Service Mapping Report

Background and Purpose

One of the roles of the Southern Melbourne Integrated Cancer Service (SMICS) is to map cancer services provided to adults by Alfred Health, Peninsula Health and Southern Health for 10 tumour streams. The purpose of this report is to:

- provide quantitative and qualitative data regarding current cancer services that will be used by the SMICS Tumour Groups and SMICS Governance Groups to plan service improvements;
- provide baseline data that can be used to evaluate SMICS' outcomes; and
- assist to identify gaps and opportunities for improving cancer service coordination.

Report Details

This report provides a summary of services provided by:

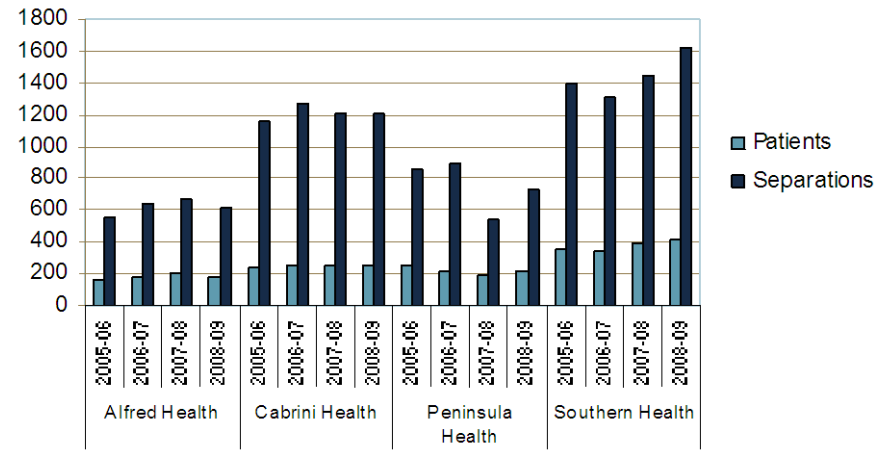
Tumour Stream:	**Lung**
Site:	The Alfred
Health Service:	Alfred Health
Data Collection Period:	January- May
Date of Report:	May 2009

This report may need to be read in conjunction with tumour stream reports for other sites.

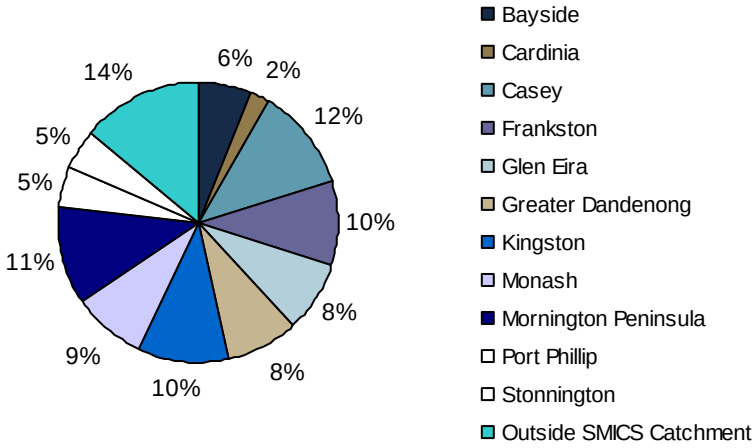
Health Service	SMICS Mapping Report (✔)
Alfred Health	
The Alfred Hospital	✔
Sandringham & District Memorial Hospital	-
Caulfield General Medical Centre	-

