The Evolving Role of Primary Care in Cancer

FRIDAY 4 MARCH 2016

Western Centre For Health Research And Education
Sunshine Hospital
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Welcome from Professor Jon Emery

On behalf of the Organising Committee, Western Health, PC4, The Victorian Comprehensive Cancer Centre and The Cancer Council of Victoria, I am delighted to welcome you to The Evolving Role of Primary Care in Cancer Conference.

Internationally there is growing recognition that, with the increasing incidence of cancer and improvements in cancer survival, primary care must take on a greater role in cancer care and control. How best to improve the integration of cancer and palliative care services presents major challenges to our health services.

Today’s conference aims to provide opportunities to hear national and international research about approaches to improve the integration of care across the cancer continuum, from community awareness, cancer screening, early diagnosis, to survivorship and palliative care. There will also be educational workshops on cancer screening, survivorship and palliative care including information about a range of local and national initiatives. Finally, we have a panel of experts from a range of perspectives to discuss and debate what and how primary care should evolve to take on this new challenge.

In addition to the program, the conference provides opportunities for delegates to interact and participate in presentations and discussions. We aim to build collaborations across the local, national and international communities interested in the role of primary care across the cancer continuum. We hope you will stay for the social function at the end of the conference.

Thank you to the Organising Committee and the team at Western Health for making this a successful conference.

Organising Committee
Professor Jon Emery
Professor Michael Green
Tim Chiu
Dr. Adrian Dabscheck
Bianca Bell
Associate Professor Justin Tse
Associate Professor Michael Jefford
Chris Enright
Elizabeth Johnson
Julia Fallon-Ferguson
Silvana Manevski
Professor Bodga Koczwara
Ashleigh Qama
Tammy Dinh
# Conference program

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<tr>
<td>09:30 – 09:40</td>
<td>WELCOME AND CONFERENCE OPEN</td>
<td>Professor Jim Bishop, Executive Director, VCCC</td>
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<td>09:40 – 09:55</td>
<td>PLENARY LECTURES</td>
<td>Professor Jon Emery – Integrated Cancer Care</td>
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<td>09:55 – 10:25</td>
<td>PLenary Lecture</td>
<td>Dr. Fiona Walter – Supporting early diagnosis of melanoma in Primary Care</td>
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<td>10:25 – 10:40</td>
<td>Q&amp;A</td>
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<td>11:00 – 12:30</td>
<td>CONCURRENT SESSIONS</td>
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<tr>
<td>11:00 – 11:20</td>
<td>SESSION 1: WORKSHOP – UPDATES ON CANCER SCREENING</td>
<td>Professor Danielle Mazza – Cervical Cancer Screening</td>
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<td>11:20 – 11:40</td>
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<td>Associate Professor Justin Tse – Prostate Cancer Screening</td>
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<td>11:40 – 12:00</td>
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<td>Associate Professor Paul Mitchell – Lung Cancer Screening</td>
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<td>11:00 – 11:15</td>
<td>SESSION 2: RESEARCH PRESENTATIONS – SURVIVORSHIP AND PALLIATIVE CARE</td>
<td>Dr. Sally Greenberg – A simple strategy to improve the coordination of care for chemotherapy patients</td>
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<td>11:15 – 11:30</td>
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<td>Lee Kennedy – Rural general practice and women with cancer identify gaps in information and support</td>
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<td>11:30 – 11:45</td>
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<td>Nicole Kinnane – How will cancer survivors use survivorship care plans (SCPs)?</td>
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<td>11:45 – 12:00</td>
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<td>Professor Geoffrey Mitchell – Using intuition or a formal palliative care needs assessment screening pathway in general practice to predict death within twelve months: a randomized controlled trial</td>
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<td>12:00 – 12:15</td>
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<td>Dr. Matthew Grant – The myths of morphine: understandings and attitudes of the general practice population</td>
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<td>12:15 – 12:30</td>
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<td>Professor Jon Emery – The ProCare Trial: a phase II randomised controlled trial of shared care for follow-up of men with prostate cancer</td>
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<td>12:30 – 13:30</td>
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<td>Lunch &amp; poster viewing session</td>
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### SESSION 3: WORKSHOP – SURVIVORSHIP AND PALLIATIVE CARE
Session Chairs: Associate Professor Michael Jefford and Dr. Adrian Dabscheck

#### SURVIVORSHIP
- **13:30 – 13:45**
  - Associate Professor Michael Jefford – *Learnings from the Victorian Cancer Survivorship Program*
- **13:45 – 14:00**
  - Ms. Meron Pitcher – *Breast Cancer shared care project*
- **14:00 – 14:15**
  - Kerry O’Donovan – *Consumer perspective*
- **14:15 – 14:20**
  - Magali De Castro – *The role of the Practice Nurse in survivorship care*

#### PALLIATIVE CARE
- **14:20 – 14:50**
  - Dr. Adrian Dabscheck and Fran Gore – *A ‘SMART’ approach to Palliative Care*
- **14:50 – 15:00**
  - Survivorship and Palliative Care: Panel discussion

### SESSION 4: RESEARCH PRESENTATIONS – SCREENING AND EARLY DIAGNOSIS
Session Chair: Associate Professor Justin Tse

#### Research Presentations
- **13:30 – 13:45**
  - Neela Konara – *Exploring and addressing cancer awareness in culturally diverse communities: a collaborative project*
- **13:45 – 14:00**
  - Dr. Sharon Licquish – *Cancer beliefs in migrant populations: Systematic review and meta-synthesis*
- **14:00 – 14:15**
  - Dr. Fiona Walter – *Patient factors associated with time to diagnosis for pancreatic cancer: findings from an English prospective cohort study*
- **14:15 – 14:30**
  - Dr. Alexis Butler – *The Compass Trial: informing the future of the National Cervical Cancer Screening Program*
- **14:30 – 14:45**
  - Dr. Jennifer Walker – *A Novel Colorectal Cancer Risk Prediction Tool (CRISP): Is it acceptable and feasible in Australian General Practice?*
- **14:45 – 15:00**
  - Hannah Cross – *Presentations to general practice before a cancer diagnosis in Victoria: Cross sectional survey of patients treated for cancer*

#### Expert Presentations and Panel Discussion
- **15:15 – 16:30**
  - The Evolving Role of Primary Care in Cancer
    - Session Facilitator: Professor Jon Emery
    - Presentations from panel members – Professor Helen Zorbas, Professor Sanchia Aranda, Associate Professor Justin Tse, Professor Robert Thomas, Elise Davies, Dr. Larry Light
    - Panel Discussion

#### Conference Close
- **16:30 – 16:40**
  - Dr. Alex Cockram, Chief Executive, Western Health
- **16:40 onwards**
  - Networking event

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*Program continued*
Speakers
Dr. Fiona Walter
MA, MB BChir, DCH, DRCOG, MSc, MD, FRCGP

Dr Fiona Walter is a GP and Principal Researcher in Primary Care Cancer Research at the Department of Public Health and Primary Care, University of Cambridge, UK. She holds an NIHR Clinician Scientist award to investigate interventions for improving GP and patient detection of melanoma, and leads a programme of primary care research focusing on the cancer pathway, from prevention, screening, early detection and diagnostics to post-treatment care. Her particular interest is in melanoma; she also leads studies on lung, colorectal, pancreatic, oesophageal, gastric and brain cancer.

Dr Walter chairs the UK’s National Cancer Research Institute (NCRI)’s Early Diagnosis sub-group for the Primary Care Clinical Studies Group (CSG), and is the Primary Care representative on the NCRI Screening Prevention & Early Diagnosis group and the Skin Cancer CSG. She is a Fellow at Lucy Cavendish College, Cambridge, and also has honorary academic roles at the Universities of Melbourne and Western Australia where she contributes to parallel programmes of work led by Prof Jon Emery on improving outcomes for cancer patients.

Professor Jon Emery
MBBch, DPhil, FRACGP, MRCGP, MA

Prof Jon Emery is the Herman Professor of Primary Care Cancer Research at the University of Melbourne and Western Health, a new Chair developed within the Victorian Comprehensive Cancer Centre. He is an NHMRC Practitioner Fellow, Director of the Cancer Australia Primary Care Collaborative Cancer Clinical Trials Group (PC4), and a Visiting Research Fellow at the University of Cambridge.

He studied medicine at Cambridge and Oxford and obtained his DPhil at Oxford on computer decision support to assess cancer risk in general practice. His research interests are in the role of primary care in cancer prevention, diagnosis and follow-up, and primary care trials of complex interventions. Much of his research entails parallel programs of work in Australia and Cambridge on cancer screening, early diagnosis and follow-up care. He has published over 170 papers and has been a Chief Investigator on research grants and awards totalling over $AUD15 million and GBP11 million.

Associate Professor Alex Cockram
MBBS, MMed (Psych), FRANZCP

Associate Professor Alex Cockram has been the Chief Executive of Western Health, Victoria, since October 2012. She is a psychiatrist by training and as a clinician and leader in mental health and acute care, is committed to providing an inclusive workplace that is highly participatory. She is an advocate for workforce training and development that supports better patient and community outcomes and inspires staff to be their best.

