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This project contributes to the strategic objectives of the NSW Cancer Plan:

Improving the survival of people with cancer through the reduction in variations in cancer outcomes across NSW, reducing the gap between evidence and clinical practice and reducing the gap between evidence and policy.

The project to develop this toolkit was coordinated by the Research in Implementation Science and eHealth Group (RISe), the University of Sydney. The Toolkit is a product of collaboration between RISe, the Cancer Institute NSW, Cancer System Innovation Managers (CSIMs) Community of Practice (CoP), Local Health Districts (LHDs), Primary Healthcare Networks (PHNs), Lung Cancer Multidisciplinary Teams (MDTs), health professionals treating lung cancer patients and health consumers. This toolkit has been piloted by South Western Sydney LHD and the Northern NSW LHD.

This toolkit supports a common approach to localised cancer care pathway development by providing key information, relevant frameworks, tools and resources. This toolkit has been prepared as a generic resource, meaning that the information and resources contained can be readily transferred or adapted to develop pathways for multiple cancer types. Lung cancer was the focus for initial implementation.

The Cancer Institute NSW has endorsed this toolkit and considers it to be relevant across all NSW jurisdictions.

Localised cancer care pathways are published on government websites such as Canrefer (NSW Government, Cancer Institute NSW 2015) and other web-based platforms, such as HealthPathways (Streamliners 2008) and Map of Medicine (Map of Medicine 2015). Dissemination strategies include promotion through PHNs and other primary care focused activities such as GP meetings, workshops and professional development programs.
Cancer care pathways

For people undergoing investigations for cancer, the pathway to confirmed diagnosis is typically complex and can be highly variable. It involves multiple procedures, provided by individuals and multidisciplinary teams of health care professionals, delivered in a number of healthcare settings, potentially spanning both public and private care settings – all occurring at a time when people are at their most vulnerable and highly anxious.

Cancer care pathways outline the best cancer care for specific cancer types (Cancer Council Victoria 2015). Localising a pathway refers to overlaying local services and referral paths onto the Optimal Care Pathway. Localised cancer care pathways provide a valuable tool to guide healthcare delivery and referral practices most appropriate to the local setting. A localised pathway fosters common understanding and transparency of the critical points along the patient pathway. This aims to promote quality cancer care and positive patient experiences by streamlining the pathway, providing a benchmark for evaluation of practice, reducing variability and achieving a timely diagnosis.

A number of Australian and international organisations have developed best practice pathways for the diagnosis and treatment of people with suspected cancer types. In Australia, the Department of Health, Victoria has commissioned the Cancer Council Victoria to review and develop appropriate optimal care pathways for a number of specific cancer types to be adopted Australia wide.

Figure 1: Benefits of implementing referral and diagnostic pathways

- Reduce waiting times
- Improve co-ordination and consistency of care
- Reduce errors
- Support access to services and information

- Reduce unnecessary costs
- Increase service transparency
- Improve resource utilisation
- Improve safety and quality
- Reduce variability
- Promote explicit standards of care

- Facilitate care planning
- Increase appropriate care
- Improve care coordination
- Improve communication between professionals and health sectors
- Support clinical decision making
- Facilitate point-of-care decision making
- Provide logical and accessible information
- Reduce uncertainty in the referral process
About this toolkit

The aim of this toolkit is to provide a practical guide for health professionals involved in the development and dissemination of localised care pathways for the diagnosis and referral of cancer. This may include, but not limited to, CSIMs, MDTs, service managers, clinical leads, and professionals with a focus on quality improvement and patient safety.

The toolkit guides the development of a localised pathway within an implementation framework that includes; identification and analysis of needs, pre-implementation project formulation, pathway mapping, dissemination, monitoring and evaluation. This process, along with associated activities, is described in Figure 2.

