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From Inpatient to Outpatient:

A CNC-Led Model Optimising Pancreatic Cancer Diagnostic Care

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THE DIAGNOSIS PROBLEM:
WHY PANCREATIC CANCER IS DIFFERENT

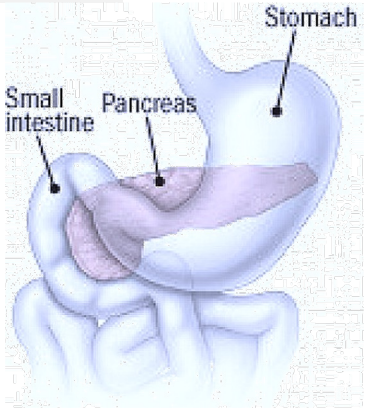
Pancreatic cancer is the **4th leading cause of cancer death** in Australia — despite being only the 11th most commonly diagnosed *(AIHW, 2024)*

5-year survival: 12–13% — one of the lowest of any cancer *(AIHW, 2024)*

Projected to become the **2nd leading cause of cancer death** in high-income countries by 2030
(Rahib et al., 2021)

THE DIAGNOSIS PROBLEM:
WHY PANCREATIC CANCER IS DIFFERENT

The pancreas is a **retroperitoneal organ –hidden away!**



No validated population screening tool

Symptoms — weight loss, new-onset diabetes, vague abdominal pain — are **non-specific and late**

80% of patients had visited their GP at least twice in the 12 months before diagnosis; 25% visited **6 or more times** *(Stapley et al., 2012)*

WHY SPEED MATTERS:
THE STAGING WINDOW —WHAT WE LOSE WHEN WE DELAY

Only 15–20% of patients present with resectable disease — the only potentially curative option
(Strobel et al., 2019)

5-year survival after complete surgical resection: **~20–25%**
(Strobel et al., 2019)

If localised: 44% 5-year survival
Regional: 15%
Metastatic: 3% *(NCI SEER, 2024)*

Waiting > 6 weeks to start treatment is associated with significantly worse 5-year survival — in resectable and locally advanced patients.
(Khorana et al., 2019)

THE AUSTRALIAN CONTEXT

Average time from **GP referral to specialist review: 3–4 weeks**
(Burmeister et al., 2016)

Average referral to treatment can exceed **2 months!!**
40% exceeding OCP timeframes *(Stokoe & Schofield, 2025)*

The national OCP for Pancreatic Cancer sets a **benchmark of MDT discussion within 10–14 days of referral** — a target that is not routinely measured at RNSH.
(Cancer Australia, 2023)

RNSH: A GROWING HPB REFERRAL HUB

2024: 48 pancreatectomies at RNSH
NSLHD residents: 17 (35%)
Outside NSLHD: 31 (65%)

2025 (September): 76 pancreatectomies at RNSH
NSLHD residents: 32 (42%)
Outside NSLHD: 44 (58%)

Data source: RNSH Pancreatic Cancer Surgical Database / Admitted Patient Dashboard, NSLHD, 2024–2025.

RNSH: A GROWING HPB REFERRAL HUB

Royal Prince Alfred: 81–100 pancreatectomies/year
Royal North Shore: 61–80 pancreatectomies/year
Westmead, Liverpool, Prince of Wales: 41–60 each
Nepean, St George, Concord: 21–40 each

2nd highest volume public pancreatic surgical centre in NSW

NSW minimum standard for a metropolitan specialist centre: ≥30 resections/year.
RNSH significantly exceeds this.

Cancer Institute NSW, 2024

THE PREVIOUS PATHWAY
COMMENCED 2023

Referral & Intake:
GP → HPB Surgeon → UGI Team → Pancreatic CNC → VCS referral via REDCap
Eligibility: ≥16 years, within NSLHD, consented, video-capable, clinically suitable

Workflow & Roles:
UGI Team: Medical governance, plan investigations
Pancreatic CNC: Coordinates imaging, diagnostics, communication
VCS RN: Organises HiTH clinic visits, performs assessments, monitors virtually
HiTH Team: Supports bloods, cannulation, wound care

Monitoring & Escalation:
Telehealth follow-up after procedures
Clear escalation process (CNC → UGI → Surgical Reg)
After-hours and emergency protocols defined