Prior to joining Western Health in 2012, A/Prof Cockram served as Executive Director of North Western Mental Health and during that time, she was appointed Associate Professor in the University of Melbourne’s Department of Psychiatry at the Royal Melbourne Hospital.

In earlier roles, A/Prof Cockram was Executive Director of Southern Health’s Mental Health Program and Associate Professor of Psychiatry at Monash University; Area Clinical Director and Acting Director of Illawarra Mental Health Services in NSW; and Director of Outpatients Psychiatry at the Austin Repatriation Hospital.

A/Prof Cockram studied medicine at Monash University, completing her RANZCP training in 1995.

She is a Board member of the Victorian Comprehensive Cancer Centre.
Professor Jim Bishop AO
MD, Mmed, MBBS, FRACP, FRCPA

Professor Jim Bishop was appointed founding Executive Director of the Victorian Comprehensive Cancer Centre in May 2011. He also holds the academic position of Herman Chair of Cancer Medicine, University of Melbourne.

Previous to his current role, Professor Bishop was the Chief Medical Officer, Australian Government, a post which he held since 2009 and prior to this he was founding Chief Executive Officer Cancer Institute New South Wales and founding Chief Cancer Officer for New South Wales. He has also held other important positions in NSW including Deputy Director General, Director of Population Health, NSW Health Department, Director of Cancer Services, Central Sydney Area Health Service and Director of the Sydney Cancer Centre, Royal Prince Alfred Hospital, Sydney.

Professor Bishop graduated from the University of Melbourne in Medicine and subsequently was awarded an MD and a Master of Medicine from the University. Later Professor Bishop was awarded a Fulbright Fellow in medical oncology at the US National Cancer Institute, Bethesda and Baltimore MD. He was also Assistant Professor of Medicine at University of Maryland at this time. Following his return from the USA, Professor Bishop worked as a clinical haematologist and medical oncologist at the Peter MacCallum Cancer Centre and founded the Division of Haematology and Medical Oncology at that hospital.

Professor Bishop is Chair of the Cancer Research Advisory Committee VCCC, Chair of the Cancer Australia Advisory Board, Chair of the Cancer Monitoring Advisory Committee: Australian Institute of Health and Welfare and Member - Scientific Committee of the International Agency for Research in Cancer, Lyon.

Professor Sanchia Aranda
RN, PhD

Professor Sanchia Aranda was appointed CEO of Cancer Council Australia in August 2015.

Professor Aranda has more than 30 years’ experience in cancer control as a clinician, researcher, educator and senior healthcare administrator.

From her early career as a Registered Nurse in New Zealand she specialised in cancer and palliative care, completing a Bachelor of Applied Science, a Master of Nursing and a doctoral thesis exploring nurse-patient relationships in cancer and palliative care. Her most recent role was Director of Cancer Services and Information and Deputy CEO at the Cancer Institute NSW.

Professor Aranda is President-elect of the Union for International Cancer Control (the world’s peak member-based cancer organisation) and a former President of the International Society of Nurses in Cancer Care.

As well as being a research fellow at the Peter MacCallum Cancer Centre, she holds academic appointments within the School of Health Sciences, University of Melbourne, and the Faculty of Nursing, University of Sydney.

Widely published in Australian and international health literature, Professor Aranda has also conducted research reviews for the National Health and Medical Research Council, Australian Research Council, Cancer Councils, state nursing boards and private sector research funding bodies.

As CEO of Australia’s peak non-government cancer control organisation, Professor Aranda is a strong independent voice on evidence-based cancer control. She is engaged in all fields of cancer from primary prevention through to survivorship and advanced care, and has a particular professional interest in improved ways to care for and support cancer patients.

Professor Aranda’s role in cancer control has been recognised nationally and internationally, and in 2013 she was named the 4th Peter MacCallum Cancer Centre Distinguished Fellow for her contributions to cancer nursing.
Magali De Castro  
RN, BN, Dip (Mgt), CertTAA  

Magali has been working in general practice for the past 10 years. As a Registered Nurse she’s worked in clinical settings varying from solo GP surgeries to super clinics and community health centres. She has extensive experience in working with the former General Practice Networks/Divisions. She was the Chronic Disease Service Integration and Practice Support Coordinator for Bayside Medicare Local and is currently the Clinical Director at HotDoc.

Magali is very passionate about teaching and her favourite area is the coordination of health promotion clinics as well as helping practices make best use of MBS item numbers for chronic disease management.

Dr. Adrian Dabscheck  
MBBS, Post Grad Dip Pall Med, Grad Cert Clinical Teaching  

Dr. Adrian Dabscheck is a full time Palliative Medicine Consultant at Western Health. He was a General Practitioner for 31 years, before re-training in Palliative Medicine at University of Melbourne. He is currently vice chair of the National Special Interest Group in Palliative Medicine and Cancer for the Royal Australian College of General Practice.

He completed post-graduate study at Harvard Medical School in Palliative Care Education and Practice in 2012 and recently completed a Graduate Certificate in Clinical Teaching at University of Melbourne.

His interests include medical education and health services research where he has led several quality improvement initiatives such as the SMART clinic at Western Health. He is currently working on a joint initiative with Oxford University in developing a Psycho-Oncology model that will be suitable for an Australian patient population.

Elise Davies  
MSc, BSc(Hons)  

Elise Davies is Executive Director Innovation and Integration at Melbourne Primary Care Network (MPCN), which operates the North Western Melbourne PHN (INWMPHN). Her current role includes oversight of the emerging PHN role in regional population health planning and commissioning. Elise is also responsible for the ongoing implementation of HealthPathways Melbourne. INWMPHN’s approach to the development of local clinical care pathways to improve delivery of evidence-based primary care and developing the INWMPHN’s role in implementing coordination of care across the acute and primary care system.

PHNs have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and improving coordination of care to ensure patients receive the right care in the right place, at the right time.

Elise is an experienced health executive with more than ten years’ experience at a senior level in the Victorian State Government, where she ran the cancer reform program, and more recently worked as a strategic advisor. She is passionate about improving patient care, innovation in service delivery, whole-of-system reform through building collaboration and partnerships and reducing disadvantage.

Elise has a strong interest in managing loss and grief, and is currently undertaking a Grad Cert in bereavement counselling. Originally from England, her diverse career includes running women’s refuges, five years of research in health and homelessness, studying the links between poverty and ill-health and a background in cancer nursing. She has a Master of Science in Health Promotion and Public Health.
Kerry O’Donovan

Kerry O’Donovan was diagnosed with stage three breast cancer in July 2013. She already describes herself as a breast cancer survivor and refers to this time in her life as a detour not a journey.

“In my mind the word journey conjures up images of a romantic drive into the sunset in a red convertible while drinking a glass of Cristal champagne. However the reality of a cancer diagnosis is unexpected, frightening and it is definitely not a choice. My detour was filled with frightening twists and turns followed by emotional valleys of depression and high peaks of treatment milestones and at the end of this detour I also discovered that I had to live with the sword of Damocles swinging over my head for the rest of my life.”

Kerry’s treatment included a mastectomy, six rounds of chemotherapy and 28 rounds of radiotherapy and when she thought her detour was completed in January 2014, her partner ended their eight year relationship. His mother had died from breast cancer and he could not deal with Kerry’s new physical and emotional scars.

Kerry is now a passionate advocate for the importance of early detection of breast cancer. She has been a guest speaker at several events for the Breast West Foundation and Western Heath and was a presenter at the the 2015 Psycho-Social Oncology Conference. Telling her story of delayed diagnosis and her subsequent detour educates women on the importance of breast awareness. As a recipient of early psychosocial intervention through Western Health, she is testament to the efficacy of the Distress Screening Program and the importance of including psychosocial oncology as a component of the holistic approach to cancer patient care in Australia.

Fran Gore

RN, GradCert Palliative Care

Fran Gore is Manager/Deputy Director of Nursing Mercy Palliative Care Services, which involves management of the community service as well as the twelve bed inpatient unit at Werribee Mercy Hospital.

Fran has had over 20 years experience in community palliative care, firstly as a nurse, and then later in the role of Clinical Nurse Consultant/Team leader. Prior to this she worked with Royal District Nursing Service in their haematology/oncology program, where she gained valuable experience in paediatric palliative care, helping many young children to die comfortably at home with their families. She has a post graduate certificate in Palliative Care.

Fran has been involved with many initiatives to improve access to palliative care in the Western region of Melbourne including establishment of an outreach program and is committed to assisting people to die in their place of choice. She has a keen interest in quality improvement and improving the provision of palliative care in the aged care setting.

Professor Michael Green

MBBS, FRACP, FACP

Professor Michael Green is the Director of Cancer Services at Western Health and is also a Clinical Professor of Medicine at the University of Melbourne. He trained at the University of Melbourne and performed post graduate studies at the Ludwig Institute at the University of Sydney.