This toolkit focuses on action points and practical tools to help achieve successful project implementation. The Cancer Institute NSW has endorsed this toolkit and considers it to be relevant across all NSW jurisdictions. This toolkit is applicable to multiple cancer types and LHDs are encouraged to utilise this resource for priority cancers.
Figure 2: Project cycle for mapping and localising cancer referral and diagnosis pathways

**Phase: Pre-implementation**
- Build context
- Engage key stakeholders
- Develop project plan
- Establish evaluation framework

**Resources & actions**
- Key documents
- Stakeholder identification matrix
- Project action plan
- Evaluation framework

**Meetings**
- MDT chair
- MDT meeting: initial engagement

**Agenda:**
- project plan
- expected outcomes
- sponsorship
- project outline
- behaviour monitoring
- engagement

**Evaluation**
- Were stakeholders identified?

**Phase: Mapping**
- Gather information and data
- Present data to MDT

**Resources & actions**
- Mapping meeting
- Medical record review
- Patient interviews
- GP surveys

**Meetings**
- Mapping meeting
- MDT meeting: present data

**Agenda:**
- review of evidence
- surveys to identify blocks and enablers, review pathway
- contribute to local optimal pathway

**Evaluation**
- Were they aware of aims and objectives?

**Phase: Implementation**
- Generate local pathway
- Gain consensus on optimal pathway
- Publish pathway

**Resources & actions**
- Sample service map
- Sample localised map

**Meetings**
- Stakeholder consensus & implementation meeting

**Agenda:**
- consensus
- partnerships
- implementation strategies
- communication strategies

**Evaluation**
- Has the pathway been published?
- Is the target audience aware of the pathway?
- Is the pathway being used?
1. Pre-implementation phase

Planning for implementation

This section of the toolkit assists in planning the implementation project. The planning or ‘pre-implementation phase’ is essential for enabling implementation success.

The pre-implementation phase involves the following key activities:

1. **Gather and review relevant information and evidence**
2. **Analysis of current situation, i.e. understanding readiness, risks and barriers**
3. **Identify and engage stakeholders and key influencers**
4. **Develop a clearly documented project action plan**
5. **Consider ethical implications of the project**
6. **Establish an evaluation framework**

1.1 Gather and review relevant information and evidence

It is essential to have a clear understanding of the evidence underpinning the intervention and the likely impact on patients, clinicians and services in the LHD. Preparation during this phase will enable the project team to be more inclusive and responsive throughout project implementation.

**Action:** Identify and review key documents, such as policies, guidelines, clinical pathways etc. Consider internal and external sources, including publications from cancer control agencies, and state and national health bodies. International sources of information and evidence may also help develop a plan for change.
Specific cancer type referral & diagnostic pathways

Department of Health, Victoria. Optimal cancer care pathways

The Optimal Cancer Care Pathways (OCP) developed by the Cancer Council Victoria on behalf of the Department of Health, Victoria have been endorsed as the national standard for best-practice in cancer care. NCERG is jointly chaired by the Commonwealth Government, the Victorian Government, Cancer Australia, Cancer Council Australia, the Clinical Oncology Society of Australia and consumers.

References:


While the whole Optimal Care Pathway provides important background and contextual information, the most relevant sections for the purpose of the specific cancer type that you are mapping, may differ.

The following references provide additional relevant literature on cancer care pathways:

- Pathways. The National Institute for Health and Care Excellence (2016)
- Cancer Care Pathways. SA Health (2013)
- Pathways. Cancer Care Ontario (2016)
1. Pre-implementation phase

1.2 Conduct environmental scan of the LHD

An environmental scan is fundamental to the pre-implementation phase in order to establish the context and performance of the LHD. This may include an assessment of:

- social determinants of health that effect patients in the LHD
- expectations, including current and projected demand for services
- capacity to anticipate and respond to challenges
- health system resources (human, physical, financial, informational)
- key stakeholders within the cancer care pathway (See Checkpoint 1.3)

**Action:** Document all relevant details of the organisation before the project commences. This will provide a baseline for project evaluation and help to expose symptoms of the problems, barriers and facilitators for change. References and information gathered in 1.1 and 1.2 can contribute to the Project Action Plan (Appendix C), including important ‘background’ information, information about the target population, and considerations for project evaluation.