Cancer Services Data: Quantitative

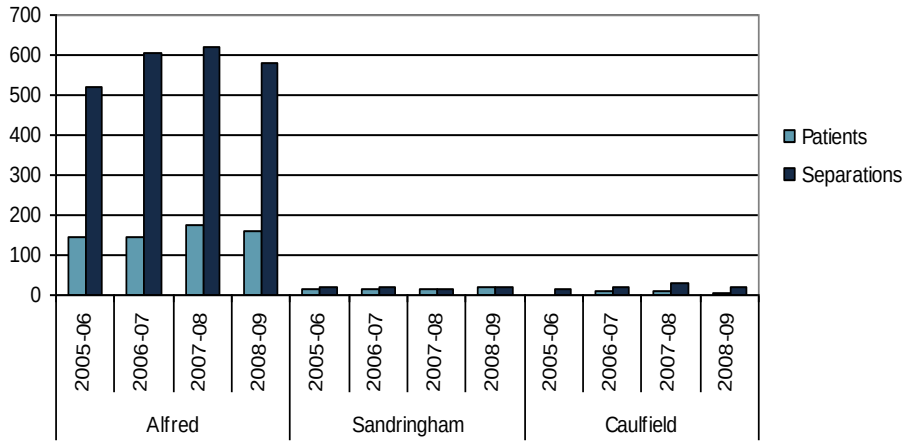
SMICS / Lung Tumour Stream Throughput 2005-09



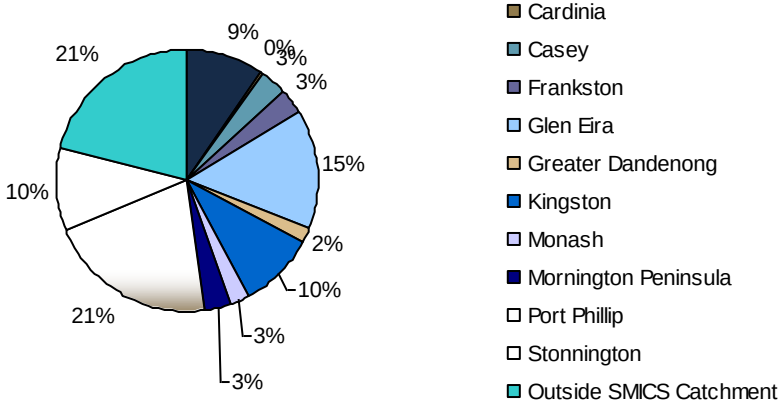
SMICS / Lung Tumour Stream Catchment Areas 2005-09



Alfred Health / Lung Tumour Stream Throughput 2005-09



Alfred Health / Lung Tumour Stream Catchment Areas 2005-09



Cancer Services Data: Qualitative

1. General Services Available Onsite

Service	*Onsite*	*Notes or comments*	*Service*	*Onsite*	*Notes or comments*
Cancer Support Nurses	✓		Palliative Care	✓	Consultation service provided
Breast Care Nurses	✓		Pain Service	✓	Provided by dept anaesthesia & available at Caulfield Hospital
Chemotherapy	✓		Pathology - Anatomical	✓	
Clinical Trials Coordination	✓		Pathology - Biochemistry	✓	
Day Surgery	✓		Pathology - Haematology	✓	
Dental Services	✓		Pathology - Genetics	✓	
Diagnostic Imaging - General	✓		Pathology - Microbiology	✓	
Diagnostic Imaging - CT	✓		Pathology - Synoptic Reporting	✓	
Diagnostic Imaging - MRI	✓		Pastoral Care -Chaplain	✓	
Diagnostic Imaging - PET	✓		Pharmacy	✓	
Diagnostic Imaging Nuclear Med	✓		Psychology	✓	
Dietetics	✓		Psycho- Oncology	✓	
Emergency Department	✓		Psychiatry	✓	
Genetic Counselling	✓		Physiotherapy	✓	
GP Liaison Units	✓		Pre-admission Clinic	✓	
Immunotherapy	✓		Prosthetics & Orthotics	✓	
Interpreting Services	✓		Radiation Oncology	✓	
Intensive Care Unit	✓		Rehabilitation Physician		Provided at Caulfield hospital
Lymphoedema Service		Not Available	Speech Pathology	✓	
Medical Oncology	✓		Short Stay Unit	✓	Alfred Centre Elective Surgery, Also have Medi Hotel
Occupational Therapy	✓		Social Work	✓	
Outpatient Clinics	✓		Support Groups	✓	Living with cancer, Look good feel better
Palliative Care Beds		Utilise Bethlehem & Cabrini			