He completed his oncology fellowship at New York University School of Medicine and was appointed to their faculty for 7 years before returning to Australia. His major clinical interest is in the treatment of patients with breast cancer, early clinical trials, the development of the hematopoietic growth factors, antiemetic treatments and new agents for cancer treatment and to this extent he has been involved in both laboratory research and clinical trials in this area. He has been a member of a number of cooperative oncology groups in the United States but now focuses his clinical research through the Australian New Zealand Breast Cancer Study Group as well as the International Breast Cancer Study Group (IBCSG). He is on the Scientific Advisory Committee of both groups and sits on the Board of Management (The Foundation Council) of the IBCSG. He has been active in the development of new drugs for the treatment of breast cancer. He is a recent member of the Breastscreen Victoria Board and previous chair of their Medical and Scientific advisory committee. He is on the board of Cancer Trials Australia and is the past chair. He has also chaired the Medical Oncology Expert Advisory Group of the National Breast Cancer Centre (NBCC). He is the current chair of the management advisory committee of the Western and Central Metropolitan Integrated Cancer Service in Victoria. He has published in excess of 170 Scientific Articles and reviews.
Associate Professor Michael Jefford  
MBBS, MPH, MHlthServMt, PhD, FRACP  
Associate Professor Michael Jefford is Deputy Head of the Department of Medical Oncology at Peter MacCallum Cancer Centre and a Principal Fellow at the University of Melbourne. 

He completed medical oncology training (FRACP) in 1999 and holds a PhD (2002) and Graduate Certificate in University Teaching (2013) from the University of Melbourne and Masters degrees in Health Services Management (2003) and in Public Health (2006) from Monash University. He is a Graduate of the Australian Institute of Company Directors. 

Michael is a practicing medical oncologist. He is also Director of the Australian Cancer Survivorship Centre, a Richard Pratt legacy, based at Peter Mac. He has led research and contributed to program development, service delivery and to the international literature regarding cancer survivorship. 

He has been awarded over $12m in grant funding as a chief / principal investigator, has published 114 peer-reviewed manuscripts and book chapters and has presented work at numerous national and international meetings. 

Dr Larry Light  
MBBS  
Dr Larry Light is a GP with over 30 years of clinical experience. He has an interest in preventive care including the early detection of cancer. His work led to the award of the 2008 RACGP Victoria General Practice of the Year. His general practice was awarded a National Primary Care Infrastructure Grant in 2011 enabling it to become a teaching practice. 

He has a strong interest in the GP management of diabetes, asthma and allergy. Dr Light’s current clinical interest involves the measurement of improvement in GP diabetes management using internationally accepted targets at a weekly diabetes case meeting. 

He is a Specialist Clinical Assistant in the Department of Allergy, Immunology and Respiratory Medicine at the Alfred Hospital in Melbourne. 

Professor Danielle Mazza  
MD, MBBS, FRACGP, DRANZCOG, Grad Dip Women’s Health, GAICD  
Professor Danielle Mazza is an Australian leader in general practice cancer research, preventive care and guideline development and implementation. She holds the Chair of General Practice at Monash University where she has been Head of Department of General Practice since May 2010. She leads a program of translational research with a focus on the early diagnosis of cancer and improving the delivery and uptake of preventive care in the general practice setting. Her methodological expertise in both guideline development and implementation and the development and trial of complex interventions are exemplified by her key contributions to Australian guideline development. This includes leadership of Cancer Australia’s national Guide “Investigating Symptoms of Lung Cancer - An evidence-based guide for general practitioners” (2012), membership of the editorial group of the RACGP’s “Redbook” Preventive Care Guidelines for General Practice 7th and 8th editions and forthcoming 9th edition and the 2nd edition of the RACGP’s “SNAP” population health guide to behavioural risk factors in general practice and membership of the Guideline Development Group for the Follow Up Care of Women with Ovarian Cancer (2010). In 2015 she was awarded a large grant from the Priority Driven Research Scheme administered by Cancer Australia for LEAD a three year project which aims to uncover why there are differences in lung cancer outcomes for Australians from culturally and linguistically diverse backgrounds by comparing their diagnostic and treatment pathways.
Dr Paul Mitchell  
BHB, MBChB, FRACP, MD, GAICD  

Dr Paul Mitchell holds the positions of Medical Oncologist at the Olivia Newton-John Cancer and Wellness Centre at Austin Health, Director of the North-Eastern Melbourne Integrated Cancer Service (Cancer Network) and Associate Professor at the University of Melbourne. Dr Mitchell is President of the Australasian Lung Cancer Trials Group (ALTG) since 2012 and has been involved in clinical and laboratory research for over 20 years, more recently focused on lung cancer. He is Chair of the Board of the recently established TACT (Thoracic Alliance for Cancer Trials) which brings together over 20 existing national and trans-national groups. Other major contributions to cancer research and clinical care are through appointments to the Lung Cancer Advisory Group of Cancer Australia and previously as non-executive director on the Board of Cancer Trials Australia. He sits on the State Government Cancer Quality and Outcomes Committee and the Program Assessing Committee of the Health Research Council of New Zealand.

Dr Mitchell trained in medical oncology in Auckland, New Zealand, followed by two years as Senior Registrar at the Royal Marsden Hospital, UK, before completing a Doctor of Medicine degree based on work at the Institute of Cancer Research, UK.

Ms. Meron Pitcher  
MBBS, FRACS  

Meron Pitcher is a General and Breast surgeon who has worked as a specialist at Western Health since 1993.

She graduated from the University of Melbourne then trained in General surgery through the Heidelberg Repatriation Hospital. She did post fellowship training in the UK in Canterbury then London at the Royal Marsden Hospital, where she developed her interest in breast cancer and soft tissue tumours.

She is Head of the Breast Unit at Western Health and Acting Head General Surgery Sunshine Hospital, where she is responsible for quality and safety in perioperative services. She is immediate past chair of the VCOG Breast Cancer Committee and recently stepped down as Senior Examiner in General Surgery for the RACS.

Her research interests include improving quality of care for breast cancer survivors.

Meg Rynderman  

Meg Rynderman is a survivor of recurrent Hodgkin disease and of hormone positive breast cancer. Treatment for her disease included radiotherapy, high dose chemotherapy, stem cell transplant, bilateral mastectomy & reconstruction.

She volunteers her time as a consumer representative for the Australian Cancer Survivorship Centre at Peter MacCallum, volunteering also for Cancer Council Victoria’s Cancer Connect program.

Meg’s 20+ year cancer journey has instilled in her a passion that other cancer survivors should be offered more appropriate support and follow-up care than she experienced in her early years and that cancer should no longer be seen as a one-off incident, but rather a whole-of-life health issue.

She regularly relates her story and the insights gained along the way to Health and Allied Health Care professionals to aid in their understanding of survivorship.

Currently, Meg is involved in writing a series of ‘survivor stories’ for the ACSC – a powerful means of offering hope to cancer patients and their families.
Professor Robert J S Thomas, OAM
MBBS, MS, FRACS, FRCS (UK)

Professor Robert J S Thomas, OAM is the Chief Cancer Advisor to the Victorian Government and Chair of the Advisory Board of Cancer Australia. He is co-chair of the National Cancer Expert Reference Group. As past Chair of the Victorian Cancer Agency he was instrumental in funding a cancer research program in Victoria. Professor Thomas is passionate about cancer reform, working to provide all Victorians with the benefits of multidisciplinary care, appropriate psychosocial support for cancer patients and carers, and access to the best translational research. He has implemented an innovative Cancer Service Framework for Victoria over the past decade which has created a new system of care for cancer sufferers in that State.

Professor Thomas holds positions on many State and Federal government cancer-related committees and brings a wealth of experience as both a cancer surgeon and researcher. He is the previous Director of Surgical Oncology and interim CEO at Peter MacCallum Cancer Centre, in Melbourne, Australia.

He has been heavily involved in the development of cancer reforms within Australia, serving as President of the Clinical Oncological Society of Australia (COSA), Chair of the National Committee creating the Colorectal Cancer Guidelines, and a member of the Ministerial Taskforce on Cancer. He was instrumental in the development of the discipline of Surgical Oncology in Australasia and initiated the creation of the Surgical Oncology Group within the Royal Australasian College of Surgeons. He is a past long-time Editor-in-Chief of the ANZ Journal of Surgery, and has served as Chair of the National Health and Medical Research Council panels. Professor Thomas has ongoing research interests in the molecular pathology of gastrointestinal tumors.

He is currently Chair of the international WISH (World innovation Summit on Health) Forum entitled Delivering Affordable Cancer Care.

Professor Thomas has published over 100 peer reviewed scientific papers and book chapters. He has been honored by the Royal Australasian College of Surgeons with the Excellence in Surgery Award.