THE PREVIOUS PATHWAY: WHY IT NEEDED TO CHANGE

Inequitable	Only NSLHD residents	Excluded 65% of our actual caseload
Multiple handovers	GPs, surgeons, Virtual Care, CNC, HITH, and allied health	Communication breakdowns, duplication, or missed steps
Lack of Evaluation Processes	No mention of KPIs or audits	No feedback loops

THE PREVIOUS PATHWAY: WHY IT NEEDED TO CHANGE

- Reactive CNC → Not the central point of contact → No defined scope within the diagnostic phase
- Lack of clinical advocacy → Reliance towards inpatient pathways → No structured position to challenge unnecessary admissions

THE PREVIOUS PATHWAY: WHY IT NEEDED TO CHANGE

Not a training problem.
Not a competence problem.
A systems problem.

REVISED OUTPATIENT WORKUP PATHWAY
(IMPLEMENTED APRIL 2025)

1. Patient Identification

Trigger: Potential new diagnosis flagged by UGI team (fellow, registrar, or practice manager).

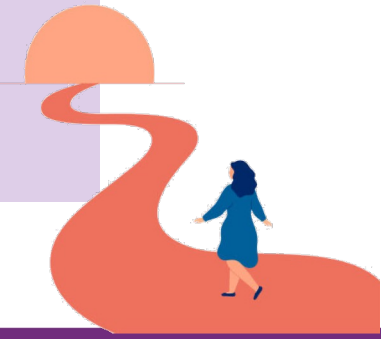
Action: Confirm referral pathway and initiate contact.

2. Initial Patient Contact

Introduce: Self and role as the Pancreatic CNC

Explain: Upcoming investigations, timelines, and support services.

Establish: Consent for communication and gather baseline information.



REVISED OUTPATIENT WORKUP PATHWAY
(IMPLEMENTED APRIL 2025)

3. Coordination of Diagnostic Workup

Investigation	Purpose
CT Triple Phase (outpatient)	Staging and vascular involvement
PET Scan (outpatient)	Identify distant metastases
Blood Tests (outpatient)	Tumour markers, liver function, CA 19-9
TTE + LFT (outpatient)	Pre-op cardiac and respiratory ax
Anaesthetics Review (outpatient)	Via Pre-Admission Clinic (PAC)

REVISED OUTPATIENT WORKUP PATHWAY
(IMPLEMENTED APRIL 2025)

4. Comprehensive CNC Assessment (Pre-admission clinic-based)

Malnutrition and unintentional weight loss

New-onset or poorly controlled T3DM

Barriers to care (e.g., transport, language, financial)

Initiate Referrals: Dietitian, endocrinology, diabetes educators, social work

Aim would be for referrals to be made to local services to **prevent over-burden** on the district's resources and **ensure appropriate follow-up** after diagnosis

REVISED OUTPATIENT WORKUP PATHWAY
(IMPLEMENTED APRIL 2025)

5. Diagnostic laparoscopies/ IR-guided biopsies

Collaborate: with SSSU NUM for a bed and UGI Fellows to schedule diagnostic laparoscopy on the emergency theatre list or coordinate with IR to prioritise urgent biopsies (typically within 3–4 days of referral)

Day Procedure: Patient attends and is discharged same day.

REVISED OUTPATIENT WORKUP PATHWAY
(IMPLEMENTED APRIL 2025)

6. Multidisciplinary Team (MDT) Presentation

Aim to complete workup within ~1 week to allow for timely MDT discussion.

MDT discussion should occur within 10-14 days after the referral has been received (as per OCP)

But did the pathway actually change anything?

DATA-DRIVEN OUTCOMES: THE NUMBERS

Planned inpatient workup admissions:	39 → 5 0 → 28 (day procedures created) Mean LOS: 8.3 days → 3.4 days **(↓ 59%)**
Unplanned inpatient workup admissions:	63 → 59 Mean LOS: 12.7 days → 8.6 days **(↓ 32%)** Residual driver: **staging laparoscopy scheduling delays (75% of admitted patients)**

Pre-implementation (Sep 2024 – Mar 2025) vs. Post-implementation (Apr – Sep 2025)

DATA-DRIVEN OUTCOMES: THE NUMBERS

Total estimated bed days saved:

~350 days per 6-month period

~$420k–$630k cost avoidance

IHACPA National Efficient Price 2025–26 ($7,258/episode) applied across mean admission LOS for this cohort. NSW Health IB2025_022.

