

**NSW GOVERNMENT RESPONSE TO RECOMMENDATIONS FROM THE LEGISLATIVE
COUNCIL SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF
CHEMOTHERAPY IN NSW**

GOVERNMENT RESPONSE

NSW Health welcomes the recommendations of the Select Committee on Off-Protocol Prescribing of Chemotherapy in NSW and notes they reflect a number of focus areas that were identified by the Inquiry under section 122 of the *Health Services Act 1997* (the section 122 Inquiry) into issues arising from the prescribing of chemotherapy by Dr John Grygiel to patients at St Vincent's Hospital and at the Western NSW Local Health District.

There has been a significant amount of work progressed to address the recommendations of the section 122 Inquiry and the Select Committee's recommendations and this work will continue to ensure improvements to cancer services are not only adopted but embedded in governance processes and service delivery.

Recommendation 1

That the Western NSW Local Health District:

- ensure that its review of medical specialist outreach service arrangements encompasses all of the Western NSW Local Health District, with a strong focus on fly-in fly-out medical specialists
- establish proper governance structures to ensure fly-in fly-out medical specialists are subject to the same safeguards as locally based clinicians.

Response: Supported

Ensure that its review of medical specialist outreach service arrangements encompasses all of the Western NSW Local Health District, with a strong focus on fly-in fly-out medical specialists

Since the section 122 Inquiry NSW Health has invested \$1.5 million to enhance rural cancer services in the Western NSW Local Health District (WNSWLHD). This has helped progress a number of initiatives, including the review and strengthening of specialist outreach service arrangements.

The Western NSW Local Health District is working towards realigning the medical specialist outreach services currently going into the Northern and Western regions to the health needs of the communities. Once these regions have been addressed WNSWLHD will look to address the rest of the district, which includes services provided to communities from Dubbo, Bathurst or Orange. Its aim is to build a stronger governance system to address issues highlighted in the section 122 Inquiry. The report on patients treated in Western NSW Local Health District (LHD) found there was a need to review fly-in fly-out (FIFO) clinical service arrangements to ensure clarity about the relationship between FIFO practitioners and locally-based services. This includes clinical record keeping and sharing, clinical care in the absence of the FIFO practitioner, clinical governance, quality improvement initiatives and service planning.

The strategy is to initially focus on FIFO medical specialists, however the overall aim is that within two years the Western NSW LHD will be 90% self-sufficient for medical specialist services, reducing its dependence on FIFO arrangements.

Over the last five years the district has actively recruited medical specialists, almost doubling the number of specialists living and employed in Dubbo and Bathurst. This has reduced the reliance on FIFO medical specialists and increased the capacity of the district to provide medical specialist outreach services.

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The strategy has two phases:

Phase 1 – The service model for Rural Aerial Health Service (RAHS) Outreach communities has been developed for the Northern and Western regions - Bourke, Brewarrina, Walgett, Lightning Ridge, Cobar, Goodooga, Collarenebri and Condobolin. The service model was designed to match medical specialist service provision to the needs of the population; implement improved governance of medical specialist outreach services including record-keeping, expectations of service and reporting of clinical outcomes; and ensure consistent formal contract documentation is in place for each medical specialist providing outreach.

Current governance structures of FIFO medical specialists have been reviewed to align with those required of locally based clinicians. WNSWLHD undertook a review of all Honorary Medical Officer contracts as part of the Visiting Medical Officer (VMO)/Honorary Medical Officer (HMO) reappointment process. This was to standardise contract arrangements and ensure alignment with relevant Ministry policies and guidelines including Standardised Licence Arrangements for VMOs Providing Private Non Admitted Services GL2009_008, Visiting Practitioner Appointments in the NSW Public Health System PD2016_052 and Salaried Senior Medical Practitioner - Rights of Private Practice - GST Treatment - PHOs PD2005_598.

Phase 2 – Roll out the agreed service model to the whole district outreach area which includes services provided to communities from Dubbo, Bathurst or Orange. Acknowledging the volume of outreach services to these larger centres, this is due for completion by December 2019.

Establish proper governance structures to ensure fly-in fly-out medical specialists are subject to the same safeguards as locally based clinicians

A Governance working group has been established, led by the Director of Clinical Governance to improve and standardise governance structures for visiting medical specialist outreach services. The group has developed a governance assessment tool to audit current practices initially at the Phase 1 RAHS outreach communities. An audit has been completed at one trial site at Bourke. Based on feedback from the first audit, the tool has been refined and will now be implemented at the remaining sites by the end of October 2017.

The assessment tool includes the following aspects identified through the district investigation in response to the Section 122 Inquiry:

- Type of service provided, the frequency, the contract and funding source
- Referral mechanism for patients to the service
- Medical record keeping/sharing, privacy of records, storage and access
- Additional resources required by the specialist which are provided by the district
- Complaint and incident management reporting
- Professional linkages for the clinicians
- Performance monitoring, quality improvement initiatives
- Professional registration
- Clinical care for patients in the absence of FIFO practitioner

In addition a new model service level agreement is being developed to provide a framework and governance structure for the provision of medical specialists from metropolitan LHDs to the WNSWLHD. The agreement includes a section detailing shared governance and the

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responsibilities of each party in clinical risk management, accountability and continuous quality improvement.

Recommendation 2

That the Cancer Institute NSW:

- ensure that, in the interests of transparency, all evaluations of the outcomes for patients who received an off-protocol flat dose of 100 mg carboplatin or reduced dose capecitabine be independently evaluated and published, subject to patient confidentiality
- keep the affected cohort of patients informed as to the capacity of the evaluation dataset to shed light on their health outcomes
- continue to monitor and assess the morbidity and mortality rates of the affected patient cohort and compare and contrast with expected ranges until at least 2022.

Response: Supported

Ensure that, in the interests of transparency, all evaluations of the outcomes for patients who received an off-protocol flat dose of 100 mg carboplatin or reduced dose capecitabine be independently evaluated and published, subject to patient confidentiality

The Cancer Institute notes that the section 122 Inquiry distinguished between outcomes for individual patients and outcomes for the affected patients as a cohort. It is also important to distinguish between clinical follow-up of individual patients and systematic monitoring of the outcomes of the patient cohort.

The section 122 Inquiry stated in its Final report on Off-protocol prescribing of chemotherapy for head and neck cancers:

The effect of off-protocol flat dose 100 mg carboplatin for head and neck cancers has not been quantified in clinical trials or prospective data collections. As such, it is not possible to determine what outcomes patients will experience, (paragraph 55).

Establishing a causal link between having received the off-protocol flat dose prescribing of 100 mg carboplatin and subsequent outcomes (disease recurrence, death) is not possible for individual patients. There are many factors that contribute to outcomes after cancer treatment, and the cancer can recur even with optimal treatment. Conversely, a patient could receive off-protocol treatment and yet not have the cancer recur. If a patient received off-protocol treatment, it is impossible to tell what outcomes would have been had he or she received a dosage according to a currently available protocol, (paragraph 57).

It would be expected that, on a population basis, a failure to adhere to protocols puts every person treated at risk of higher rates of cancer recurrence and higher overall mortality. This does not translate to a quantifiable change in an individual's risk for recurrence or death. In the context of this Inquiry, one cannot quantify the extent of any harm to an individual, (paragraph 58).

In its interim report on Off-protocol prescribing of chemotherapy for head and neck cancers, the section 122 Inquiry recommended that St Vincent's Hospital offer to patients who received a 100 mg flat dose of carboplatin more intensive follow-up to detect any loco-regional or distant disease at the earliest possible time (interim report Recommendation 4). In making that recommendation, the section 122 Inquiry acknowledged that the peer-reviewed literature provided no guidance on what actions to take in these circumstances. The Ministry of Health, through an independent review has confirmed that all affected patients contacted by St Vincent's Hospital were offered more intensive

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follow-up to detect any loco-regional or systemic recurrent disease. The Director of Cancer Services at St Vincent's Hospital Sydney has formal responsibility for reviewing the full patient cohort on a monthly basis until all patients have been followed for five years from the time the chemotherapy concluded. St Vincent's has ensured regular reports on this cohort are generated in the Oncology Management Information System so they can be reviewed, including patients who may be seen by other Ear, Nose and Throat (ENT) and Head and Neck surgeons.

The section 122 Inquiry's final report on Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers amended Recommendation 4 to add that St Vincent's Hospital Sydney will report on patient outcomes to the hospital's Patient Safety and Quality Committee and Clinical Council. It is stipulated this will be six monthly and annually to the Ministry through the Deputy Secretary for System Purchasing and Performance (SPP). St Vincent's Hospital has been regularly reporting to the Patient Safety and Quality Committee since December 2016, with the first report on patient outcomes provided to the St Vincent's Health Network Sydney Clinical Council in February 2017. The first annual report was provided to the Deputy Secretary SPP on 19 May 2017. The Ministry of Health will continue to monitor this process.

For patients treated at the Western NSW Local Health District, the section 122 Inquiry noted that, in the view of the section 122 Inquiry's clinical Expert Panel, there was no need for any change to the clinical follow-up for the cohort of people who had received reduced doses of chemotherapy (WNSWLHD Report Recommendation 4).