Associate Professor Justin Tse
MBBS MMed (Research) FRACGP FACHI

Justin Tse is Director of Medical Education (Clinical Dean) at St Vincent’s Hospital Clinical School, University of Melbourne. He completed his residency training at Royal Melbourne Hospital and then entered general practice training. In conjunction with his GP training, he embarked on the research pathway and completed his thesis in Prostate Cancer screening in primary care. He has held appointments within the Department of General Practice, Victorian Metropolitan Alliance (GP training organisation) and as Clinical Sub-dean at Royal Melbourne Hospital Clinical School.

In addition to his appointment at St Vincent’s Hospital Clinical School, he is a Research Fellow at the Cancer Council of Victoria and Chair - RACGP NFSI network in Cancer and Palliative Care. His research interests include medical education and the increasing role of technology in medical practice.

Professor Helen Zorbas, AO
MBBS, FASBP, MAICD

Professor Helen Zorbas is CEO of Cancer Australia, the Australian Government’s national agency in cancer control. Helen has been responsible for directing a number of national cancer control initiatives to improve evidence-based practice, policy and health service delivery, in both the clinical and psycho-social aspects of cancer care.

She is Conjoint Professor in the School of Medicine, University of Western Sydney.

In 2013 Professor Zorbas was appointed an Officer of the Order of Australia (AO) in recognition of her distinguished service to public health through leadership in the delivery of improved information and services to cancer patients and their families and contributions to research and clinical trials.
Abstracts
SURVIVORSHIP AND PALLIATIVE CARE

A simple strategy to improve the coordination of care for chemotherapy patients

AUTHORS
GREENBERG S

INSTITUTIONS
Western Health (WH), St Vincent’s Hospital Melbourne (SVHM) and Ballarat Health Services (BHS)

BACKGROUND
Oncology patients develop symptoms due to disease and treatment. Knowledge of chemotherapy toxicity and management remains the domain of Medical Oncology / Haematology Teams (MOH) however, the majority of patients receive chemotherapy in the ambulatory setting where GPs are consulted to assess and manage toxicities. Adequate communication between MOH and GPs is vital to ensure optimal coordinated care. Oncologists from three public health organisations collaborated to review and improve communication between hospitals and GPs for patients who are commencing chemotherapy.

METHODS
1. Retrospective audit of communication between hospitals and GPs including processes involved, content and timing
2. Surveys and focus groups determining what information should be shared between hospitals and GPs from the consumer, GP and MOH perspective
3. Developed, trialled and evaluated a communication tool between hospitals and GPs

RESULTS
Quality improvement projects run across multiple institutions are possible with a motivated team. The review phase demonstrated significant gaps between information required by and provided to GPs. A single page communication tool to be sent to GPs prior to or on the day of chemotherapy commencement was designed and piloted. This process was successful for a majority of patients at Hospital A (86%) and B (81%) but not C (24%). The proportion of GPs receiving information prior to or on day of chemotherapy improved from 54% to 82% overall. The quality of information improved especially in respect to potential adverse effects of treatment (35% to 88%), advise on managing these (8% to 79%), indicators for urgent review (5% to 75%), processes for contacting the hospital (10% to 77%) and provision of contact details (29% to 100%). There was no improvement in proportion of communication including psychosocial or supportive care issues (34% to 27%). There was no evidence of improvement in GP satisfaction or confidence in managing toxicities however only 17% of GPs surveys were returned. Targeted phone discussions with GPs who gave negative feedback were more encouraging.

CONCLUSION
The communication standard between MOHs and GPs at three hospitals was poor. MOH, GPs and consumers identified key factors which should be communicated at the time of chemotherapy commencement. A standardised single page letter faxed to GPs improves timeliness and quality of correspondence. Further work is required to ensure this Tool can be established and maintained at all institutions involved. Communication regarding psychosocial care and improving GPs confidence in treating chemotherapy patients require further analysis and improvement.
Rural general practice and women with cancer identify gaps in information and support

AUTHORS
KENNEDY L, Reed M, Riches S, Steele R, Reeves G.

INSTITUTIONS
BreaCan, Barwon South Western Region Integrated Cancer Service, Grampians Integrated Service

BACKGROUND
DHHS funded BreaCan for a needs analysis of the information and support needs of women with cancer in the Victorian rural regions of Barwon South West and Grampians.

METHODS
A Consumer survey was completed by 130 women. A service provider survey was completed by 170 service providers. Hard copies of the service provider survey were sent to GPs in the regions using Primary Health Networks mailing lists. 116 GPs responded (representing 64% of respondents).

RESULTS
For some women, their General Practitioners (GPs) provided excellent information (56%) and support (58%), others thought their GPs could be more aware of available information and support. Results from the service provider survey reported that GPs have time to provide women with information (77%) and inform them about support services (73%). 80% reported they would like to be better informed about non-clinical topics and (83%) would like appropriate information about where women can go to obtain more information and access support services.

DISCUSSION/CONCLUSION
The importance of general practice for rural women with an experience of cancer was very clear throughout this project. Consumers spoke of this important relationship and the response rates of general practice in the project also reflected a high level of engagement on this issue. Access to information and support on non-clinical issues was cited by both consumers and general practice as not being satisfactory. The growing rates of cancer survivorship combined with the predicted rise in cancer incidence and prevalence rates also point to the growing importance of the general practice role in cancer care.

How will cancer survivors use Survivorship Care Plans (SCPs)?

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BACKGROUND
SCPs have been internationally endorsed as a communication tool that can support care transitions and shared care and enhance patient-centred care and self-management during the post-treatment survivorship phase. The literature highlights a number of barriers to implementation. To develop sustainable approaches to deliver SCPs, we investigated how cancer survivors might use SCPs.

METHODS
The study was conducted at a single site (Peter Mac). Eligible patients from 10 clinical services up to 12 months post cancer treatment and/or receiving ongoing cancer treatments, were approached in outpatient clinics or via phone interview. A survey assessed survivors’ preferences regarding format, content and intended use. Proposed minimum sample size of 200.

RESULTS
Two hundred and thirty surveys were returned (RR 68%). Over half (56%) of respondents had completed treatment within the previous 6 months, with 10% receiving ongoing treatments. Most (65%) had not previously received a SCP. Almost all (98%) desired further information. Most common information requested in a SCP: ‘list of symptoms to watch out for and report’ (76%), ‘summary of treatment received’ (70%), ‘plan for when I should have follow-up appointments’ (70%), ‘things I can do to look after myself’ (67%). Most common suggested use was as: ‘a record of cancer treatment’ (63%), ‘a reminder of things to do to look after myself’ (57%) and ‘to help me understand my cancer experience’ (56%). Over half (52%) would share the information with their GP. Most indicated a preference for paper-based resources (91%), over half (55%) requested information delivery during face-to-face discussion with health professionals. There was support for both brief (36%) and more detailed versions (42%).

DISCUSSION/CONCLUSION
While similar to international findings, results suggest alternate ways of providing the information that survivors desire. A flexible approach to SCP interventions is warranted. Impressing the value of sharing SCPs with GPs is recommended.
Using intuition or a formal palliative care needs assessment screening pathway in general practice to predict death within twelve months: a randomized controlled trial

AUTHORS
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BACKGROUND
Population aging will lead to more deaths, most being non-malignant with an uncertain trajectory, but some will have cancer. Identification of risk of dying could facilitate effective end of life care planning.

METHODS
Randomised controlled trial of tools to predict risk of death (PT) at 12 months compared with unguided intuition (I). Population: General Practice records of patients ≥70 years. Primary outcome – proportion of patients correctly identified as being at risk of death. Secondary outcomes– screening diagnostic test characteristics; process evaluation.

RESULTS
Thirty-nine GPs randomized (19 PT, 20 I) Twelve month data available for 4365 screened patients (PT - 12 GPs, 1525 patients; I - 18 GPs, 2840 patients), of whom 142 died at 12 months (PT - 47(3.3%), I- 95(3.1%) p=0.638) PT GPs identified more patients at risk of dying (179 (11.8%)) than intuition (154 (5.4%):  p<0.001). PT had higher sensitivity and lower specificity than intuition, but no difference in positive or negative predictive value.

DISCUSSION/CONCLUSIONS
PT was better at predicting actual death, but both PT and intuition were similarly effective at predicting death when screening a GP population. PT had a higher false positive rate. Being focused on accurate death prediction might not be the best option for initiating end of life planning. Recognition of increasing burden of illness as a trigger to escalating planning might be a better response.

The myths of morphine: understandings and attitudes of the general practice population

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AIMS & RATIONALE
Morphine is a commonly used medication that evokes a wide range of responses and attitudes. These views cause significant barriers to providing adequate analgesia and symptom control, and lead to anxiety and conflict within the family and with health professionals. There is a lack of literature examining the general public’s understanding and attitudes to morphine use, and their expectations of communication on this subject. This project aims to explore the array of attitudes in the community which may underlie these assumptions, who may in ten or twenty years have a family member or friend, or themselves be diagnosed with cancer, and require the use of morphine.

METHODS
Participants were recruited from General Practice (GP) clinics throughout the Australian state of Victoria, and completed a short survey. The survey was based upon result from a qualitative study and informed by the Barrier’s Questionnaire. Inclusion criteria involved over the age of 18, and presenting to a GP clinic. The survey collected demographic information, past exposure to morphine use and cancer care, and a 30 item Likert scale discussing attitudes and understanding of morphine use.