Data source: RNSH Pancreatic Cancer Surgical Database / Admitted Patient Dashboard, NSLHD, 2024–2025.

MEETING THE NATIONAL OPTIMAL CARE PATHWAY: MEASURING TIMELINESS

1.5 days

Referral → CNC contact

Target: ≤2 days ✓

8 days

Referral → workup complete

Target: 7–10 days ✓

12 days

Referral → MDT discussion

Target: 10–14 days ✓

Manual audit of 28 patients. Diagnoses included BR-PDAC, LA-PDAC, metastatic PDAC, Pancreas NET, and distal cholangiocarcinoma.

Data source: RNSH Pancreatic Cancer Surgical Database / Admitted Patient Dashboard, NSLHD, 2024–2025.

THE PATIENT EXPERIENCE: QUANTITATIVE RESULTS

4.39/5

Overall experience rating

Target: ≥4.0 ✓

85.7%

CNC contact within 2 days

Target: ≥80% ✓

4.57/5

Ease of reaching the team

Highest-scoring domain

85.7%

Would recommend service

Target: ≥70% ✓

THE PATIENT EXPERIENCE: QUALITATIVE THEMES

CNC as the anchor

Named consistently, and emotionally as the element that made the pathway work

"The CNC was a lifeline — she kept me calm and informed."

Speed as reassurance

Moving faster than expected directly reduced anticipatory distress

"The speed from referral to answers was remarkable."

THE PATIENT EXPERIENCE: QUALITATIVE THEMES

Post-procedure information gap

CNC absorbing communication failures from surgical teams — a structural gap

"I wasn't told what to expect after — the CNC helped when I called."

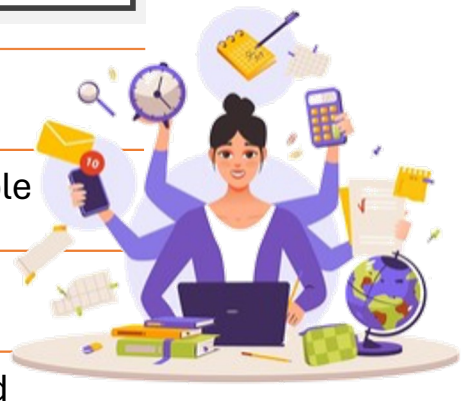
The results wait — anxiety in the silence

Lowest-scoring domain (3.64/5). Patients asked for contact, not faster results

"The wait between tests and MDT caused a lot of anxiety."

THE CNC ROLE IN THIS PATHWAY

What the CNC role looked like in practice:



- First point of contact
- Coordinated multiple investigations across multiple teams, Provided information gaps
- Conducted a holistic assessment –physical and psychosocial
- Inpatient to outpatient conversion - once admitted patients were stable, the CNC organised remaining work-up as outpatient. ↓ Unplanned LOS: 12.7 → 8.6 days
- Collected and analysed the audit data

OVERALL PROGRESS SO FAR...

59%
reduction in planned admission length of stay

100%
of OCP timeliness benchmarks achieved

“lifeline”
patients’ word for the CNC experience

One CNC. Existing resources. No additional funding.

What might be possible if we intentionally designed systems around it?

THE TRANSFERABLE TOOLKIT

1 Pathway Protocol
Eligibility, step-by-step process, roles, escalation pathways, and discharge criteria — editable for any cancer service.

2 Pre-admission Assessment Checklist
Structured screening tool for malnutrition, new-onset T3DM, social barriers, language needs, and allied health referral triggers.

3 Patient Survey Instrument
15-question survey with validated QI domains.
Benchmarked against OCP standards.

4 KPI Audit Template
Pre-built spreadsheet capturing LOS, procedure type, admission profile, timeliness metrics, and OCP benchmark comparison.

5 Executive Business Case
Financial model with local cost-per-bed-day inputs. Generates site-specific cost avoidance figures for any volume.

6 Site Adaptation Guide
What to keep fixed, what to customise, minimum requirements for launch, and a 90-day implementation checklist.

The ask: one pilot site, one CNC, six months, defined KPIs.

THE TAKE HOME MESSAGE

Coordinated

Consistent
Consistent
Consistent

Communication

THANK YOU.
THOUGHTS? QUESTIONS?

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