In its interim report, the section 122 Inquiry recommended that the Cancer Institute flag the patients identified by the Inquiry so that their outcomes could be systematically evaluated on a regular basis and survival analyses undertaken on this cohort of patients in relation to people with comparable disease (Recommendation 6).

The section 122 Inquiry made a similar recommendation in its report on patients treated at Western NSW Local Health District, with respect to patients for whom a flat dose of 100 mg carboplatin or a reduced dose of capecitabine was prescribed (Recommendation 15).

The Cancer Institute has put in place a process for flagging the affected patients on the NSW Cancer Registry and is undertaking regular systematic monitoring. From an evaluation perspective, the numbers of patients are small. In the longer term, if there are sufficient data to inform a meaningful analysis of the patient cohort as a whole, it will be undertaken.

Keeping affected cohort of patients informed of capacity of evaluation dataset to shed light on their health outcomes

As indicated above, the section 122 Inquiry reported that it would not be possible to identify what the outcome would have been for an individual affected patient, had he or she received a dosage according to protocol. The Cancer Institute acknowledges, as did the section 122 Inquiry, the effect this uncertainty has and will continue to have on the patients and their families.

Affected patients treated at both St Vincent's Hospital Sydney and Western NSW LHD have been offered an ongoing contact point they can utilise to discuss their care. In addition, individual people with cancer will be kept informed of their clinical status through their usual clinical follow-up.

Continue to monitor and assess the morbidity and mortality rates of the affected patient cohort and compare and contrast with expected ranges until at least 2022.

The section 122 Inquiry recommended that St Vincent's Hospital report on patient outcomes to the Hospital's Patient Safety and Quality Committee every six months and annually to the Ministry of Health (Recommendation 4 of the Final Report).

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Recommendation 3

That the NSW Ministry of Health, in the interests of transparency and building the community's trust in the health system, publish the results in detail of its audit of public cancer patients, subject to patient confidentiality.

Response: Supported

The Audit of Cancer Care in NSW was finalised by the local level review teams on 7 July 2017. Once the cases were received an administrative review was undertaken of the 1,802 cases to ensure appropriate information has been provided and documented. The final report on the Audit of Cancer Care in NSW has been drafted and the audit steering committee is being consulted. It is anticipated this will be published by 23 October 2017.

Recommendation 4

That the Cancer Institute NSW examine whether, beyond allowable individualised dose adjustments, a model for oversight of significant variations to chemotherapy protocols should be adopted statewide.

Response: Supported

The Cancer Institute has considered this recommendation and advises that, consistent with the information provided in the submission from NSW Health to the Select Committee, a state-wide model for oversight of significant variations from chemotherapy protocols is being developed, which is as follows:

- The Cancer Institute is working with local health districts (LHDs) to standardise and optimise the use of Oncology Management Information Systems (OMIS). This includes standardising processes for developing and approving patients' care plans, as well as processes for documenting the rationale for variations from protocols.
- LHDs will develop standardised reports on protocol variation to be considered by relevant organisational quality and safety committees and morbidity and mortality committees. Each local health district will be responsible for reviewing and responding to any reported variances.

The Ministry of Health advises that information received from the LHDs in response to the section 122 Inquiry confirms that there are already in many services review processes in place for variations. Many note this is a manual process that will be enhanced by the further embedding of automated processes.

Recommendation 5

That the Cancer Institute NSW ensure that all local health districts and specialty health networks have a functioning oncology management information system in place by early 2018.

Response: Supported

The Cancer Institute is supporting the implementation of OMIS in all local health districts that have not yet implemented an OMIS. This process is still on track to be finalised by early 2018. The Cancer Institute is also working with all LHDs to standardise and optimise the use of OMIS across the state to support improved clinical care, data analysis and reporting. This includes the transition to

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electronic prescribing for all chemotherapy. NSW Health will invest \$6 million over three years specifically to support this process.

Going forward this will be complemented by an overall commitment by the Government to invest \$536 million in eHealth across the state which will see the phasing out of paper patient files and expanding the Electronic Medications Management (eMeds) program. This will result in patients in NSW receiving safer and more coordinated care.

Recommendation 6

That the NSW Ministry of Health and Cancer Institute NSW develop and implement an action plan to ensure that all people diagnosed with notifiable cancer in New South Wales have their care overseen by a multidisciplinary cancer care team that includes all relevant medical, nursing, pharmacy and allied health staff.

Response: Supported

In NSW many cancer services already take a multidisciplinary approach to cancer treatment and care.

A prioritised action in the state-wide NSW Cancer Plan (TAB A) is to implement and evaluate strategies to ensure that all people diagnosed with cancer have their care overseen by a multidisciplinary team (MDT). The Cancer Institute has worked with local health districts (LHDs) to establish a state-wide MDT Community of Practice that will support LHDs in strengthening their systems, engagement and processes for multidisciplinary cancer care, thereby strengthening the capacity of the NSW health sector to deliver high quality, patient-centred, integrated multidisciplinary care. The MDT Community of Practice has already agreed several work priorities, which include:

- developing a standardised suite of MDT resources (including minimum Terms of Reference).
- establishing an MDT coordinator network to foster collaborative working relationships and working groups to share learnings about differences in Oncology Management Information Systems (OMIS).

As with all prioritised actions in the NSW Cancer Plan, the action about ensuring the care of people with cancer is overseen by an MDT will be monitored and evaluated, and its outcomes reported, in line with the NSW Cancer Plan Evaluation Framework.

The NSW Cancer Plan prioritised actions have also been aligned to the NSW Health Strategic Priorities for 2017/18. These priorities are embedded in the Performance Agreements held between the Ministry of Health and the individual pillar organisations, including the Cancer Institute.

Recommendation 7

That the NSW Ministry of Health and the Cancer Institute NSW undertake and publish a review of best practice in multidisciplinary cancer care teams that considers the evidence about:

- the benefits of ongoing team oversight of individual patients
- the role of the team with respect to oversight of chemotherapy dosing decisions
- team membership
- whether clinician attendance should be compulsory.

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The review should then form the basis for NSW Health policy in respect of multidisciplinary cancer care teams across New South Wales.

Response: Supported

Cancer Australia has recently reviewed the materials on multidisciplinary cancer care that were prepared by the National Breast Cancer Centre in 2005. The new documents are published on the Cancer Australia website (<https://canceraustralia.gov.au/clinical-best-practice/multidisciplinary-care/all-about-multidisciplinary-care>) and are attached at TAB B. They include a flexible definition of multidisciplinary care, entitled the Principles of Multidisciplinary Care, and a set of web-based tools Cancer Australia has developed to assist health professionals and health service administrators in the implementation of multidisciplinary cancer care at the local level. In preparing these documents, Cancer Australia has thoroughly considered the most recent evidence regarding best practice multidisciplinary cancer care. NSW Health endorses Cancer Australia's national approach.

Recommendation 8

That NSW Ministry of Health:

- continue to build the capacity of all health professionals to fulfil their ethical and legal obligations with regard to informed consent
- with the Cancer Institute NSW, implement further strategies to empower patients to fully exercise informed consent.

Response: Supported

NSW Health is currently developing new procedures for consent, which builds on the information in the current policy directive Consent to Medical Treatment – Patient Information. The Consent to Medical Treatment Manual draft is currently in the consultation phase and is due to be released later in 2017.

The draft manual contains a number of guiding principles including that patients must be provided with sufficient information about their condition, treatment options and prognosis in order to make or contribute to their own treatment decisions and that information provided to patients needs to be tailored to the individual's needs and circumstances.

The manual has been developed to achieve the following outcomes:

- Health Practitioners and managers are informed and understand the legal requirements for obtaining consent from patients and advising patients of material risks associated with treatment to assist them in discharging their legal obligations.
- Patient's consent or refusal of treatment is recorded and documented appropriately.
- Patient autonomy and decision making is respected and that patients are provided with appropriate information relevant to their treatment.
- Health Practitioners and managers are informed and understand their legal obligations with regard to providing treatment to patients who do not have the capacity to consent.

NSW Health recognises the imperative of the health system to empower all patients, including people who have been diagnosed with cancer, in their decision-making, particularly through the provision of information and facilitating better interactions between patients and doctors.

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Recent strategies the Cancer Institute has put in place to empower patients include the TIPS (**T**eam, **I**nvolvement, **P**lan, **S**upport) four-point information sheet to help patients have conversations with their doctors and ultimately help them to manage their cancer care. **Team** is about having cancer care overseen by a multidisciplinary cancer care team. **Involvement** is about patients being informed and involved in decision-making about their treatment and care. **Plan** means a patient knows the next step in his or her treatment and who to contact about it. **Support** refers to patients knowing about the people and services available to support them.

A key resource that directly supports the TIPS approach is the eviQ patient information sheets, which contain a wealth of information to ensure patients understand the therapeutic intent of their treatment, and the toxicities that may occur (and how likely they are to occur), especially those that are life-threatening. Patients are informed about the toxicities that require them to seek medical help. The patient information sheets also provide contextual information about changes to chemotherapy doses, and questions for patients to ask their treating clinicians.