RESULTS
290 surveys were returned from 8 GP clinics across an array of urban and regional areas.

Data analysis is currently ongoing using grouped variable analysis. Initial analysis demonstrates participants believed strongly that morphine was used for pain, but could also serve other uses; especially to make the end of life more peaceful. Cancer was not viewed as inherently painful, and would not ultimately require the use of morphine. There were concerns around addiction and tolerance, but participants did not show concern that initiation of morphine was associated with the end of life. Overall, the majority of participants did not believe that morphine had any effect on life expectancy, and disagreed that doctor’s might use it in this way (the double-effect).

The ProCare Trial: a phase II randomised controlled trial of shared care for follow-up of men with prostate cancer.

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BACKGROUND
There is a growing prevalence of prostate cancer survivors who require follow-up after treatment. This randomised phase II trial aimed to test the feasibility and provide estimates of efficacy of a model of shared care for men after completion of treatment for prostate cancer.

METHODS
Men who had completed surgery and/or radiotherapy for low to moderate risk prostate cancer within the previous eight weeks were eligible. Participants were randomised to usual care or shared care. Shared care entailed substituting two hospital visits with three visits in primary care, a survivorship care plan, recall and reminders, and screening for distress and unmet needs. Outcome measures included psychological distress, prostate cancer-specific quality of life, satisfaction and preferences for care and health care resource use.

RESULTS
88 men were randomised (Shared Care n=45; Usual Care n=43). There were no clinically important or statistically significant differences between groups on distress, prostate cancer-specific quality of life, or satisfaction with care. Preferences for follow-up care models differed between groups (p=0.0007), with a shared care model being preferred by 63% of intervention patients compared to 24% of controls after 12 months. There was high compliance with PSA monitoring in both groups. The shared care model was cheaper than usual care (Shared care $1,411; Usual Care $1,728; difference $323 (plausible range $91-554)).

CONCLUSION
Well-structured shared care for men with low to moderate risk prostate cancer is feasible and appears to produce clinically comparable outcomes to standard care at lower cost.
SCREENING AND EARLY DIAGNOSIS

Exploring and addressing cancer awareness in culturally diverse communities: a collaborative project

AUTHORS
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BACKGROUND
Migrants tend to have poorer cancer outcomes and this disparity may be partially attributed to cancer knowledge and beliefs. The International Cancer Benchmark Project (ICBP) surveys, administered in each countries’ national language, examined international variation in cancer survival; focussing on cancer awareness, symptoms, perceptions, beliefs and health care access issues.

This project involved collaboration between researchers at the University of Melbourne, Department of General Practice and the Cancer Council Victoria Diversity Team to engage Arabic and Chinese migrant communities in Melbourne to tailor, translate and trial an Australian version of the ICBP survey for cultural acceptability and relevance. This is the first time that the ICBP survey was modified for culturally and linguistically diverse (CALD) populations.

METHODS
Cognitive interviewing techniques were used to gather feedback about the Australian version of the ICBP from Chinese and Arabic speaking community members. The surveys were modified for cultural relevance and acceptability and translated, before being administered to community groups alongside cancer prevention sessions via the assistance of a bilingual health facilitator. Focus groups were also conducted to gather qualitative data about the sessions.

RESULTS
The Arabic and Chinese participants (n=97) demonstrated low literacy about cancer in general and particular beliefs about cancer that may impact screening completion and help-seeking for a cancer diagnosis. The Arabic participants also had low levels of cancer literacy and expressed cultural and spiritual beliefs about cancer that may impact screening participation and timely diagnosis. The Chinese group required more information about tumour-specific incidence in Asian populations, Hepatitis B information and how and when to screen for bowel cancer.

CONCLUSIONS
These findings will inform primary care and community-based organisations to facilitate help-seeking and increase screening participation in these communities. The method will also be applied to other CALD groups to identify areas of greatest need.

Cancer beliefs in migrant populations: Systematic review and meta-synthesis

AUTHORS

BACKGROUND
Culture is a social determinant of health that acts on a community and population level. Migration from developing to developed countries is growing rapidly. It is important to understand the impact cultural beliefs have on help-seeking and timely cancer diagnosis which can influence culturally safe and appropriate health services worldwide. This is the first systematic review and meta-synthesis of culturally specific factors influencing symptom appraisal and help-seeking in culturally or ethnically diverse populations. The aim of this review was to identify, compare and synthesise published qualitative evidence regarding cancer beliefs in migrant populations.

METHODS
Systematic review and meta-synthesis of qualitative research using Critical Interpretative Synthesis. Searches of Web of Science, Medline, CINAHL and PsychINFO databases for relevant research published in English between the years 2004-2014.

RESULTS
167 abstracts were retrieved and reviewed by two experienced researchers. 47 full papers were retrieved and evaluated for relevance to the research question and methodological quality. 12 papers met these criteria and were included in the meta-synthesis. Critical Interpretative Synthesis was conducted by three experienced qualitative researchers. The constant comparative method was used to identify which themes were most relevant for each ethnic group. Five major themes of attitudes, secrecy, fear, health-care access barriers, knowledge and fatalism were identified across all migrant groups; with variations in sub-themes (i.e. health literacy, god’s will) found among the groups.

DISCUSSION/CONCLUSION
If health services are to be relevant, evidence-based and effective in meeting the needs of migrant or ethnic populations, cancer beliefs common to these groups must be considered. This review found that the most important beliefs impacting help-seeking are culturally specific faith-based understandings of the causes and progression of cancer and inadequate knowledge about the causes, signs and symptoms of cancer. These findings can inform the development of interventions to promote earlier presentation for cancer diagnosis in patients from these cultural backgrounds.
Patient factors associated with time to diagnosis for pancreatic cancer: findings from an English prospective cohort study.

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BACKGROUND
The UK has lower survival rates for pancreatic cancer than other comparable countries. We aimed to identify the symptoms and patient factors influencing time to pancreatic cancer diagnosis.

METHODS
Prospective cohort study of participants referred for suspicion of pancreatic cancer in two English regions. Data on symptoms and healthcare presentation were collected using a patient questionnaire; primary care and hospital records were examined for diagnostic routes, intervals and clinical outcomes. Descriptive and regression analyses examined associations between symptoms and patient factors with Total Diagnostic Interval (TDI), Patient Interval (PI), and Health System Interval (HSI).

RESULTS
Among 391 participants, 30% were diagnosed with pancreatic cancer (metastatic disease 35%), 12% with other malignancies, and 58% with non-malignant conditions. There were no differences in gender, age or deprivation levels between participants diagnosed with pancreatic cancer and non-cancer. Less than half the cohort (40%) had a solitary first symptom; multiple first symptoms were common. In this referred population there was no evidence of differences in first symptoms; jaundice, weight loss, fatigue and loss of appetite were more frequent subsequent symptoms among cancer than non-cancer cases (all p<0.001). There was no evidence of differences in TDI, PI or HSI for those with cancer versus non-cancer diagnoses (total cohort: median TDI 138 days (IQR 66-268), median PI 14 (0-55), median HSI 77 (29-160)). First symptoms associated with shorter TDIs were jaundice (HR=1.38, 95%CI 1.07-1.78, p=0.013) and loss of appetite (HR=1.42, 1.11-1.82, p=0.006), and with longer TDIs were indigestion (HR=0.71, 0.56-0.89, p=0.003) and back pain (HR=0.77, 0.59-0.99, p=0.04). Anxiety, depression and diabetes co-morbidities were associated with longer HSIs.

DISCUSSION/CONCLUSION
Doctors, as well as patients, respond less promptly to some symptoms of pancreatic cancer than others. Healthcare professionals should be vigilant to the possibility of pancreatic cancer in patients with symptoms and mental health or diabetes comorbidities.

The Compass Trial: informing the future of the National Cervical Cancer Screening Program

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BACKGROUND
New Guidelines for the National Cervical Screening Program will be introduced on 1 May 2017. The primary screening test will look for oncogenic (“high-risk”) HPV (human papillomavirus). It is anticipated that the changes (along with HPV vaccination) will decrease the number of cervical cancers in Australia by 15-22%.

Primary HPV DNA testing has been endorsed as a primary cervical screening method by the International Agency for Research on Cancer. Evidence suggests that HPV screening is more sensitive in detecting precancerous lesions than cytology-based screening and that it can safely be conducted at a longer interval. However to date there have been no specific trials that support primary HPV DNA testing for cervical screening in the Australian context.

Compass is a randomised controlled trial being conducted by VCS Inc and UNSW Australia which aims to recruit 121,000 women to compare 2.5 yearly cytology-based cervical screening with 5-yearly primary HPV screening in Australian women aged 25-69 years. Eligible participants are women, aged 25-69 years, attending for routine screening at participating practices in Victoria.