2. Overview of Treatment and Care

Critical Point[1]	Patient Journey	Supporting Structures & Processes
Community Level	• The patient recognises symptoms or receives an abnormal screening result (if applicable) and sees the General Practitioner (GP).	• A GP typically requests a CT scan and where an abnormality is detected, the patient is referred to a specialist.
↓		
Initial Diagnosis & Referral	***Private Consultant*** • Patients are referred to a private respiratory physician, cardiothoracic surgeon, or medical oncologist and further investigative / diagnostic tests are arranged as required. Following diagnosis, patients are referred to the General Respiratory Outpatient Clinic, a cardiothoracic surgeon or medical oncologist. ***Outpatient Clinic*** • ***General Respiratory Outpatient Clinic:*** Patients attend the public General Respiratory Outpatient Clinic (Tue AM) and are seen by the respiratory physician, registrar and / or resident. Patients are then referred for further investigative / diagnostic tests to determine diagnosis. • ***Cardiothoracic Outpatient Clinic:*** Patients are referred to the public Cardiothoracic Surgery Outpatient Clinic (Wed PM) and are seen by the cardiothoracic surgeon and registrar/resident. Where further tests are required, the patient is referred to the General Respiratory Outpatient Clinic for further investigation. • ***Medical Oncology Outpatient Clinic***: Patients are referred to a private medical Oncologist or to the Medical Oncology Outpatient Clinic (daily) located at William Buckland Radiotherapy Centre (WBRC). Where further investigations are required, patients are referred to the General Respiratory Outpatient Clinic to be seen by a respiratory physician. ***Hospital Transfer*** • Patients may be transferred from another hospital for specialist treatment.	
↓		

[1] Ministerial Taskforce for Cancer (Draft June 2005), Critical points of Patient Management Framework

Critical Point[1]	Patient Journey	Supporting Structures & Processes
Determine Treatment Program	***Surgery*** • Patients attend the Cardiothoracic Surgery Outpatient Clinic to discuss their treatment options. • Where surgery is determined as appropriate, the patient is provided with a date for surgery. • Any relevant clinical trials that are available are discussed with the patient.	***Multidisciplinary Team Meeting*** • **The Lung Multidisciplinary Meeting** is held weekly and attended by the respiratory physician, cardiothoracic surgeon, registrar, resident, medical oncologist, radiation oncologist, radiologist, and palliative care consultant. • All lung cancer patients are discussed at this meeting. The patient's diagnosis and treatment pathway is determined by the team. Patients are often re-presented at this meeting throughout the treatment journey.
	Radiation Oncology • Patients attend the public Radiation Oncology Outpatient Clinic to discuss their radiotherapy treatment with the radiation oncologist. Patients meet with the radiotherapy nurse following the clinic as required. • Any relevant clinical trials are discussed with the patient.	***Radiation Oncology Clinic*** • Following attendance at the clinic, a letter is sent to the patient's GP. • A radiation oncology research coordinator maintains information on the clinical trials that are currently available to cancer patients.
	Medical Oncology • Patients attend the public Medical Oncology Outpatient Clinic to discuss chemotherapy treatment options with the medical oncologist. • Any relevant clinical trials are discussed with the patient.	***Medical Oncology*** ▪ A medical oncology research coordinator maintains information on the clinical trials that are available to cancer patients.
↓		
Implement Treatment Program	***Surgery*** • Patients attend a Preadmission Clinic prior to surgery to assess fitness for surgery. • Following surgery, the patients are admitted to Ward 2F for recovery.	***Surgery:*** • **The Ward 2F twice daily Ward Round** is attended by the ward registrar, resident and nursing staff to monitor patient recovery. • **The Ward 2F Weekly Discharge Planning Meeting** is attended by: ward resident, nurse unit manager, ward nursing staff, dietitian, occupational therapist, physiotherapist, social work, speech pathologist and pharmacist. • The purpose of this meeting is to discuss and plan patient discharge. • A discharge summary is provided to the patient's GP. • Ward staff schedule outpatient follow up appointments for the patient.