1.3 Identify and engage stakeholders and key influencers

The Agency for Healthcare Research and Quality (2014) defines stakeholders as “persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision.” To increase the success of the project, engage key stakeholders from the beginning of the project. Early engagement will ensure that the project approach and strategies are tailored to a local context. This will assist in leveraging support and facilitate project sustainability. Key stakeholders often become champions in their local areas which encourages user acceptance and ultimate implementation success.

1.3.1 Stakeholder identification and analysis

Identifying stakeholders should be one of the first steps in the project. Stakeholders are those with a concern, interest, or who may be impacted by the project, including clinicians, patients, caregivers, administrators, service managers, policymakers, and others. It is important to remember that no one stakeholder represents the entire setting or process.
Use the following questions to help identify the project stakeholders:

- Who is responsible for the wider project or policy?
- Who will potentially be impacted by the outcomes of this project?
- Who has a stake or interest in the issue?
- Who is critical to service delivery?
- Who makes and influences decisions?
- Who contributes much needed resources?
- Who might take a negative stance or block the project?

Stakeholders for consideration include:

<table>
<thead>
<tr>
<th>Director of Cancer Services (or his/her nominee)</th>
<th>Chair of multidisciplinary team(s) (MDT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local general practitioners</td>
<td>Cancer care coordinator(s)</td>
</tr>
<tr>
<td>Nurses</td>
<td>Consumers</td>
</tr>
<tr>
<td>Allied health practitioners</td>
<td>Specialist nurses (CNC, CNE)</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>HealthPathways</td>
</tr>
<tr>
<td>Primary Healthcare Network representative</td>
<td>Relevant cancer clinicians e.g. respiratory physicians, surgeons, medical oncologists and radiation oncologists attending MDTs</td>
</tr>
</tbody>
</table>

Once potential stakeholders have been identified, the following questions should be addressed:

- Are the stakeholders representative of a mix of perspectives, experiences and roles relative to the project?
- Will the project be biased by alliances within the stakeholder group?
- Have marginalised or harder to reach stakeholders been considered and adequately represented?
- Are there additional organisations and/or individuals who should be included that have not been identified?
- Who can help identify unrepresented stakeholders?

The next step is to perform a stakeholder analysis. This allows identification of the potential strengths and weaknesses, levels of influence and support, and their likely attitudes to the project.
1. Pre-implementation phase

1.3.2 Meet with key stakeholders

Typically the key stakeholders for this project will have a high level of expertise, hold a position of influence and/or leadership, and express their buy-in and support. This group will be the leaders in change, inject diverse perspectives and new ideas, and help to identify and address risks. Given the pivotal role and influence of multidisciplinary teams in the delivery of care, it would be likely those members of local tumour specific MDT(s) would constitute the core of this group.

The Chair of the MDT is an ideal key contact for the ongoing development and implementation of the localised pathway. A good starting point is to organise a meeting with the Chair to discuss the project and early engagement with the MDT. It is recommended that a brief presentation is prepared for the MDT regarding the project's aims and activities. Ensure the Director of Cancer Services (DCS) is aware of the project and invite them to participate in mapping activities as appropriate.

**Action:** Meet with MDT Chair to gain buy-in, discuss project plans and how best to engage with the MDT.

1.4 Develop a clearly documented Project Action Plan

Developing a Project Action Plan sets the scene for the project and presents a high level approach early, which will help guide discussions and stakeholder engagement. A clear strategy provides a consistent guide with actionable steps for the development, execution and evaluation of the implementation project.

1.5 Human ethics

Ethical implications should be considered early in the project pre-implementation phase. All human research projects in Australia must fit with the guiding principles outlined in the National Statement on Ethical Conduct in Human Research (Commonwealth of Australia 2015). There are more than 200 Human Research Ethics Committees (HREC) in institutions and organisations across Australia. It is recommended that the relevant HREC is contacted for advice (List of HRECs registered with NHMRC). It is important to seek HREC clarification regarding ethical review if there is intention to publish or present project findings.

**Decision point:** Decide/consider if a national ethics application form or low negligible risk application form is required for the data collection methods (medical record review/service questionnaire/consumer interview).
1.6 Review evaluation framework and gather baseline data

During the pre-implementation phase of the project, it is important to review the project evaluation framework (refer to evaluation section). Re-visit this evaluation section throughout the project, as evaluation is critical across the project course, not something that is solely completed at the project end. The framework, evaluation questions and data collection methodologies should be discussed with key stakeholders during initial meetings.