METHODS
Health practitioners seek consent from eligible women to participate in Compass during a regular cervical screening consultation. Practitioners will provide women with a study information sheet and ask them to sign a consent form. Only a liquid-based cytology (LBC) sample will be taken. This is returned to VCS Pathology where randomisation will occur and samples will be analysed.

The recommended screening interval for women with negative results will be 2.5 years in the cytology screening arm, and 5 years in the primary HPV screening arm. The laboratory reports, issued to practitioners, will specify the recommended management.

DISCUSSION/CONCLUSION
In this presentation we will discuss the Compass Trial and show how participation will offer GPs a unique opportunity to be well informed and prepared for the introduction of new Guidelines in May 2017.
A novel Colorectal Cancer Risk Prediction tool (CRISP): Is it acceptable and feasible in Australian general practice?

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BACKGROUND
In Australia, many individuals at increased risk of colorectal cancer (CRC) are not having regular colonoscopy, while many at average risk are being over-screened with colonoscopy rather than use the recommended faecal occult blood test (FOBT). Risk assessment tools could potentially support better risk-stratified CRC screening in primary care.

METHODS
Applying the Medical Research Council Framework for the evaluation of complex interventions, this study explored the context and applicability of the CRC risk assessment tool (CRISP) tool in general practice. 15 GPs used CRISP in two simulated consultations followed by in-depth interviews based on the Normalisation Process Theory. Practice nurses (PNs) and practice managers were interviewed independently for their perspectives on integrating CRISP into general practice.

RESULTS
GPs and PNs saw potential value in the CRISP tool especially the ability to discuss the impact of lifestyle factors on CRC risk. Many GPs lacked trust in the recommendations about use of FOBT and overrode CRISP recommendations, preferring to use colonoscopy as a screening test. GPs felt they did not have time to use the tool in routine consultations but both GPs and PNs believed that a nurse-led model of using CRISP would be effective. Limited use of clinical audit about CRC screening meant that practices would not currently have systems in place to monitor the impact of using CRISP on their CRC screening.

CONCLUSION
The CRISP tool has potential value in general practice but a systems approach involving nurse-led CRC risk assessment would be the preferred model of integration. This study has informed development of the tool including additional risk outputs to support recommendations about use of FOBT in average risk patients. A trial of a nurse-led intervention to implement risk-stratified CRC screening using CRISP is in progress.

Presentations to general practice before a cancer diagnosis in Victoria: Cross sectional survey of patients treated for cancer.

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BACKGROUND
The majority of patients diagnosed with cancer initially consult with a general practitioner (GP) about their symptoms. GPs are therefore pivotal in the timely diagnosis of cancer. There is a little evidence about GP consultations and factors associated with time preceding a cancer diagnosis in Australia. This study aimed to examine variation in number of GP visits preceding a cancer diagnosis.

METHODS
Analysis of data from the Cancer Patient Experience Survey (CPES) from 1552 patients with one of 19 cancers (response rate 38%) treated in 5 Victorian Comprehensive Cancer Centre hospitals; comparative data from the 2010 CPES on 40,749 patients in England (response rate 67%).

RESULTS
Thirty-four per cent of Victorian (426/1248) and 23%, (9550/40,749) of English patients had visited a GP at least three times before referral to a hospital doctor. There was large variation by cancer type in the proportion of patients who visited their GP at least three times before referral: in both populations myeloma and pancreatic cancer were most strongly associated with multiple GP visits; patients with melanoma, breast or endometrial cancer were less likely to have visited their GP at least three times before referral. Cancer type was also associated with the duration of the interval from symptom onset to seeing a hospital doctor: in the Victorian sample it took at least three months for over a third of patients with prostate or colon cancer to see a hospital doctor (34.9 and 34.8% respectively).

CONCLUSION
Certain cancers are more often associated with multiple GP visits suggesting they are more challenging to recognise early. In Victoria, longer duration from first symptom to seeing a hospital doctor for colon or prostate cancer may reflect poorer community symptom awareness, later GP referral or limited access to gastroenterology or urology services.
SCREENING AND EARLY DIAGNOSIS

1. Protocol for the CHEST Australia Trial: a Phase II randomised controlled trial of an intervention to reduce time to consult with symptoms of lung cancer.

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BACKGROUND
Lung cancer is the most common cancer worldwide, with 1.3 million new cases diagnosed every year. It has one of the lowest survival outcomes of any cancer because over two thirds of patients are diagnosed when curative treatment is not possible. International research has focused on screening and community interventions to promote earlier presentation to a healthcare provider to improve early lung cancer detection. This paper describes the protocol for a phase II, multi-site, randomised controlled trial (RCT), for patients at increased risk of lung cancer in the primary care setting, to facilitate early presentation with symptoms of lung cancer.

METHODS/ANALYSIS
The intervention is based upon a previous Scottish CHEST trial which comprised of a primary-care nurse consultation to discuss and implement a self-help manual, followed by self-monitoring reminders to improve symptom appraisal and encourage help seeking in patients at increased risk of lung cancer. We aim to recruit 550 patients from two Australian states: Western Australia and Victoria. Patients will be randomised to the Intervention (a health consultation involving a self-help manual, monthly prompts and spirometry) or Control (spirometry followed by usual care). Eligible participants are long-term smokers with at least 20 pack years, aged 55 and over, including ex-smokers if their cessation date was less than 15 years ago. The primary outcome is consultation rate for respiratory symptoms. Secondary outcomes collected at baseline, and 12 months include: knowledge of symptoms of lung disease, symptom appraisal and help seeking behaviour, anxiety, depression, cancer worry and health service utilisation.

RESULTS
550 patients have been recruited into the CHEST trial from 17 General Practices from Victoria and Western Australia. The response rates for questionnaires range from 97% (baseline), 80% (1 month) and 64% (12 months) to date, and questionnaires are continuing to be collected. Of the 550 enrolled in the trial, 143 have consulted again so far with respiratory symptoms. We aim to have a complete data set by November 2016.

DISCUSSION
This RCT builds on the previous Scottish CHEST trial, which showed promising preliminary evidence in reducing the time to consult with symptoms indicative of lung cancer. It also represents the first Australian trial to test this type of intervention and measure its impact on health care consultations.
2. Did the CHEST Australia intervention create a behaviour change in seeking medical help for high risk lung cancer patients? – A qualitative study.

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BACKGROUND
Lung cancer is the most common cancer worldwide, with 1.3 million new cases diagnosed every year. It has one of the lowest survival outcomes of any cancer because over two thirds of patients are diagnosed when curative treatment is not possible, suggesting many people wait considerable time before presenting with symptoms to a healthcare provider.

OBJECTIVE
To explore the experiences of high-risk lung cancer patients who were exposed to a complex intervention (consultation and self-help manual (CHEST Intervention)) to determine the impact of the intervention on consulting behaviour and identify any barriers to consultation.

METHODS
A purposive sample of participants who received the intervention in the CHEST Trial in Perth, Australia were interviewed. Patients were asked about their experience of the CHEST consultation and self-help booklet, their recall of the main messages, their symptom appraisal and issues relating to help-seeking when they develop symptoms. Thematic analysis was conducted to draw common themes between the patients.

RESULTS
Semi-structured interviews have been conducted with 10 participants at increased risk of lung cancer. A major barrier to consulting with the GP was identified—many patients were put off by the “lecturing” or reprimanding by the GP to stop smoking. Many felt stigmatised and labelled as an outcast in society and by their own families because of their smoking. This was reinforced when they visited the GP. In contrast, many found the intervention a more relaxed, non-threatening environment where they could openly talk about their smoking and lung health and not be judged. Many found the Intervention booklet useful and informative and liked the concept of looking at something positive for their lung health. Any negative images related to smoking were seen to increase resistance to quitting and many preferred the positive messages and reminders from the CHEST intervention. A clearer understanding of what symptoms to look for and when to seek help from the GP was recalled by many after the intervention, and for some the intervention reinforced what they already knew. However, a general overall mistrust of the GP was identified, due to various reasons such as misdiagnosis, not understanding addiction, or not taking symptoms seriously.

CONCLUSIONS
Interventions to promote earlier consultation to the GP for high risk lung cancer patients appear to be useful if delivered in a relaxed, and non-lecturing environment. The messages must be positive and potentially through a nurse-led model. The impact of the CHEST intervention and results of the CHEST trial will be reported in 2017.
3. Cancer Diagnosis and Culture (CDC) Project: Exploring patient and health system factors in timely diagnosis of cancer in CALD communities

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BACKGROUND
Migrants diagnosed with cancer in Australia often have poorer outcomes than comparable non-migrant groups, and to date there is limited research on CALD patients with cancer in Australia. Within individual cultural groups there are often specific and commonly held beliefs about cancer relating to aetiology and prognosis. The impact of these beliefs has been explored to some degree on the uptake of cancer screening in Australia but there has been no research relating to symptom appraisal and help-seeking. This project is exploring whether these culturally-specific beliefs contribute to later diagnosis of cancer in the Vietnamese community.