Critical Point[1]	Patient Journey	Supporting Structures & Processes
	Radiation Oncology • On first day of treatment, a nurse meets the patient and performs an initial patient assessment and organises referrals to appropriate support services. • Patients are reviewed weekly by the radiation oncologist during treatment. If a patient becomes unwell during treatment, they are admitted to Ward 7 East. • Where required, the patient attends an outpatient appointment with the dietitian at WBRC (Monday PM, Wednesday AM, Friday AM, and Friday PM).	***Radiation Oncology*** • Nursing staff perform a patient assessment prior to treatment to assess needs and discusses the treatment process. • Management guidelines regarding the treatment of lung cancer patients support the development of the patient's treatment program. • An annual audit is undertaken to inform practice. • A patient management database is maintained. • Quality meetings are held quarterly.
	Medical Oncology • Patients attend WBRC for chemotherapy and are reviewed weekly by the medical oncologist during treatment. • If a patient becomes unwell during treatment, they are admitted to Ward 7 East.	***Medical Oncology*** • See above for the Lung Multidisciplinary Meeting.
	Clinical Support and Other Services • During all stages of treatment, patients are referred to a physiotherapist, occupational therapist, speech pathologist, social worker, dietitian, psychologist, psychiatrist, cancer support nurse or the Palliative Care Consult Service as required. • Following discharge, patients are referred to Hospital in the Home, Royal District Nursing Service and/or Local Government services as required.	***Clinical Support and Other Services*** ***Psychosocial Support*** • During the patient journey, clinicians undertake an informal assessment of psychosocial needs and facilitate referrals to social work, psychology, psychiatry and / or the Cancer Support Nurse. There are no formal supportive care screening tools in use. • Living with Cancer and Look Good Feel Better programs are available for cancer patients.
↓		
Follow-Up	***Respiratory Physician*** • Patients attend the General Respiratory Outpatient Clinic for follow-up appointments and are seen by the respiratory physician. Ongoing tests are undertaken to monitor the patient's progress. ***Surgery*** • Patients are followed up in the Cardiothoracic Outpatient Clinic. Follow up is usually every 3 months for the first year, then every 6 months for 5 years. ***Radiation Oncology*** • Patients are followed up by the radiation oncologist at the Radiation Oncology Outpatient Clinic.	***Physician / Surgery / Radiation Oncologist / Medical Oncologist*** • Follow up is shared between the clinicians who were involved in managing the patient's care.

Critical Point[1]	Patient Journey	Supporting Structures & Processes
	Medical Oncology • Patients are followed up by the medical oncologist at the Medical Oncology Outpatient Clinic.	
↓		
Determine & Implement Treatment Program for Recurrence	***Physician / Surgery / Radiation Oncology / Medical Oncology*** • If there is disease recurrence, patients are re-presented for discussion at the Lung Multidisciplinary Meeting to determine appropriate management.	
↓		

End of Life Care	• Management of end-of-life issues and / or symptom management are facilitated by the Palliative Care Consult Team.	• Inpatient palliative care beds are sourced at Bethlehem Hospital which has 33 dedicated palliative care beds.
		• Cabrini Palliative Care is also a palliative care referral source which has 22 inpatient beds and a community palliative care service.
		• Other services available in the community include
		  ○ South Eastern Palliative Care,
		  ○ GPs
		  ○ RDNS

3. Summary of issues, comments and improvements

Issues↓	Issues Raised 2005	Issues Raised 2009
	• No central database is available to maintain information about the diagnosis and management of lung cancer patients • Limited resources available to coordinate meetings and / or maintain a database • Limited access to psychosocial support for the patient during the investigative / diagnostic stage of their journey.	• There is still a lack of adequate IT support and no lung cancer database • We still seek further support and resources to help coordinate meetings and update a database • We still have relatively little psychosocial support during the pathway
Improvements↓	**Improvements to Service**	
	• PET scanning is now available on site. • The attendance of a project officer in an administrative role at the Multidisciplinary Team Meetings and the development of agendas for upcoming meetings.	