**Action:** Clearly document the evaluation methods and timing in the Project Action Plan.

1.6.1 Self-reflection

Throughout the project, it is important to capture any lessons learnt and critical success factors, as this forms key evaluation information. This information facilitates the sharing of new knowledge gained, and prevents any future repeat of undesirable project outcomes. Self-reflection should be completed following key project milestones, e.g. following stakeholder meetings, following the medical record review etc. Regular evaluation can be useful in the preparation of project team updates, progress reports, and promoting project uptake.

**Template:** Self-Reflection Template at Appendix D

**Resource:** Evaluation Framework (Section 4)
2. Mapping phase

Capturing local referral and diagnostic pathways

This section of the toolkit provides the methodology and relevant tools to capture how patients currently enter and move through the service, up to the point of confirmed cancer diagnosis. Mapping involves looking in detail at the connected steps or actions in a patient’s journey to determine:

- current practice in the referral and diagnosis of a specific cancer stream in the LHD
- compliance with optimal care standards specific to cancer type stream
- significant variations in practice
- data on which to base intervention/solution
- baseline measures against which future progress can be measured.

In collaboration with broad multidisciplinary representation, it is pivotal to the project’s success to gain consensus around “ideal” local cancer care pathways for referral and diagnosis. This will enable the development of a localised and annotated pathway detailing information about the referral and diagnostic processes within the LHD.

2.1 Hold initial mapping meeting

The purpose of the initial service-mapping meeting is to generate a high level local map of the services available to patients. This is not a comprehensive map but rather a starting point for future exploration and the addition of specific detail. The following action steps can guide meeting preparation.

- Identify and engage several key stakeholders and schedule a brief mapping meeting. Alternatively, use an existing meeting, such as an MDT meeting.
- Invite additional participants as appropriate to ensure a representative sample of pathway stakeholders. For example, representation could include stakeholders across primary care, surgery, medical oncology, radiation oncology, allied health and care coordination.
- If more than one MDT is in operation within the LHD, it is preferable that separate mapping meetings are conducted then compared.
- Allow approximately 1hr for this meeting and clearly specify the aim and scope of the service mapping activity. A clear introduction to the project, including a brief overview of the evidence and benefits, will facilitate stakeholder buy-in and participation.
- Ask participants to describe the interconnected steps and actions experienced in the “typical” patient pathway.
- Scribe the process discussed on long paper or a white board, or have participants construct a pathway by posting steps with post-it-notes. This becomes the high level service map to which further detail will be added.
2.2 Conduct medical record review

Please note for the purpose of this activity, a ‘record’ refers to an entry or notes (either written or electronic) that are made to mark an occasion of care with a patient.

National Institute for Clinical Excellence (2002) defines a record review or audit as a common feature of a quality improvement process “that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change”.

The purpose of this review is to obtain relevant service and process information that contribute to the mapping of local referral and diagnostic pathways, including who initiates referral and where diagnostic test and investigations are performed and by whom. Access to information contained in primary health care and private specialist records may be limited.