The Canrefer online directory [<https://www.canrefer.org.au/>] supports the **Team** aspect of TIPS by providing information for patients and their general practitioners about specialists who are active members of multidisciplinary cancer care teams. The website also contains a guide to questions people may want to ask their oncologist as they consider their treatment options or seek to find more information about their cancer.

The Health Care Complaints Commission (HCCC) also acts as an independent agency for health consumers to seek information on their rights in the health system and for them to have an avenue for resolution if they feel these rights have not been upheld. The HCCC has specific information for health consumers on consent and information on how to raise these concerns.

Recommendation 9

That the NSW Ministry of Health implement improved patient consent procedures which include that:

- all patients are provided with a copy of the NSW Cancer Institute's eviQ chemotherapy protocol at education sessions ahead of their first treatment
- when consent is obtained after a non-eviQ plan is recommended, patients are provided with information about the proposed protocol, including the clinical rationale for it, and a completed patient consent form is scanned into the patient information system.

Response: Supported

All patients are provided with a copy of the NSW Cancer Institute's eviQ chemotherapy protocol at education sessions ahead of their first treatment

The Cancer Institute is aware from data obtained about usage of the eviQ website that the eviQ program is embedded in the clinical workflow of all treatment centres in NSW. This data also indicates high use of the eviQ information that is written specifically for patients.

Recently the information provided in eviQ patient information sheets has been expanded, in response to requests from treatment centres. eviQ patient information now includes information about changes to chemotherapy drug doses, questions to ask treating clinicians and information about patient support resources provided by the Cancer Council NSW.

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Treatment centres commonly use the eviQ patient information in their patient education sessions and to further embed this, the Secretary, Ministry of Health will reinforce the importance of this process with all local health district and specialty network chief executives. A memo outlining this advice will be sent by 1 October 2017.

When consent is obtained after a non-eviQ plan is recommended, patients are provided with information about the proposed protocol, including the clinical rationale for it, and a completed patient consent form is scanned into the patient information system

The new draft consent manual, due for completion at the end of 2017, now includes the stipulation that if a medical practitioner is aware that a proposed treatment or procedure is outside accepted practice or not covered by relevant clinical guidelines, there is a particular onus to draw this to the patient's attention and explain the clinical rationale for the variation. They are also required to document this and any discussion relevant to the patient's decision to proceed in the Health Record.

Recommendation 10

That the NSW Ministry of Health ensure that all key clinical staff are educated in expectations regarding valid informed consent.

Response: Supported

In conjunction with the development of the new Consent to Medical Treatment Manual, NSW Health is working with the Health Education and Training Institute (HETI) to create a new eLearning module to help familiarise clinicians with the new manual.

The Antineoplastic Drug Administration Course, offered through the Cancer Institute's eviQ Education program, includes a module for health professionals on educating patients and carers. Its learning outcomes include:

- Describe the potential and actual ethical issues in the care of patients receiving treatment for a cancer diagnosis including informed consent, advocacy and duty of care.
- Assess the information needs and learning requirements of patients and carers / family members before, during and after the administration of antineoplastic drugs.
- Use supportive care resources and appropriate sources of patient information when providing education for patients and carers / family members.
- Accurately document provision of education in a patient's medical record.

NSW Health also has a number of other training packages that assist in understanding and promoting best practice in regards to informed consent. For example NSW Health has created a web resource for health professionals on legal issues relating to end of life, including consent to treatment - <http://healthlaw.planningaheadtools.com.au/>. HETI also has courses relevant to legal obligations and consent such as 'Assessing Capacity' for Junior Medical Officers, 'Nursing, Midwifery and the Law' (which includes consent for nurses), 'Guardianship Application Process' (which includes substitute consent).

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Recommendation 11

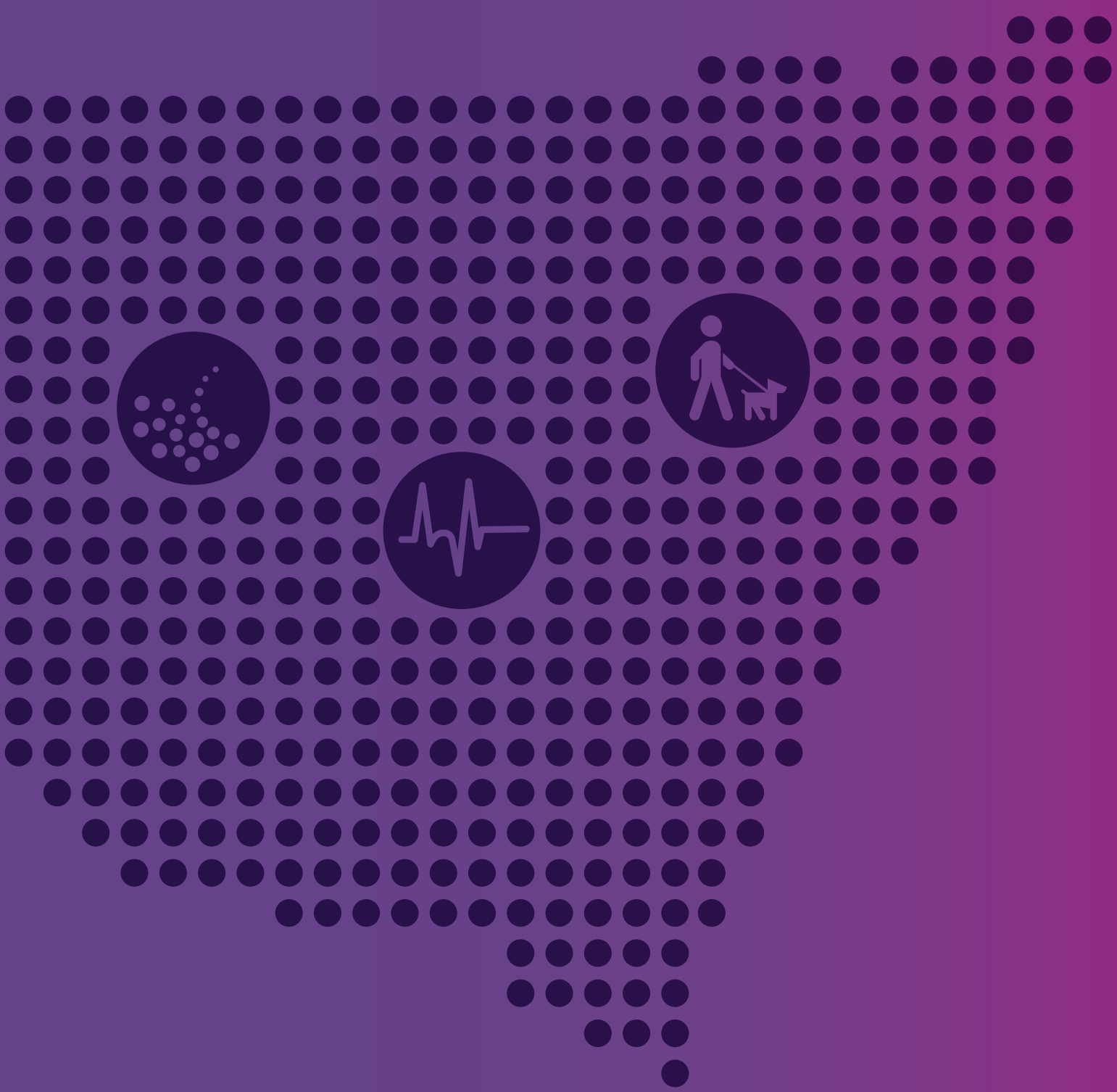
That the NSW Ministry of Health consider establishing a system of independent patient advisor advocates in hospital cancer services, based on the official visitor model, as a means of empowering patients.

Response: Supported

NSW Health is still considering the recommendation but preliminary advice is that it is not necessary given there are already a number of mechanisms for support for people with cancer.

NSW Cancer Plan

A statewide plan for lessening
the impact of cancers in NSW



Acknowledgements

The Cancer Institute NSW would like to acknowledge and thank the many people and organisations that contributed to the development of the NSW Cancer Plan including people affected by cancer, community members, leaders in cancer control and health care professionals. As well as many government and non-government organisations, specialist cancer services, cancer charities and research institutions.

Legislation administered Cancer Institute (NSW) Act 2003

National Library of Australia Cataloguing-in-Publication data:
NSW Cancer Plan



Publisher

Cancer Institute NSW



State Health Publication Number:
(CI) 160120

ISSN: 978-1-74187-612-3

Key words: Cancer, New South Wales,
Australia.

Suggested citation for manuscripts and
publications NSW Cancer Plan, Cancer
Institute NSW, Sydney, April 2016

Further copies of this publication can be
downloaded from: cancerinstitute.org.au

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Foreword

Minister for Health



The impact of cancer is felt across our whole community. With a society that is living longer and ageing, cancer continues to be one of the leading causes of premature death.

Whilst we know that if you live in NSW your chances of surviving cancer are among the highest in the world, the NSW Government is committed to further lessening the impact of cancers. The goals of the NSW Cancer Plan reflect this mission with a continued focus on reducing the incidence of cancer, increasing the survival of people with cancer and improving the quality of life of people affected by cancer.