METHODS
30 Vietnamese patients with a recent diagnosis of colorectal, breast or lung cancer will be recruited, as well as 30 non-CALD patients for comparison. The study will use an exploratory mixed-methods design. Semi-structured interviews are being used to explore participants’ symptom appraisal, decisions about help-seeking and interactions with the healthcare system. The Total Diagnostic Interval (time from first symptom to diagnosis) and its sub-components will be calculated. A mixed methods matrix analysis will identify factors contributing to longer and shorter diagnostic intervals in CALD and non-CALD cancer patients.

RESULTS
Preliminary findings include: Vietnamese patients have limited knowledge of causes and symptoms of cancer. There is reduced awareness of their cancer symptoms, which are reattributed leading to delays in help seeking. The limited awareness could be due to little exposure to others with cancer. There is a sense of fatalism and pragmatism in several patients.

DISCUSSION/CONCLUSION
Cancer diagnosis is a motivating factor for improving health behaviours. Culturally specific factors will be targeted for the development of appropriate resources and interventions aimed at improving cancer knowledge and awareness to reduce diagnostic delay and therefore improve cancer outcomes in CALD populations.


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BACKGROUND
Lung cancer is the leading cause of cancer mortality worldwide. In Australia, lung cancer kills more people than breast, prostate, and ovarian cancer combined. Culturally and linguistically diverse (CALD) patients are especially vulnerable with higher mortality rates than Anglo-Australian patients. Reasons for this are unclear as there are no Australian-specific data examining the barriers existing along the lung cancer pathway from symptom appraisal to treatment in CALD populations.

METHODS
Informed by the Aarhus Statement, we will undertake a mixed-methods, observational cohort study comprising prospective identification of lung cancer patients, patient symptom questionnaires, case-note analysis of hospital and general practice records, and interviews with lung cancer patients to obtain detailed data on their diagnostic and treatment pathways. We will also interview general practitioners and hospital specialists to obtain their perspectives on health system factors that may be contributing to diagnostic delay. Participants will be prospectively recruited from cancer services in Victoria, New South Wales, and Queensland.

RESULTS
The primary outcome will be the length of four key time intervals (appraisal, help-seeking, diagnosis, and pre-treatment intervals) for CALD and Anglo-Australian patients with lung cancer. Data will also be collected on lung cancer staging; patient variables (eg, demographics, attitudes and beliefs, symptoms experienced); practitioner variables (eg, GP demographics, types of specialists seen); and health system variables (eg, involvement of a multidisciplinary team, types of investigations undertaken).

DISCUSSION/CONCLUSION
Our study will be the first to examine the underlying factors that influence the pathways to presentation, diagnosis, and treatment in CALD patients and specifically measure the time intervals between diagnosis and first definitive treatment in CALD patients. Such information will be vital in understanding the difference in health outcomes between lung cancer patients from CALD backgrounds and Anglo-Australian patients and can be used to design interventions aimed at improving health outcomes in these patients.
5. The role of screening in the early detection of cancer related lymphoedema

AUTHORS
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BACKGROUND
Development of secondary lymphoedema following nodal dissection is one of the most severe long term problems for survivors of melanoma and breast cancer. Data in the literature report up to 49% of axillary dissection and 64% of inguinal dissection patients will develop lymphoedema. Early intervention has been shown to decrease duration and severity of lymphoedema, making screening essential for early detection and therefore early management. In its early stages, lymphoedema is localised to the extracellular fluid, and may go undetected. Bioimpedance spectroscopy (BIS) is an assessment method specific to the measurement of extracellular fluid and is ideal for early detection and monitoring. Screening for lymphoedema offers an intervention aimed at reducing physical impairment and psychological distress for the patient and reducing medical costs for both the patient and the health service. Routine pre and post operative screening at The Peter MacCallum Cancer Centre Physiotherapy Department is offered to all patients undergoing axillary and inguinal dissection surgery.

METHODS
A literature review was undertaken to: (1) identify current methods used to screen for lymphoedema; (2) confirm optimal time points for lymphoedema screening; (3) determine prevalence of lymphoedema following nodal surgery for cancer; and (4) examine the cost and cost effectiveness of lymphoedema screening.

RESULTS
Key findings from the review confirm that BIS is an appropriate and cost effective screening tool to identify early lymphoedema.

DISCUSSION
Early detection and intervention in lymphoedema has been shown to be effective in increasing a patients’ quality of life while decreasing limb swelling, and also decreasing the medical cost of treatment for lymphoedema. Health professionals involved with the care of cancer patients should be informed regarding the benefits of this simple, portable and cost effective method of screening for lymphoedema.

6. The Effect of Online Mindfulness Training in Cancer Survivors Reporting Chemotherapy-related Cognitive Impairment

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BACKGROUND
Acute cognitive changes during and after chemotherapy are reported to occur in 14-85% of cancer survivors. Usually symptoms improve following completion of treatment and gradually thereafter, but 34% of this population report persistent symptoms into remission. Reports consistently detect that this causes significant distress, thus importance is placed on quality of life as any self-detectable deterioration in the way an individual perceives their world can be devastating to wellbeing and function.

The purpose of this study was to: 1) determine whether participation in online mindfulness training (OMT) could improve perceptions of cognitive impairment (PCI) and abilities (PCA), quality of life (QoL) and mindfulness tendency, and 2) explore survivors’ perceptions of cognitive impairment and the impact on various aspects of their lives.

METHODS
This study adopted a mixed methods research design. Cancer survivors randomised to a wait-list control (n = 6) or intervention group (n = 6) completed the Functional Assessment of Cancer Therapy–Cognitive Function, European Organisation for Research and Treatment of Cancer Quality of Life Core Questionnaire and Five Facet Mindfulness Questionnaire, on which analyses of variance and correlations were conducted. Two semi-structured interviews were conducted with participants. Thematic analysis was conducted on interview responses. Data was collected before randomisation and at the end of the four-week intervention period.

RESULTS
Improvements in PCA and QoL were found to be correlated (r = 0.562, p = 0.072) and controlling for positive changes in FFMQ weakened this relationship (r = 0.117, p = 0.747). Themes identified in the final analysis were: 1) perceptions that cognition was impaired, 2) impairment negatively impacted QoL and survivorship, and 3) despite challenges to motivation, OMT and mindfulness practice benefited cognition and emotional wellbeing.

DISCUSSION/CONCLUSION
This study found OMT resulted in clinically and statistically significant improvements in PCA and QoL due to mindfulness practice.
7. Home-based multi-disciplinary rehabilitation in inoperable lung cancer: a phase II randomised controlled trial protocol and baseline data

AUTHORS

INSTITUTION(S)
The University of Melbourne

BACKGROUND
Lung cancer (LC) is the leading cause of cancer related death in Australia, having a 5-year survival of 14.1%. There is a growing body of evidence supporting exercise interventions for people with LC. Home-based exercise may be feasible for those undergoing treatment for inoperable non-small cell lung cancer (NSCLC).

METHODS
Aims:
1. To compare the functional and patient-reported outcomes of multi-disciplinary home-based rehabilitation with usual care in people with inoperable NSCLC.
2. To assess the barriers and enablers of participation to exercise.
3. An exploratory aim is to assess the effect of the intervention on survival.

Ninety-two participants from three hospitals in Melbourne, Australia.

Intervention:
Participants receive 8-weeks of home-based physiotherapy and nursing symptom self-management support (weekly home-visit and telephone sessions). Physiotherapy involves individualised prescription of aerobic and resistance exercises, incorporating behavioural change.

Outcomes:
At baseline, 9-weeks and 6 months: functional exercise capacity, strength, physical activity, quality of life, activity motivation and self-efficacy, psychological distress and resilience. Survival censored at 3-years.

RESULTS
Thirty-eight participants have been recruited, with recruitment ongoing. Baseline demographics: mean (SD) age 63 (12.31) years, gender 50% male, disease stage n (%); IIB 1(2.6), IIIA 8(21.1%), IIIB 7(18.4) and IV 22(57.9), histology includes n (%); adenocarcinoma 25(65.8), squamous cell carcinoma 9(23.7). Baseline six-minute walk test mean (SD) distance was 473.4 (129.4) meters, 72% of predicted values.

DISCUSSION/CONCLUSION
Physiotherapy rehabilitation is not part of current guidelines for people with LC. This intervention is designed to be translated into clinical practice and can include patients in rural settings.

8. How is physical activity measured in lung cancer? A systematic review of outcome measures and their psychometric properties

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BACKGROUND
Physical activity (PA) levels are low in people with lung cancer (LC). Emerging evidence supports the use of interventions to increase PA in this population.

METHODS
Aims: 1. To identify and synthesise outcome measures which have been used to assess PA levels in people with LC and 2. to evaluate, synthesise and compare the psychometric properties of each outcome measure identified.

A systematic review of articles from searches conducted of five electronic databases and personal records. Eligible studies were those which assessed PA using either performance-based or patient-reported measures. For aim 2, studies identified in aim 1 reporting on at least 1 psychometric property were included. Two independent reviewers assessed eligibility and risk of bias with the consensus-based standards for the selection of health status measurement instruments.