2.2.1 Medical record review methodology

The following steps serve as a guide to undertaking a medical record review.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define the purpose of the review</td>
<td>Clearly articulate the purpose of the review, including the aim and objectives, which helps to establish a common understanding of the activity.</td>
</tr>
<tr>
<td>2. Consult with peers and relevant stakeholders</td>
<td>Seeking input from others can generate support and harness existing expertise. Key stakeholders can advise on issues of review feasibility, design, and conduct.</td>
</tr>
<tr>
<td>3. Agree on data points and data definitions</td>
<td>Reviewing the medical record review template and agreeing on data definitions contributes to accurate and timely data abstraction. A data dictionary is a standard tool used to document definitions. Definitions resolve ambiguity and guide how the data are to be abstracted from the record.</td>
</tr>
<tr>
<td>4. Identify potential sources of data</td>
<td>There are multiple information sources from which data about the patient’s care experience can be abstracted. Identifying which records contain relevant data will help inform the scope of the review. A list of potential sources of patient data is provided below.</td>
</tr>
<tr>
<td></td>
<td>• electronic medical records: Cerner or equivalent (including FirstNet for ED data, SurgiNet for Surgical data, and Powerchart for MDT data)</td>
</tr>
<tr>
<td></td>
<td>• paper based medical records</td>
</tr>
<tr>
<td></td>
<td>• GP patient records</td>
</tr>
<tr>
<td></td>
<td>• private specialist records</td>
</tr>
<tr>
<td></td>
<td>• radiation oncology data system: ARIA</td>
</tr>
<tr>
<td></td>
<td>• medical oncology data system: MOSAIQ, ARIA, CHARM, Cerner and some small custom systems</td>
</tr>
<tr>
<td></td>
<td>• medical imaging: PACS</td>
</tr>
<tr>
<td></td>
<td>• community health: CHIME/FERRET/CHARM/CHOC.</td>
</tr>
</tbody>
</table>
## 2. Mapping phase

<table>
<thead>
<tr>
<th>5. Specify how to select sample cases for review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select only cases with a definitive primary cancer diagnosis for the cancer type being mapped to ensure complete data for analysis.</td>
</tr>
<tr>
<td>Where available, the District’s Performance Monitoring Unit or Hospital Data Management Unit may be able to provide a list of patients with a primary diagnosis of the specific cancer type.</td>
</tr>
</tbody>
</table>

It is recommended that approximately 10 patient records be retrospectively reviewed to contribute information to the mapping of local care pathways. The sample of patient records for review should represent:

- **Current practice:** Identify a consecutive sample of 10 patients diagnosed within an appropriate time frame for case selection. A patient may have received care over the past 6 months. If this is not sufficient, the timeframe should be extended.
- **A cross-section of the population:** Determine a representative sample of the local population. Avoid sample bias that may occur by selecting cases from a single service provider or single treatment cohort.

<table>
<thead>
<tr>
<th>6. Conduct a preliminary review (1-3 records)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducting a preliminary review helps to identify feasibility issues, for e.g. if the data is available. It may be necessary to consult with specific clinicians to ascertain how patient information is recorded.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Allocate resources and perform record review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying the available resources and specifying resource allocation ensures adequate preparation of the reviewer(s). Where more than one reviewer is involved in the data abstraction, consideration of inter-rater reliability etc. may be required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Perform data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given the small sample size (n=10), plotting the data on a pathway with timeline points is one useful method of presenting the project findings. Extreme (outlier) information should be noted, e.g. why there is a lengthy time between appointment dates or how a patient was fast-tracked along the pathway.</td>
</tr>
</tbody>
</table>
2.2.2 Sample size and timing

The following table is an example of a record review completed at three points in time.

<table>
<thead>
<tr>
<th>Project stage</th>
<th>Why</th>
<th>Anticipated timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>At project initiation</td>
<td>To achieve baseline</td>
<td>Project commencement (n=10)</td>
</tr>
<tr>
<td>Following the project</td>
<td>To look for possible short term changes in the patient journey</td>
<td>6 months post pathway implementation (n=10)</td>
</tr>
<tr>
<td>Following the project</td>
<td>To look for possible long term changes in the patient journey</td>
<td>18 months post pathway implementation (n=10)</td>
</tr>
</tbody>
</table>

2.2.3 Potential challenges

While the advantages to performing a record review are well documented (Gearing et al. 2006), it is important to acknowledge the potential challenges that may impact on this activity. As previously noted, information and data entries about occasions of care are captured in a number of records or data systems. One of the main challenges in reviewing a patient’s journey to diagnosis is the breadth of information held across multiple records and multiple service settings that are not linked. Other well-recognised challenges include:

- incomplete documentation and variance in the quality of information recorded by medical professionals
- missing records
- information that is unrecoverable, unrecorded, or a poor representation of what actually occurred
- difficulty interpreting information (e.g. jargon, acronyms etc)
- sample selection bias (i.e. are the review cases representative of the majority of the population?)
- number of records and inconsistency and incompleteness of records makes it unlikely that a definitive statement can be made about the impact of any intervention.