Cancer, like many other chronic diseases, requires integration across the care continuum, across multiple health settings and by multiple health providers. This plan is a blueprint to ensure that people affected by cancer can access appropriate, high quality, integrated, evidence-based cancer care that is delivered safely and effectively as close to their home as possible. The NSW Government is committed to providing everyone with the right care, at the right time, in the right place.

NSW is not alone in the challenges it faces to provide the best possible cancer control system, and we will continue to collaborate with our national partners on co-ordination, best practice research, evidence-based treatment, supportive care and healthcare reform. The Cancer Institute NSW has taken strong national and international leadership in cancer control, particularly in the areas of surgical optimisation, prevention campaigns and referral pathways. Such leadership will continue and be expanded over the coming years.

Collaboration and partnerships between people affected by cancer, the community, non-government agencies, government agencies and the NSW health system will build strong cancer services across the state. In this regard, this plan will provide a clear direction for cancer control at the statewide level and will support the work of clinicians, managers and service providers to serve the needs of their local community.

It is a plan that will ensure that the best cancer care is provided across NSW.

A handwritten signature in black ink that reads "Jillian Skinner". The signature is written in a cursive, flowing style.

The Hon. Jillian Skinner MP
Minister for Health

Introduction

Chief Cancer Officer



I am pleased to be able to present the NSW Cancer Plan. It represents the culmination of a year-long period of consultation with those affected by cancer, the community, clinicians and colleagues on what needs to be done to reduce the burden of cancers in NSW. It embodies our collective expertise, experience and knowledge, and showcases a desire to build on the work that has already been done in creating one of the best cancer care systems in the world.

The NSW Cancer Plan provides a comprehensive and inclusive roadmap for the way the health system, healthcare professionals and organisations, and the community, will work together to develop and deliver cancer prevention, screening, early diagnosis, treatment services and survivorship initiatives. It focuses on providing an integrated cancer system and recognises the importance of joining primary health care and the specialist sector more effectively to ensure that those affected by cancer are at the centre of care provision.

Whilst this plan is for everyone in our community affected by cancer, it includes a particular focus on Aboriginal communities and culturally and linguistically diverse (CALD) communities, recognising the poorer cancer outcomes that many people in these communities experience. This plan provides an additional focus on lung, bowel and primary liver cancer, acknowledging the considerable impact they have on the community and the potential there is to make substantial improvements to cancer outcomes.

I am confident the activities detailed in this plan will have a positive impact on the health of NSW. For the first time, this impact will be measured by a cycle of annual public reporting. The Cancer Institute NSW and its partners will be more accountable for the strategies that are developed and implemented and this information will be used to improve the performance of cancer services and programs.

This statewide plan will ensure that the Cancer Institute NSW provides leadership and works with its partners to bring about meaningful generational change and end cancers as we know them.

A handwritten signature in black ink, appearing to read 'David Currow'.

Professor David Currow

Chief Cancer Officer and CEO, Cancer Institute NSW

Cancers in NSW

Cancers impact on the lives of many people - by coping with the diagnosis of cancer, caring for loved ones, searching for a cure, making lifestyle decisions to lower cancer risks, or living with cancer.

In NSW, someone is diagnosed with cancer, on average, every 13 minutes.¹ By 2021, approximately 53,000 people every year across NSW will be told that they have cancer.²

NSW is the most populous Australian state, with 7,565,500 residents⁴ and has the third highest incidence of cancer.⁵ Cancer is a significant cause of death in NSW, being responsible for approximately 30 per cent of all deaths.^{6,7} With a population that is growing and living longer, it is anticipated that for some cancers, such as prostate and breast cancer, incidence may increase⁸ with more people living with the disease. However, cancer survival rates are the highest they have ever been in NSW and age standardised mortality continues to fall.⁹

Although the burden of cancer is shared by all, the distribution of its impact is not equal.

A number of groups within the community have a higher incidence of cancer and have poorer cancer outcomes. This affects Aboriginal communities, culturally and linguistically diverse communities, those from lower socio-economic backgrounds and those from some regional and rural communities.

There are also some specific cancers (such as lung, bowel and primary liver cancers) where a greater emphasis on translating evidence into practice will ensure that people affected by these cancers experience better outcomes.

The treatment of cancers, like many other complex chronic health conditions, requires patient-centred care that is integrated across multiple health settings, from: general practice to specialist care, public and private hospitals; community services and self-management.

Most common cancers, NSW¹⁰

Males				Females			All People		
Rank	Cancer	Number	% of Total	Cancer	Number	% of Total	Cancer	Number	% of Total
1	Prostate	6,815	30.4	Breast	4,728	27.7	Prostate	6,815	17.3
2	Bowel	2,862	12.8	Bowel	2,291	13.4	Bowel	5,153	13.1
3	Melanoma*	2,344	10.5	Melanoma*	1,554	9.1	Breast	4,756	12.0
4	Lung	2,147	9.6	Lung	1,428	8.4	Melanoma*	3,898	9.9
5	Non-Hodgkins lymphoma	852	3.8	Uterine	760	4.4	Lung	3,575	9.1

Most common cancer deaths, NSW¹¹

Males				Females			All People		
Rank	Cancer	Number	% of Total	Cancer	Number	% of Total	Cancer	Number	% of Total
1	Lung	1,669	21.9	Lung	1,118	18.4	Lung	2,787	20.3
2	Prostate	987	13.0	Breast	955	15.7	Bowel	1,720	12.6
3	Bowel	948	12.4	Bowel	772	12.7	Prostate	987	7.2
4	Pancreatic	407	5.3	Cancers of unknown primary	420	6.9	Breast	961	7.0
5	Melanoma*	349	4.6	Pancreatic	397	6.5	Pancreatic	804	5.9

* Melanoma refers to melanoma of the skin only

NSW is at the forefront of cancer control globally.

If you live in NSW your chances of surviving cancer are amongst the highest in the world.³

Cancer Institute NSW

The Cancer Institute NSW was established under the Cancer Institute (NSW) Act 2003 and is Australia's first statewide cancer control agency.

The objectives of the Cancer Institute NSW, as detailed by the Cancer Institute (NSW) Act 2003, are to:

- 1) reduce the incidence of cancer in the community
- 2) increase the survival rate for people diagnosed with cancer
- 3) improve the quality of life of people diagnosed with cancer and their carers
- 4) provide a source of expertise on cancer control for the government, health service providers, medical researchers and the general community.

The Cancer Institute NSW is funded by the NSW Government and provides the statewide strategic direction for cancer control in NSW. The Cancer Institute NSW has a 13-year history of developing and implementing activities that support the community to: decrease their risks of cancer; utilise cancer screening services and access world class treatment services necessary to optimise cancer outcomes.

Achieving improved cancer outcomes in NSW

The improvement of cancer outcomes in NSW will only be achieved by working together across the state with:

- Local Health Districts
- Primary Health Networks
- Specialty Health Networks
- NSW Ministry of Health
- NSW Health Pillars
- Government and non-government agencies.



Our mission

Working together to lessen the impact of cancers.

Our vision

To end cancers as we know them.

Major achievements of the NSW Cancer Plan 2011-2015

Collaborate	Facilitate	Invest	Educate
	New	New	New
Engaged people affected by cancer in all aspects of the Cancer Institute NSW's work.	Facilitated access to BreastScreen NSW by Aboriginal women, which has increased participation from 31.4% in 2009–2010 to 37.4% in 2014–2015.	Initiated Translational Cancer Research Centres which have connected researchers, clinicians and health services (irrespective of administrative boundaries) to address key questions facing cancer care in NSW.	Developed the <i>Listen out for Lung Cancer</i> campaign, which has increased awareness of lung cancer symptoms without stigmatising smokers.
New	New	New	New
Implemented the <i>NSW Skin Cancer Prevention Strategy 2012–2015</i> which co-ordinated endeavours across 13 organisations and supported the ban on cosmetic use of commercial solarium in December 2014.	Encouraged breast cancer screening participation by women from culturally and linguistically diverse communities which has resulted in a participation rate of 45.0%.	Developed Australia's first fully integrated statewide Clinical Cancer Registry to deliver data on the quality of cancer care in NSW.	Developed eviQ education modules that have been successfully implemented across NSW and nationally. For example, the Antineoplastic Drug Administration Course has been implemented in over 285 hospitals nationally.
New	New		New
Held annual meetings with Local Health Districts and Medicare Locals to report on cancer service delivery and benchmark performance across the state.	Developed the Aboriginal Quitline service which has gained credibility in the community, as demonstrated by a 32.0% increase in calls between 2012–2013 and 2013–2014.	Increased the capacity of BreastScreen NSW services which now includes 45 BreastScreen NSW sites and 16 mobile vans (which visit more than 160 locations every two years).	Developed <i>Cancer treatment side effects: a guide for Aboriginal Health Workers</i> , which provides practical information to assist in managing the potential side effects of cancer treatment.
New	New		New
Collaborated with clinicians and health agencies to understand variation in cancer outcomes and drive system improvement.	Enhanced the accessibility of the Arabic, Chinese and Vietnamese Quitlines.	Invested in cancer research over a period of ten years, including for clinical trials support, making the Cancer Institute NSW the largest NSW based funder of cancer research.	Developed a new range of patient education information materials for people undergoing cancer treatment which have been translated into nine languages so far.
	New		
	eviQ has now been endorsed by all Australian jurisdictions as the preferred resource for evidence-based cancer treatments.	Strengthened public interest studies and doubled the number of people participating in clinical trials since 2004.	Contributed to a decline in adult current smoking prevalence from 17.2% in 2010 to 15.6% in 2014 through the Cancer Institute NSW's tobacco control campaigns.
	New		
	Facilitated the sharing of research infrastructure across NSW to ensure equitable access and optimal use of investments in scientific equipment.		Contributed to a decrease in young people's preference for a suntan from 60.2% in 2006–2007 to 41.4% in 2013–2014.
	New		
	Increased iCanQuit participation, with approximately 500,000 unique website visits in 2014–2015, an increase of 30% from the previous year.		
	New		
	Continued growth of Canrefer, with an average of 17,235 views per month in 2012–2015 and the listing of 223 hospitals and cancer services, 204 multidisciplinary teams and 1052 specialists.		
	New		
	In 2015, 95% of the NSW population had access to a cancer centre within 100 kilometres of their residence. People in rural NSW received 85% of their healthcare within their Local Health District.		