RESULTS
Aim 1: Thirty-four studies using 21 different measures of PA were identified. Seventeen studies used performance-based measures. The Godin Leisure Time Exercise Questionnaire (GLTEQ) was the most frequently used patient-reported measure.

Aim 2: Psychometric properties were reported for 13 of the measures identified, most frequently for movement sensors. Two studies reported on properties of the GLTEQ. Quality ratings for risk of bias were low.

DISCUSSION/CONCLUSION
There is significant heterogeneity amongst studies regarding: method of measurement, LC stage and measurement timing along the cancer treatment continuum. Greater consensus regarding PA outcome reporting could be achieved by using a consensus approach such as a Delphi process. Future studies should include assessment of psychometric properties of the measurement tool being used. Where feasible both performance-based and patient-reported measurements of PA should be undertaken.
9. Partnering with a local community health organisation to provide rehabilitation to cancer survivors

AUTHORS

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BACKGROUND
It is internationally recognised that exercise programs are beneficial for cancer survivors and should be integrated into the cancer care pathway. However, for patients residing in the Western region of Melbourne, there are currently no health service specific cancer rehabilitation programs available. Western Health (WH) partnered with Djerriwarrh Health Services (DjHS) to pilot a rehabilitation program at Melton Health (MH).

METHODS
Two separate breast and prostate specific rehabilitation programs were developed and implemented at MH. The education programs were designed following close consultation with consumers. Patients participated in one hour education and individualised exercise sessions twice a week for six weeks. Exclusion criteria included: all other tumour streams, patients receiving active radiotherapy and/or chemotherapy and unable to independently participate in a group setting either due to physical or cognitive limitations.

RESULTS
A total of 13 patients were referred to each breast and prostate group. Of those referred, reasons for non-enrolment included not feeling ready to exercise and not feeling well enough. In the breast group, nine patients enrolled and one participant withdrew after three sessions. In the prostate group, five patients enrolled and one participant withdrew after one session. Breast and prostate participants completed an average of eight and seven sessions respectively. The reason for withdrawing was related to resuming employment. All participants reported the program to be beneficial and provided them with self-management strategies.

CONCLUSION
An effective partnership was developed between a tertiary and community health service to establish cancer specific rehabilitation program that was feasible and acceptable for patients with breast or prostate cancer. There is opportunity to further develop the programs and embed them as part of the exercise rehabilitation service at MH.

10. Effective methods of giving health related information in cancer: an overview of synthesized evidence

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BACKGROUND
The 2012-13 Cancer Patient Experience Survey by the Victorian Comprehensive Cancer Centre (VCCC) highlighted service gaps in the area of patient communication and information provision within five major cancer treatment centres/services in Victoria. Opportunities for improvement in communication were identified as: providing information about cancer and side effects of treatment, availability of financial help and prescriptions cost; and the provision of care plans.

The “What did you say?” project was initiated by Western Health to address the communication gaps identified in the survey. This project aims to explore information and communication needs of cancer patients and develop strategies to improve communication between care providers and patients. Phase 1 of the project involved a comprehensive literature search to identify patient preferences about information and effective modes of communication. We will present the results from Phase 1.

METHODS
A systematic literature review was conducted in Medline, Embase, PsycINFO, CINAHL and Cochrane library. Due to an enormity of primary studies, only synthesised evidence was considered for inclusion. Systematic reviews including any intervention aimed at information provision to patients or clinician-patient communication in relation to cancer and its management were included. The included studies were scrutinised against the Preferred Reporting Items for Systematic Reviews and Meta-Analysis items (PRISMA) framework.

RESULTS
The authors identified 2934 citations and retrieved 198 full texts; 78 systematic reviews met the inclusion criteria and were categorised under eight main communication themes: internet and technology based (n=8), patient preferences (n=19), educational and education specific tools (n=8), non-educational tools (n=21), nurse-delivered interventions (n=7), qualitative synthesis (n=2), education training for health workers (n=10) and pain specific (n=3).

DISCUSSION
The project is ongoing. The evidence will be used to develop, pilot and implement an inventory of tools, processes and materials that will improve the understanding of communication strategies for clinicians working in health services and those working with cancer patients in the primary care setting.
11. The role of generalist community nurses in cancer care

**AUTHORS**

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**BACKGROUND**
Improved integration between primary care and specialist cancer services is recognised as pivotal to improving both the patient’s experience and overall health outcomes. To date this has focused mainly on the integration between the general practice and the cancer setting, with an emphasis on completion of cancer treatment. Generalist community nurses are well placed and skilled to provide in-home care for patients during and after cancer treatment. Providing generalist community nurses with education to update their knowledge on cancer and management of chemotherapy symptoms allows them to confidently provide clinical care for these patients. This paper will present the findings from a cancer-specific web-based education program focused on increasing confidence in generalist community nurses providing home-based care for patients receiving chemotherapy.

**METHODS**
63 nurses from Sydney Local Health District were recruited into the study. To date, 34 nurses have completed all seven components of the education program. Nurses completed a six-item questionnaire before and after the completion of the education program. They rated their confidence in management of chemotherapy related side effects, identifying the need for referral to and liaising with the cancer centre or hospital and knowledge of where to access reliable cancer treatment information.

**RESULTS**
Scores ranged from 1 (Strongly disagree) to 6 (Strongly agree), with higher scores indicating greater confidence. There was a significant improvement in mean confidence across all items from pre (3.17, SD 0.80) to post education (4.02, SD 0.39, P <0.001).

**CONCLUSION**
Generalist community nurses providing home-based care for cancer patients were more confident after completing a cancer-specific web-based education program.

12. Integration of Cancer Council Support Services into usual care – A pilot study

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**BACKGROUND**
Many cancer patients report unmet needs in information provision and support. As an adjunct to existing hospital services, Cancer Council Victoria’s Cancer Information and Support Service (CISS) provide a means for meeting these needs. Currently no model of care exists that routinely incorporates referral to a community-based CISS as part of usual care. The challenge is to devise an acceptable and feasible method of increasing awareness and use of community-based information and support services.

**METHODS**
This was a 6-month prospective pre-post intervention study. Western Health clinicians attended a single education session providing information and a ‘prescription pad’ to refer patients to CISS. Clinicians completed evaluation surveys to assess feasibility and acceptability. Patients referred to CISS were contacted to participate in a telephone interview to assess their perceptions of the referral system. Primary outcome was change in call volume to CISS from Western Health patients.

**RESULTS**
Thirty-one health professionals participated in the study with 156 referrals made. Calls to CISS increased up to 80% per month by Western Health patients. Staff expressed support for the intervention and confidence that the referral could be incorporated into routine practice. Twenty-six patients were interviewed, with 75% reporting they remembered being given the referral. Of these, most reported they still had the referral with them ‘just-in-case’. Common reasons for not contacting CISS included: ‘burden of information’ at the time of diagnosis or commencement of treatment, ‘not the right time’, or forgot due to ‘treatment-related’ memory loss.

**DISCUSSION/CONCLUSION**
This project demonstrates a feasible system for referral of patients to community-based support services as part of routine care. Further work is needed to identify the most appropriate point in the cancer trajectory to present the patient with a referral. Resources to remind patients about these services are also required should their circumstances and support needs change.
13. A clinical placement program for primary care professionals at a comprehensive cancer centre

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BACKGROUND
Around 1 million Australians have a personal history of cancer. There are increasing calls for formalised models of shared care, integrating care between oncology and primary care teams. Shared care appears to result in improved management of comorbid illness, enhanced preventive care as well as appropriate cancer-specific management. With the growing numbers of cancer survivors and the limited health workforce, sustainable models of care need to be developed. A project was undertaken to determine whether a placement program for general practitioners (GPs) and general practice nurses (GPNs) was feasible and of clinical and professional value, and provided an opportunity for knowledge and skills transfer.

METHODS
The program was undertaken at a specialist cancer centre. The program aimed to recruit at least 4 GPs and 8 GPNs, who attended multidisciplinary meetings and outpatient clinics for a total of 10 hours. All participants participated in pre and post-placement semi-structured interviews. The principal objective was to determine whether generalists and hospital based oncology specialists found the clinical placement: (1) was feasible and of clinical and professional value, and (2) provided an opportunity for knowledge and skills transfer.

RESULTS
16 GPs, 12 GPNs and 9 oncologists participated. Generalists rated the placement highly: program learning outcomes entirely (63%) or partially (37%) met; personal learning needs entirely (70%) or partially met (30%); relevance to practice entirely (89%), partially (11%). Generalists would recommend the program to colleagues and could identify knowledge and skills transfer, however learning was largely observational rather than participatory. Learning opportunities were skewed toward generalists, rather than oncologists. All participants showed enthusiasm to address the challenges of providing shared care for survivors. The program was perceived to be clinically and professionally valuable, with all respondents indicating they would recommend the placement to colleagues.

CONCLUSION
The clinical placement program was feasible and highly regarded.

REFERENCES