The absence of information or misinterpretation of information can lead to inaccurate judgements of process or performance. It may also impact on the organisation’s ability to demonstrate change. In planning the medical record review, it is useful to identify and discuss potential challenges with key stakeholders, and where possible, generate strategies to minimise impact.
2. Mapping phase

2.3 Conduct stakeholder interviews

A variety of stakeholder interviews can inform the development of a localised pathway. If some stakeholder groups were not present during the mapping meeting, the health professional questionnaire below can capture information to confirm current referral patterns and patient pathways. Please note that the questionnaire template is lung cancer specific, and will need to be tailored to the specific cancer type being mapped.

Discuss the need for a national ethics application form or low negligible risk application through your local Human Research Ethics Committee (HREC) is required prior to initiation of stakeholder.

Invaluable information can also be gathered through interviews with cancer patients and their carers. Interviews can provide a more complete picture of the patient pathway, filling gaps or missing information that may not have been available via medical records. Please note that the interview template is lung cancer specific, and will need to be tailored to the specific cancer type being mapped.

2.4 Generate draft service map

Map the local service to the point of diagnosis and make note of any significant variations in patient care. An analysis of the medical record review and stakeholder interviews will inform the additional detail of the high level map from the initial MDT mapping meeting. The detail should include the service centres and diagnostic modalities of the patient pathway. The resource below provides an example of a draft service map for lung cancer.
2.5 Compare current practice to optimal care standards

Through an analysis of data collected, compare the patients’ pathways and time intervals with the optimal pathways. The table below includes key time points for comparison. At a minimum, timelines from GP referral to first specialist appointment should be noted along with the specialist first referred to and whether or not they are part of a MDT.

<table>
<thead>
<tr>
<th>Step in pathway</th>
<th>Care point</th>
<th>OCP (from presentation)</th>
<th>NICE (from presentation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation, initial investigations and referral</td>
<td>Test results received from initial investigations by a GP</td>
<td>Insert timeframe as specified in the OCP for the specific cancer type being mapped e.g. 7 days (for lung cancer)</td>
<td>Insert timeframe as specified in the NICE Pathways for the specific cancer type being mapped e.g. 7 days (for lung cancer)</td>
</tr>
<tr>
<td></td>
<td>Specialist appointment</td>
<td>Insert timeframe as specified in the OCP for the specific cancer type being mapped e.g. 14 days (for lung cancer)</td>
<td>Insert timeframe as specified in the NICE Pathways for the specific cancer type being mapped e.g. 14 days (for lung cancer)</td>
</tr>
<tr>
<td>Diagnosis, staging and treatment planning</td>
<td>Treatment planning</td>
<td>Insert timeframe as specified in the OCP for the specific cancer type being mapped e.g. Before treatment begins (for lung cancer)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seen by an MDT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>Surgery, radiotherapy and chemotherapy (keep and/or insert relevant treatment types)</td>
<td>Insert timeframe as specified in the OCP for the specific cancer type being mapped e.g. 42 days (for lung cancer)</td>
<td>Insert timeframe as specified in the NICE Pathways for the specific cancer type being mapped e.g. 45 days (31 days from specialist appointment)(for lung cancer)</td>
</tr>
</tbody>
</table>

Template: Data Presentation Template at Appendix J
2. Mapping phase

2.6 Gain consensus and finalise the optimal local pathway

In collaboration with broad multidisciplinary representation, gain consensus around ‘ideal’ local service pathways for referral and diagnosis of the specific cancer at a face-to-face meeting. In preparation for the consensus meeting, a presentation of the evidence should include a brief description of the project, a presentation of a draft service map (2.4) and variations found in patient pathways (2.5) for discussion. It is likely that determination of an ideal pathway will generate considerable debate and the meeting will require active facilitation.