New Achievements as a result of activities initiated under the NSW Cancer Plan 2011-2015

NSW State Health Plan

The NSW State Health Plan: Towards 2021, provides the strategic framework for the NSW Health system and brings together NSW Health's existing plans, programs and policies and sets priorities across the system for the delivery of 'the right care, in the right place, at the right time'. It details three strategic directions:

Direction 1: Keeping people healthy

Direction 2: Providing world class clinical care

Direction 3: Delivering truly integrated care

The NSW Cancer Plan contributes to *the NSW State Health Plan: Towards 2021*, as well as the Premier's priorities which include tackling childhood obesity and improving service levels in hospitals. There are also a number of other plans, strategies and key frameworks that will guide the work undertaken in cancer control including:

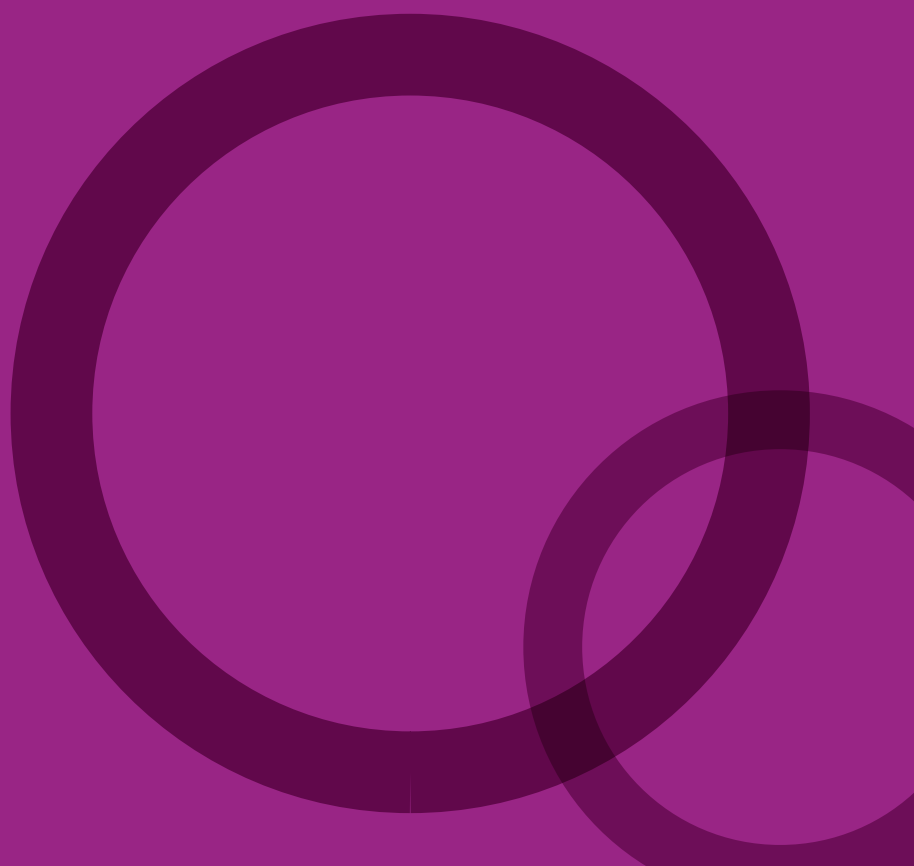






NSW Cancer Plan

The purpose of the NSW Cancer Plan is to provide the platform to facilitate a co-ordinated, collaborative approach to change the face of cancers in NSW.



NSW Cancer Plan

This plan has been specifically developed as a whole of government and non-government statewide plan. It provides the opportunity to strengthen existing partnerships and develop new ones to work together to lessen the impacts of cancers.

Throughout the actions of the NSW Cancer Plan, there is an explicit focus on improving cancer outcomes across the state and lessening the gap for groups within the community who currently experience poorer cancer outcomes.

The NSW Cancer Plan is the fourth cancer plan, and builds on the success of previous plans. It reflects an integrated and collaborative approach to reducing the burden of cancers in NSW.

Development of the NSW Cancer Plan

The development of the NSW Cancer Plan has involved extensive consultation with more than 1,000 individuals, including people affected by cancer, community members, leaders in cancer control, and health professionals, as well as many government and non-government organisations. This has been achieved through workshops, small group engagements, individual consultations and a public consultation process.

Goals of the NSW Cancer Plan

The goals of the NSW Cancer Plan reflect the Cancer Institute (NSW) Act 2003:

Goal 1: To reduce the incidence of cancer

Goal 2: To increase the survival of people with cancer

Goal 3: To improve the quality of life of people with cancer

The NSW Cancer Plan also articulates eight objectives that will facilitate the actions necessary to make progress towards these goals.

