of waiting times for all modalities (surgery already available, can the same be done for chemotherapy and radiotherapy).
    - The importance of capturing treatment intent.
    - MDM opportune moment to capture data variables such as staging and ECOG.
    - Timely feedback loop of data to clinicians – example of Qld Clinical Outcomes Data QCORE (not having to wait two years for next forum)

20. Identify centres and MDMs that do things well and share with all as learning opportunity – facilitate cross-pollination especially between different MDMs.