At this meeting the following questions should be answered regarding how the localised pathway should be presented:

1. What entry points should be listed in the pathway (e.g. numbers of clinics or individual clinicians)?

2. Which services and clinicians should be listed in a localised pathway? (e.g. only specialists who are members of the MDT)

3. Is this listing of clinicians and services consistent for all stages of the specific cancer?

4. Is this listing of clinicians and services consistent across the LHD? (different hospitals within the LHD may have different MDTs and specialists to refer to)

At the conclusion of the consensus meeting, the information gathered should document a defined, localised pathway that details where, who, and how referral and diagnostic processes should ideally be delivered to patients across the LHD including links to specific services and clinicians with contact details.
3. Dissemination of localised pathway

Careful consideration should be given to how the localised pathway will be disseminated and promoted. This section of the toolkit focuses on identifying the internal/external drivers and scope for successful implementation. Preparing for dissemination will allow:

- clear and succinct articulation of the drivers for effective dissemination
- acceptance and buy-in from key stakeholders
- effective communication with stakeholders to ensure they are well informed of any changes.

This project includes placing of the localised pathway on the Canrefer site and hosting of the localised pathway on third party programs such as HealthPathways and Map of Medicine. It is recommended that third party programs be engaged as early as possible. Negotiations including the method of clinician listing on the site will need to occur. It is recommended that all clinicians who are members of the MDT are listed with contact details and hyperlink to their Canrefer page. It is recommended that consideration be given to listing specialists who are not members of the specific cancer type MDT to align with listings on Canrefer.

Some LHDs will need to consider the geographical boundaries of the area that the third party program listing includes. It might be necessary to engage with LHDs that exist within the boundary of the PHN.

Additional dissemination strategies include:

- promotion of pathway through GP communications channels including PHN newsletters and other communications.
- promotion through Royal Australian College of GPS (RACGP) and Australian College of Rural and Remote Medicine (ACCRM).
- promotion through GP workshops and other activities

The Dissemination Action Plan template helps set out the key messages about the pathway, identify the target audience and methods of communication and dissemination. It prompts consideration of any risks or issues and facilitates the development of a communication strategy.

Template: Dissemination Action Plan Template at Appendix K
4. Evaluation

Evaluation at each phase of the project is important to capture lessons learnt and critical success factors to facilitate the sharing of knowledge gained and prevent the repeat of undesirable outcomes. The evaluation will address the following objectives:

- To gain broad stakeholder representation that is engaged in generating a localised pathway for cancer diagnosis and referral.
- To clearly map and define the localised cancer diagnostic and referral pathway that represents local services and ideal diagnostic and referral timelines.
- To implement the pathway using dissemination methods and communication strategies that reach the target audience.

In the pre-implementation phase the evaluation framework should have been reviewed and considered. This will assist completion of the evaluation template at Appendix L. The framework, evaluation questions and data collection methodologies should be discussed with key stakeholders.

Once evaluation activities have been undertaken, consideration should be given as to how to ensure that the evaluation results are used.

Three questions for consideration post-evaluation:

1. What is the method for interpreting the results internally?
2. What is the process for promoting the results externally?
3. How will the results be stored so that others can use them in the future?

It is useful to consider ways to return any information collected back to the participants. Reporting back to the participants can encourage greater involvement in the future and help to improve the evaluation process.
### 4.1 Evaluation framework

The Evaluation Framework was developed through a program logic process that involved pilot sites, the Cancer Institute NSW and the Expert Advisory Group. The program logic methodology was used to develop the key objectives, evaluation questions, indicators and tools below.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Evaluation question</th>
<th>Activities</th>
<th>Indicators</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Pre-implementation Phase</strong></td>
<td>To gain broad stakeholder representation that is engaged in generating a localised pathway for cancer diagnosis and referral</td>
<td>Q1.1 Were stakeholders identified?</td>
<td>• Stakeholder identification and analysis</td>
<td>• Environment scan template (See Checkpoint 1.2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Type/number of services and service governance identified</td>
<td>• Stakeholder identification matrix (Appendix A)</td>
</tr>
<tr>
<td></td>
<td>Q1.2 Were stakeholders aware of project aims and objectives?</td>
<td>• Project initiation and planning meeting</td>
<td>• Service(s) support and cooperation for this project (e.g. Cancer Services, PHCN, MDT etc)</td>
<td>• Project Action Plan (Appendix C)</td>
</tr>
<tr>
<td></td>
<td>(Have they been informed, consulted, involved, collaborated and empowered?)</td>
<td></td>
<td>• Type/number of stakeholders informed of project</td>
<td>• Meeting Observation Template (Appendix B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Type/number of key influencers and decision makers are represented on project steering group</td>
<td>• Self-reflection evaluation(s) (Appendix D)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Type/number of stakeholders who are engaged in specific project activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Type/number showing willingness to take action to implement</td>
<td></td>
</tr>
</tbody>
</table>
## 4. Evaluation