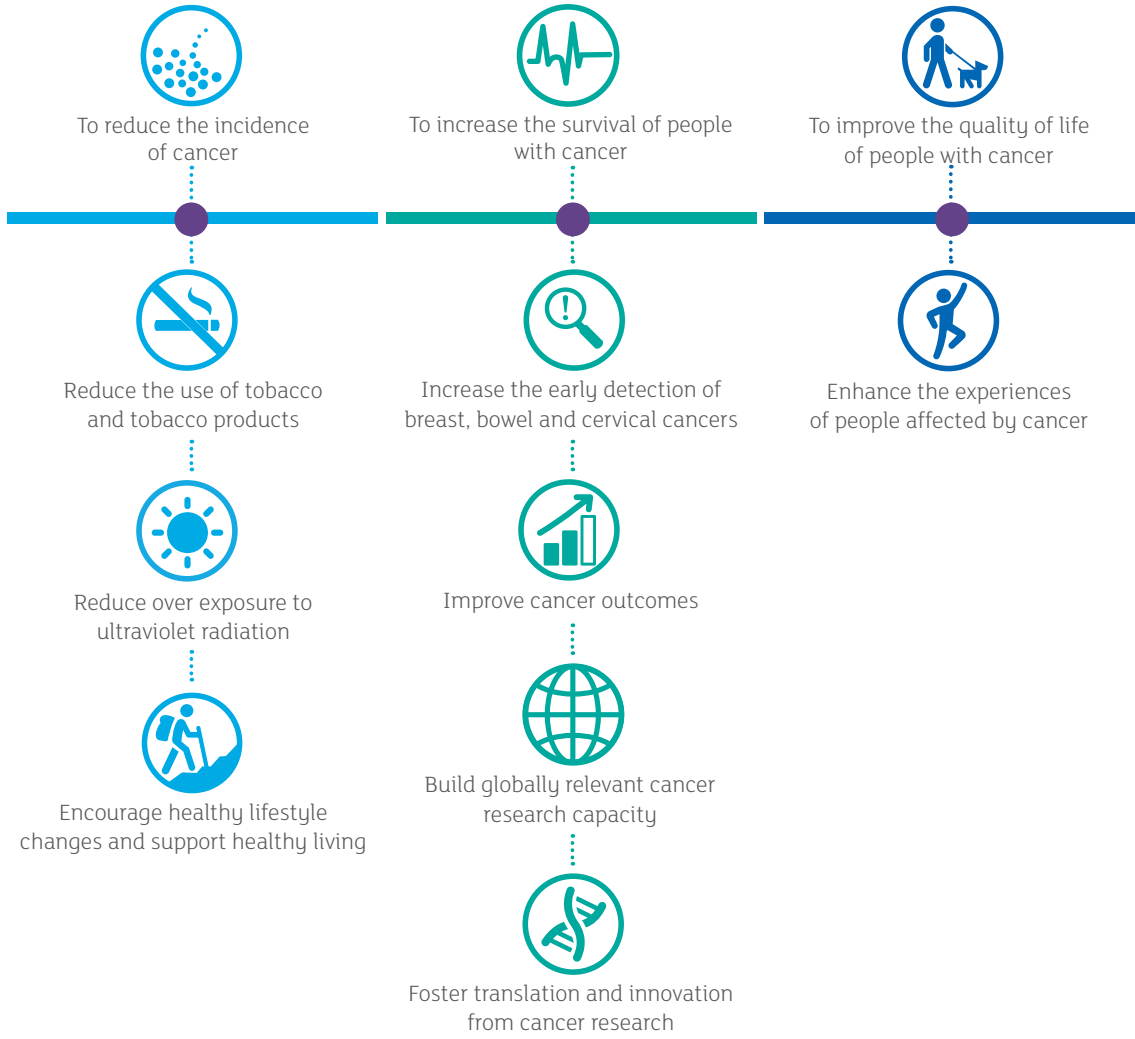
NSW Cancer Plan overview

Vision To end cancers as we know them

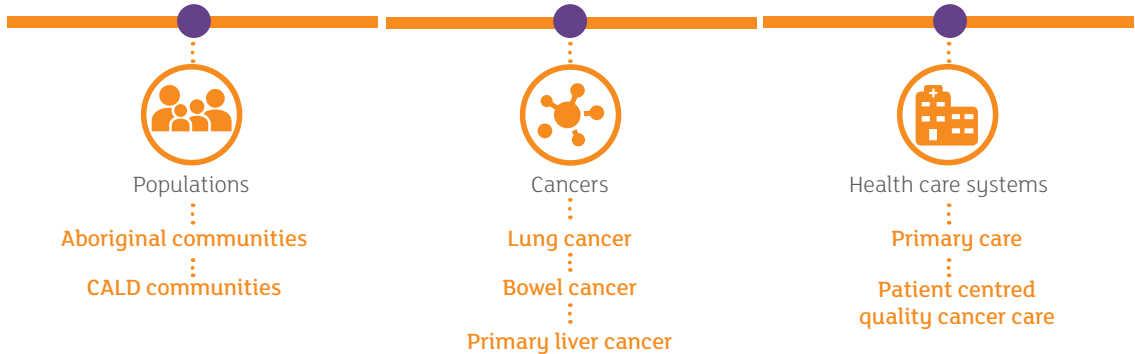
Goals



Objectives



Focus areas



Focus populations

The NSW Cancer Plan will implement initiatives to improve cancer outcomes across the community, whilst also recognising that within NSW there are people or communities who have a higher risk of cancers and experience poorer cancer-related health outcomes.

The needs of these communities will be addressed by specific actions in the NSW Cancer Plan. These priority populations include, although are not limited to, Aboriginal communities and culturally and linguistically diverse communities.

- Aboriginal communities have a higher incidence of cancer than non-Aboriginal communities (461 per 100,000 compared with 434 per 100,000) and Aboriginal people are more likely to die from cancer than non-Aboriginal people (252 per 100,000 compared with 172 per 100,000).¹²
- Aboriginal communities also have a higher prevalence of cancer-related risk factors.¹³
- Compared with non-Aboriginal peoples, Aboriginal peoples may be less likely to access cancer screening services, use support and treatment services and, as a result, may also experience poorer outcomes during and after cancer treatment.¹⁴
- A number of culturally and linguistically diverse communities also have a higher incidence of cancer.¹⁵
- Some culturally and linguistically diverse communities have a higher prevalence of cancer-related risk factors.^{16,17}
- Many culturally and linguistically diverse communities are also less likely to access screening services, to test for cancer or use cancer support services. Therefore, they may experience poorer cancer outcomes.¹⁸

Focus cancers

While working to improve the outcomes for all cancers, the NSW Cancer Plan will focus additional attention on lung, bowel and primary liver cancers.

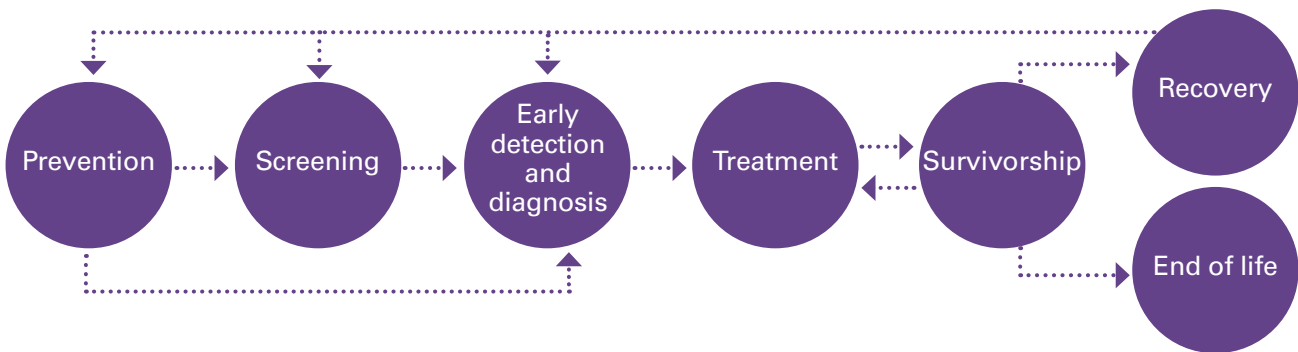
- Lung cancer is responsible for more deaths than any other cancer in NSW and Australia.^{19, 20}
- Bowel cancer causes approximately 80 deaths each week²¹ and Australia has one of the highest incidences of bowel cancer in the world.²² However, early detection can dramatically reduce this figure.
- Primary liver cancer incidence rates have increased significantly over the last 10 years.²³ Chronic hepatitis B and C infections, cirrhosis of the liver, harmful alcohol consumption and obesity all contribute to these increases.

Lung and bowel cancer are two of the priority cancers detailed in the National Healthcare Agreement.

Health care systems of focus

Complex, chronic conditions such as cancers require patient-centred care integrated across multiple health settings.²⁴

The NSW Cancer Plan will focus on the systems of health care that underpin the cancer pathway.



These systems include:

1. Primary health care, which is a pivotal part of health care provision and the interface between the community and the tertiary health care sector.
2. Patient-centred quality cancer health care, which is the service delivery system in which health practitioners diagnose, treat and care for people affected by cancer.

These systems of care are also complemented and supplemented by services and support offered in the community setting.

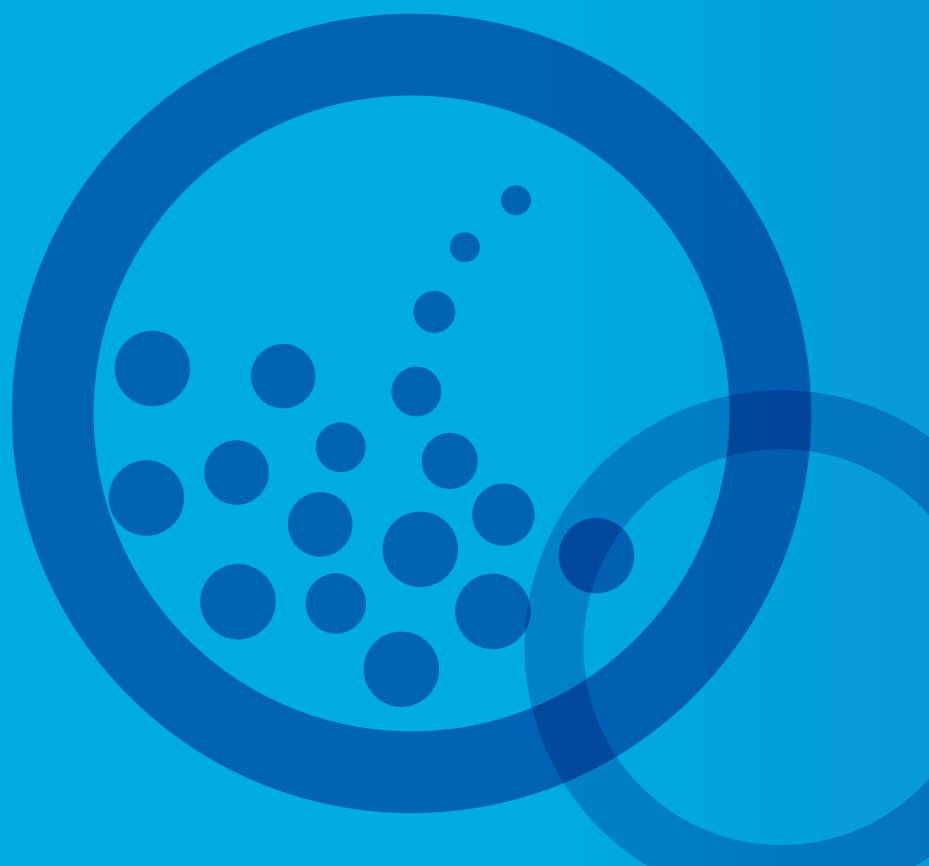
The health care that underpins the cancer pathway needs to become a rapid-learning system so as to advance the evidence-base and transform the way in which evidence, research, data and information are applied to improve cancer care for people affected by cancer. The NSW Cancer Plan will learn from and build on past experiences, and will use data and information to inform the ongoing development of programs and services.





