Cancer Institute NSW

Calvary Mater Newcastle

Time Maters

Sharing care in Calvary Mater Newcastle cancer service

Background: The Cancer Institute NSW has partnered with Calvary Mater Newcastle (CMN) and Hunter New England Local Health District (HNELHD) to explore the opportunities within CMN cancer service to transfer patients receiving follow-up care to a shared care model. The project aims to enable the Cancer Institute NSW (CINSW), CMN cancer service, Hunter New England and Central Coast Primary Health Network (CCHNEPHN), general practitioners (GPs) and consumers to work together to improve the experience of people diagnosed with cancer, improve the experience of the medical oncology team and provide improvements to the delivery of care.

Case for change

CMN is the largest cancer service in the HNELHD. Visits to their oncology outpatient cancer service have more than doubled in the past 10 years. During post active treatment, people affected by cancer remain in the care of their specialist for at least five years. As cancer survivorship continues to rise, this approach to care is no longer sustainable. In fact, the Time Maters diagnostic process showed that approximately 1 in 4 patients aren't accessing the care that they need.

However, if we change our approach to care, we can meet the growing demand, enhance patient experience and ensure the long-term sustainability of the CMN cancer service.

Through collaboration and innovation, we may shape the future of cancer care at CMN, delivering excellence and improving the lives of people affected by cancer.

Goal

To identify and promote an integrated shared care model that improves access, service delivery and communication for cancer patients receiving follow-up care at CMN.

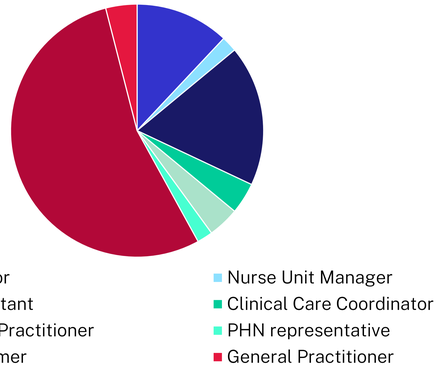
Objectives

- To increase the percentage of colorectal follow-up care and prostate (ADT) patients that are offered a shared care model from 0% to 40% by December 2024.
- To increase the percentage of colorectal follow-up care and prostate (ADT) patients that are provided written communication about their ongoing care from 0% to 100% by December 2024.
- To improve staff experience scores that shared care with GPs would free up time to spend on new patients and/or other tasks from 33% to 90% by December 2024 (CMN staff survey, 2022).

Method

The Agency for Clinical Innovation Redesign Methodology was applied to identify challenges experienced by patients and staff at CMN outpatient cancer service. Qualitative data obtained through focus groups, 1:1 interviews and surveys, along with qualitative data obtained from CMN oncology information system, Bureau of Health Information and CINSW was used to identify and validate findings. Information gathered was analysed and themed to understand the extent of the issue, the improvements needed and the potential solutions. Literature reviews were conducted at multiple phases of the project to support recommendations.

Stakeholders consulted



Key findings

- CMN is at capacity and continues to receive new patients as well as treat existing patients for ongoing surveillance and follow-up care with no shared care models utilised.
- Elements of the care provided could be safely managed by a GP.
- Localised processes for follow-up or surveillance care results in inconsistent process and workflow.
- Limited written information provided to patients results in uncertainty about follow-up care.

Solutions

Develop and implement GP shared care plan/s
Plans will be collaboratively designed to meet patient, treatment, GP and CMN needs

Develop and implement a patient triage tool
To identify patients to triage to GP shared care model, including biopsychosocial measures

Develop internal localised processes and workflow
To provide an integrated service delivery, including communication flows and recurrence fast track

Develop standardised patient information packs
To empower patients to take control of their treatment alongside the oncology and primary care teams

Review CMN patient information application
To utilise existing tools and technology and better inform patient care

Results

An early outcome and process mixed-method evaluation will be conducted at the completion of the patient pilot. The project will evaluate the implementation of cancer follow-up and surveillance shared care between cancer services and GPs across two patient pilots. The domains of appropriateness and effectiveness will be assessed for quality improvement purposes.

Implementing solutions

The Time Maters project implementation has commenced. Working groups have been established with membership from Calvary Mater Newcastle, general practitioners and patient representatives. The groups are responsible for the collaborative design of the shared care model/s and other solutions designed to support the integration of shared care.

The pilot is scheduled for January 2024 to December 2024.

Sustaining change

The Time Maters project has been designed to embed the new model into service delivery at CMN. Service KPI's and internal localised processes are being developed for implementation alongside the model of care.

Lessons learnt

- Early engagement across clinical staff and leadership within CMN was critical for embedding change.
- Collaboration has been a key factor of the projects success.
- There is no one size fits all approach to cancer care, it is important to operationalise models of care within the context of the local health districts patient needs and demographic.
- Establishing a partnership between HNELHD, CMN, CINSW, CCHNEPHN, consumers and GPs within leadership, governance structures and resource sharing has aided in the project outcomes.

Acknowledgements

All staff at Calvary Mater NSW cancer service, Hunter New England Local Health District, Hunter New England and Central Coast Primary Health Network, General Practitioners and patient representatives who participated in the collaborative design of the project. Agency for Clinical Innovation.

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Working together to lesson the impact of cancer