### Phase 2: Mapping Phase

<table>
<thead>
<tr>
<th>Objective</th>
<th>Evaluation question</th>
<th>Activities</th>
<th>Indicators</th>
<th>Tools</th>
</tr>
</thead>
</table>
| To clearly map and define the localised cancer diagnostic and referral pathway that represents local services and ideal diagnostic and referral timelines | Q2.1 Has current practice been identified? | • Initial mapping meeting  
• Retrospective medical record review  
• Stakeholder interviews | • A high level local map of diagnostic and referral services is generated  
• Case examples of pathways experienced by patients generated from medical record review data  
• Timeline data estimated from record review data  
• Type/number of stakeholder interviews to gain/confirm pathway information | • Mapping meeting template (Appendix E)  
• Medical record review template (Appendix F)  
• Health professional interview template (Appendix G)  
• Consumer interview template (Appendix H) |
| Q2.2 Has consensus on a local pathway been achieved (which acknowledges different populations and reflects best practice)? | • Generate localised pathway  
• Pathway consensus meeting | • Stakeholder reflection of current practice against best practice recommendations  
• A localised cancer diagnostic and referral pathway is generated that incorporates local service information, optimal care standards, and reflects the unique requirements of the local population  
• The pathway has sign-off from relevant service governance (DCS, MDT Chair) | • Meeting Observation Template (Appendix B)  
• Consensus meeting records  
• Self-reflection Evaluation (Appendix D)  
• Diagnostic and referral pathway with local service information and timelines |
<table>
<thead>
<tr>
<th>Objective</th>
<th>Evaluation question</th>
<th>Activities</th>
<th>Indicators</th>
<th>Tools</th>
</tr>
</thead>
</table>
| **Phase 3: Dissemination Phase** | **To implement the pathway using dissemination methods and communication strategies that reach the target audience** | Q3.1 Has the pathway been published? | - Identify local dissemination platform  
- Liaise with relevant IT/publisher to upload pathway to platform | - Published on Canrefer  
- Published on relevant local pathways platform, e.g. HealthPathways, Map of Medicine, Cancer Services portal etc. | - Project Action Plan (Appendix C)  
- Published pathway  
- Dissemination Action Plan Template (Appendix K) |
| | Q3.2 Is the target audience aware of the pathway? | - Communication strategy implemented | - Type/number of communication mediums utilised to raise awareness | - Dissemination Action Plan Template (Appendix K) |
| | Q3.3 Is the pathway being utilised? | - Evaluation | - Number of GPs who access and apply pathway recommendations to their management suspected cancer cases | - Record audit at 6 and 18 months following implementation  
- Number of GPs who access HealthPathways lung cancer pathway on website |
| | Q3.4 Is the pathway impacting on practice? | - Evaluation | - Decrease in inappropriate referrals  
- Increased patients seen within recommended timeframes | - Record audit at 6 and 18 months following implementation |


Appendices

List of Appendices

Appendix A: Stakeholder Identification, Engagement and Communications Matrix

Appendix B: Meeting Observation Template

Appendix C: Project Action Plan Template

Appendix D: Self-Reflection Template

Appendix E: Mapping Meeting Template

Appendix F: Medical Record Review Template

Appendix G: Health Professional Questionnaire Template

Appendix H: Consumer Interview Template

Appendix I: Sample Service Map

Appendix J: Data Presentation Template

Appendix K: Dissemination Action Plan Template

Appendix L: Evaluation Template