Goal 1: To reduce the incidence of cancer

The first goal of the NSW Cancer Plan is to reduce the incidence of cancer through improving modifiable cancer risk factors.



Overview

The strategies and prioritised actions detailed in this goal build on the considerable work that has already been done in lowering cancer incidence and focuses on reducing:

- smoking prevalence
- overexposure to the sun
- other cancer-related lifestyle risk factors (such as physical inactivity, alcohol use, being overweight or being obese).

A whole-of-population approach will be supplemented by the development of specific actions targeting priority populations. In the area of tobacco control, priority populations include (but are not limited to):

- pregnant women
- Aboriginal communities
- culturally and linguistically diverse communities
- regional and rural communities
- socio-economically disadvantaged communities
- young people
- people newly diagnosed with cancer
- people transitioning to and currently in custody
- lesbian, gay, bisexual, transgender and intersex communities
- people with other drug and alcohol dependencies
- people with mental health issues.




In relation to skin cancer prevention, priority populations include adolescents, young adults and males aged 40 years and over. Prioritised actions regarding supporting healthy lifestyles will incorporate a lifespan approach focusing on the early years, children, adolescents and young people, the reproductive years, and adults in general.

Initiatives under this goal will have an impact on all cancers including bowel cancers (particularly through the promotion of healthy eating and physical activity), lung cancers (through the reduction in smoking) and liver cancers (particularly through the reduction of harmful alcohol use and hepatitis infections).

Data, information, research and evidence will be used to inform the ongoing development of programs and services. Appropriate consultation with communities, and engagement with those affected by cancer will also inform the development of initiatives aimed at reducing the incidence of cancer. Whilst it is acknowledged that cancer screening contributes to reducing the incidence of breast, bowel and cervical cancers, for the purposes of the NSW Cancer Plan, cancer screening activities have been included alongside early detection activities under goal 2, to increase cancer survival.



Prioritised actions

Objectives	Strategies	Prioritised actions	Leads / Co-leads
 <p>Reduce the use of tobacco and tobacco products</p>	Implement and evaluate a comprehensive system-wide approach to tobacco control.	Continue to implement and evaluate the <i>NSW Tobacco Strategy 2012-2017</i> , including tobacco control regulation and public education campaigns that target priority populations.	MoH / CINSW
	Engage with the community and key stakeholders to develop, implement and evaluate activities that prevent tobacco use and assist smokers to quit smoking and maintain cessation.	Implement and evaluate social marketing programs aimed at priority populations.	CINSW
		Deliver evidence-based, effective and efficient NSW Quitline and iCanQuit services that focus on: 1) priority populations 2) health professionals 3) continuous quality improvement 4) integration, innovation and promotion.	CINSW
		Embed brief interventions for smoking cessation in all clinical care.	MoH / LHDs / SHNs / PHNs / HETI / ACI / CCNSW / CINSW
		Embed brief interventions for smoking cessation in community settings.	CCNSW / CINSW / MoH
		Generate and use new evidence to inform strategic planning, and the development and implementation of further tobacco control policies, projects and services.	CINSW
 <p>Reduce over exposure to ultraviolet radiation</p>	Engage with the community and key stakeholders to develop, implement and evaluate comprehensive skin cancer prevention activities.	Implement and evaluate the <i>NSW Skin Cancer Prevention Strategy</i> , including social marketing programs that target priority populations.	CINSW / CCNSW
		Generate and use new evidence to inform strategic planning, and the development and implementation of skin cancer prevention policies, projects and services.	CINSW
 <p>Encourage and support healthy lifestyle choices</p>	Implement and evaluate a comprehensive approach to physical activity, healthy eating and overweight or obesity prevention and management.	Continue to implement and evaluate the <i>Healthy Eating and Active Living Strategy 2013-2018</i> , including the facilitation of referrals to the Get Healthy Information and Coaching Service and Go4Fun.	MoH
	Implement and evaluate a comprehensive approach to reduce the harms associated with alcohol use.	Implement and evaluate initiatives aimed to reduce the harms associated with alcohol use across the community.	MoH
	Implement and evaluate strategies to reduce hepatitis infections.	Continue to implement the <i>NSW Hepatitis B Strategy 2014-2020</i> and <i>NSW Hepatitis C Strategy 2014-2020</i> as they relate to reducing hepatitis B and hepatitis C infections.	MoH / LHDs / SHNs





Goal 2: To increase the survival of people with cancer

The second goal of the NSW Cancer Plan is to increase the survival of people with cancer.



Overview

The strategies and prioritised actions detailed under this goal will continue the work that has been done to screen the population for breast, cervical and bowel cancers, increase the earlier detection of cancers, improve cancer outcomes, build research capacity and foster translational cancer research. There will be a concerted effort to ensure that the complexity of providing cancer services is recognised with a focus on collaboration between primary health care and a patient-centred quality cancer system.

A number of actions included in this goal provide additional focus on lung and bowel cancers and primary liver cancer for high risk populations. A focus on these cancers acknowledges the considerable impact that they have on the community and how increased awareness, earlier assessment and improved treatment pathways will make a substantial difference to cancer outcomes.

There are also a number of priority populations that warrant particular attention across the strategies and actions outlined under this goal, namely (but not limited to):

- Aboriginal communities
- culturally and linguistically diverse communities
- regional and rural communities
- disadvantaged socio-economic communities
- young people.

Appropriate consultation with communities, and engagement with those affected by cancer, will inform the development of initiatives aimed at improving the survival of people with cancer. Data, information, research and evidence will also be used to inform the ongoing development of programs and services.

As noted previously, cancer screening also contributes to goal 1, reducing the incidence of cancer, but for the purposes of the NSW Cancer Plan cancer screening activities have been included alongside early detection activities. Breast, cervical and bowel cancer screening programs are the three national population-based screening programs in Australia.²⁶





Prioritised actions

Objectives	Strategies	Prioritised actions	Leads / Co-leads
<p>Increase the early detection of breast, bowel and cervical cancers</p>	Deliver effective, evidence-based programs that increase the early detection of breast, bowel and cervical cancers.	Implement and evaluate the national breast screening and cervical screening programs within NSW. Support the National Bowel Cancer Screening Program, including a specific focus on priority populations.	CINSW / LHDs / SHNs
		Ensure that breast, bowel and cervical screening programs have the required capacity and capabilities to support increased participation by the general community and priority populations.	CINSW / LHDs / SHNs
		Generate and use new evidence to inform and improve the delivery of breast, bowel and cervical cancer screening programs.	CINSW
		Engage with people in the relevant age groups and the community in the development and implementation of breast, bowel and cervical screening programs (including a focus on clients' experiences of breast cancer screening and assessment services).	CINSW / LHDs / SHNs
	Develop, implement and evaluate innovative strategies that increase participation in screening programs with a specific emphasis on priority populations.	Develop, implement and evaluate comprehensive social marketing programs, with a focus on and engagement with priority populations that encourage breast, cervical and bowel cancer screening participation.	CINSW
		Partner with primary health care providers to promote and encourage breast, cervical and bowel cancer screening in accordance with evidence-based pathways.	CINSW / PHNs
		Implement activities that support the use of risk assessment tools and diagnostic pathways in primary health care.	CINSW / PHNs
<p>Improve cancer outcomes</p>	Facilitate the earlier detection of cancers by supporting the adoption of evidence-based risk assessment tools.	Implement activities to support the monitoring of people at risk of cancer due to lifestyle or other factors.	MoH
		Scope initiatives that would provide for the enhanced monitoring of people identified with high risk of familial cancers.	LHDs / SHNs / CINSW
		Develop, implement and evaluate initiatives for people affected by breast, cervical, bowel and other cancers, that: <ul style="list-style-type: none"> facilitate earlier assessment facilitate relevant surveillance improve diagnostic pathways allow timely access to best practice treatment pathways. Similar initiatives to be implemented should other national screening programs be introduced.	CINSW / LHDs / SHNs / PHNs
	Strengthen the capacity of the cancer system to deliver high quality, patient-centred, integrated, multidisciplinary care, with a focus on reducing unwarranted clinical variation.	Implement and evaluate strategies to ensure that all people diagnosed with cancer have their care overseen by a multidisciplinary team, facilitated statewide by Canrefer.	CINSW / LHDs / SHNs / PHNs
		Support clinician-led benchmarking and quality improvement activities statewide.	ACI / CINSW

Objectives	Strategies	Prioritised actions	Leads / Co-leads
 <p data-bbox="129 1245 288 1290">Improve cancer outcomes</p>	<p data-bbox="325 943 659 1093">Strengthen the capacity of the cancer system to deliver high quality, patient-centred, integrated, multidisciplinary care, with a focus on reducing unwarranted clinical variation.</p>	<p data-bbox="683 376 1158 450">Facilitate better engagement of primary health care throughout the cancer care continuum, including during treatment.</p>	<p data-bbox="1181 376 1326 398">CINSW / PHNs</p>
		<p data-bbox="683 472 1142 568">Support clinicians to communicate the cancer care treatment plan to people affected by cancer and their general practitioner (in a timely manner).</p>	<p data-bbox="1181 472 1382 495">LHDs / SHNs / PHNs</p>
		<p data-bbox="683 591 1134 710">Implement key initiatives under the <i>NSW Rural Health Plan: Towards 2021</i> as it relates to the provision of cancer prevention, screening, early detection and treatment in regional and rural NSW, including:</p> <ul data-bbox="683 714 1158 1451" style="list-style-type: none"> • Cancer prevention and health promotion initiatives in rural communities such as the Get Healthy Information and Coaching Service, NSW Quitline and iCanQuit. • Integration of alcohol advice into existing prevention programs, such as the Get Healthy Information and Coaching Service. • Get Healthy at Work in rural settings, with a focus on physical inactivity, poor nutrition, overweight and obesity, tobacco use, harmful consumption of alcohol and ultraviolet radiation exposure. • Ensure at-risk populations in rural communities have access to prevention programs such as the Needle and Syringe Program, vaccination for Hepatitis B and community education campaigns as they relate to viral hepatitis. • Support for those in rural communities facing critical end-of-life decisions or requiring access to palliative care including out-of-hospital options, by continuing to implement the <i>Advance Planning for Quality at End of Life Action Plan 2013-2018</i> and the <i>NSW Government Plan to Increase Access to Palliative Care 2012-2016</i>. • Ensure statewide research initiatives consider the research needs of rural areas, including those focused on growing research assets, infrastructure and investment. 	<p data-bbox="1181 591 1390 687">MoH / NSW Office of Preventive Health / Office for Health and Medical Research</p>
		<p data-bbox="683 1469 1129 1543">Redesign models of care to ensure equitable and sustainable access to needs-based cancer genetics.</p>	<p data-bbox="1181 1469 1398 1520">CINSW / LHDs / SHNs / ACI</p>
		<p data-bbox="683 1565 1139 1639">Redesign models of care to ensure equitable and sustainable access to needs-based psycho-oncology.</p>	<p data-bbox="1181 1565 1398 1617">CINSW / LHDs / SHNs / ACI</p>
		<p data-bbox="683 1662 1145 1704">Facilitate allied health support for people during treatment and whilst recovering from treatment.</p>	<p data-bbox="1181 1662 1310 1684">LHDs / SHNs</p>
		<p data-bbox="683 1722 1145 1796">Engage with people affected by cancer and the community in the design and implementation of cancer services.</p>	<p data-bbox="1181 1722 1398 1744">LHDs / SHNs / CINSW</p>
	<p data-bbox="325 1906 647 1980">Support clinicians to deliver evidence-based cancer treatment and care.</p>	<p data-bbox="683 1812 1150 1886">Improve the eviQ program as a core resource for the delivery of evidence-based treatment and care.</p>	<p data-bbox="1181 1812 1254 1834">CINSW</p>
		<p data-bbox="683 1908 1150 1982">Support the implementation of the <i>National Service Delivery Framework for Adolescents and Young Adults with Cancer</i>.</p>	<p data-bbox="1181 1908 1426 1960">MoH / relevant SHNs and LHDs</p>
		<p data-bbox="683 1998 1110 2072">Support the ongoing development and co-ordination of paediatric oncology services across the state.</p>	<p data-bbox="1181 1998 1230 2020">MoH</p>



Objectives	Strategies	Prioritised actions	Leads / Co-leads
<p>Improve cancer outcomes</p>	Develop programs to improve outcomes in priority cancers.	Develop, implement and evaluate initiatives that: <ul style="list-style-type: none"> • identify population groups at higher risk of cancers • increase awareness of signs and symptoms where a diagnosis of cancer needs to be excluded • facilitate earlier diagnosis • facilitate relevant surveillance • improve diagnostic pathways • allow timely access to best practice treatment pathways for people affected by lung, bowel and primary liver cancer. 	CINSW / ACI
		Continue to implement the <i>NSW Hepatitis B Strategy 2014-2020</i> and <i>NSW Hepatitis C Strategy 2014-2020</i> as they relate to improving the health outcomes of people living with hepatitis B and hepatitis C.	MoH / LHDs / SHNs
	Improve capacity to report on the quality of the cancer system.	Develop public reporting datasets and benchmarks to improve the quality of the cancer system and reduce unwarranted clinical variation.	CINSW / BHI
		Facilitate increased collaboration with researchers that focus on reducing unwarranted variations in clinical outcomes.	CINSW / ACI
		Expand NSW, national and international benchmarking by greater involvement of the community, clinicians and health planners in formal benchmarking.	CINSW
		Develop systems to better understand occupational cancers.	CINSW / SW NSW
	Engage in system redesign and quality improvement to reduce unwarranted clinical variation.	Develop initiatives that facilitate the use of evidence-based approaches to system redesign and quality improvement.	CINSW / ACI
		Develop evidence-based tools and resources that support optimal practice, including in primary health care.	CINSW / ACI / PHNs
<p>Build globally relevant cancer research capacity</p>	Make NSW a destination of choice for cancer clinical trials.	Invest in strategic and efficient clinical trial infrastructure.	CINSW
		Develop Local Health District strategic plans for cancer clinical trials selection and implementation, and when appropriate, closure.	LHDs / SHNs
	Build workforce capacity.	Invest in fellowships to attract, support and retain cancer researchers.	CINSW
	Foster the sharing of resources and innovation in the research environment.	Embed equitable access to research infrastructure.	CINSW
		Utilise communities of practice to undertake collaborative initiatives that build research capacity, infrastructure and connections between researchers and clinicians.	CINSW
<p>Foster translation and innovation from cancer research</p>	Invest in translational cancer research to create improvements in cancer control.	Further develop models to optimise the translation of cancer research findings and evidence into clinical practice.	CINSW
	Facilitate access and utilisation of data holdings.	Expand access to and use of cancer-relevant data.	CINSW / CHeReL (MoH)





Goal 3: To improve the quality of life of people with cancer

The third goal of the NSW Cancer Plan is to improve the quality of life for people with cancer and those affected by cancer.



Overview

The strategies and prioritised actions detailed under this goal focus on supporting people with cancer to keep healthy during and after a cancer diagnosis and embedding survivorship support within the cancer system where appropriate; utilising engagement and patient reported measures to improve the cancer system; and providing care and support for people at the end of life.

The strategies and actions detailed under this goal will continue work already undertaken in building a patient-centred quality cancer system. It should be noted that the strategies and prioritised actions articulated under goal 2 will also contribute to improving the quality of life of people affected by cancer.

Priority populations for the strategies and activities detailed under this goal will include:


- Aboriginal communities
- culturally and linguistically diverse communities
- regional and rural communities
- disadvantaged socio-economic communities.

Appropriate consultation with communities and engagement with those affected by cancer will inform the development of initiatives aimed at improving the quality of life of people with cancer. Data, information, research and evidence will also be used to inform the ongoing development of programs and services.





Prioritised actions

Objectives	Strategies	Prioritised actions	Leads / Co-leads
 <p>Enhance the experiences of people affected by cancers</p>	<p>Support people with cancer to keep healthy during and after a cancer diagnosis and treatment (including survivorship).</p>	<p>Implement strategies, and develop and disseminate tools and resources that support people affected by cancer to appropriately self-manage.</p>	CINSW / CCNSW
		<p>Develop and disseminate information to support patient decision making about cancer treatment, care and survivorship, appropriate for different levels of health literacy and priority groups.</p>	CINSW
		<p>Provide accessible information and support to people affected by cancer.</p>	CCNSW / CINSW
		<p>Ensure survivorship management after treatment.</p>	LHDs / SHNs
		<p>Build stronger links to physical rehabilitation services for people with cancer.</p>	CINSW / LHDs / SHNs
		<p>Facilitate access to psychosocial support for people affected by cancer.</p>	LHDs / SHNs / CCNSW
		<p>Embed interventions for smoking cessation in cancer diagnosis and treatment services.</p>	LHDs / SHNs / CINSW / MoH
	<p>Utilise consumer engagement and patient reported measures in system improvement and redesign.</p>	<p>Implement key initiatives under the <i>NSW Rural Health Plan: Towards 2021</i> to improve engagement with regional and rural NSW.</p>	MoH
		<p>Improve activities that facilitate the cultural safety and appropriateness of cancer services.</p>	LHDs / SHNs / CINSW
		<p>Develop initiatives that facilitate greater engagement of people affected by cancer and the community in service planning and delivery.</p>	LHDs / SHNs / CINSW
<p>Develop methods to collect patient experience and patient outcomes to inform the planning and implementation of cancer service improvement activities.</p>		BHI / CINSW / ACI	
<p>Provide care and support for people who are dying from cancer, their families and their carers.</p>	<p>Implement the <i>NSW Government Plan to Increase Access to Palliative Care 2012-2016</i> as it relates to the development of a statewide model for palliative and end-of-life care.</p>	ACI / LHDs / SHNs / MoH	
	<p>Develop online learning resources that support health professionals to engage in end-of-life and advance care planning for those affected by cancer.</p>	HETI	

Implementation, monitoring and evaluation of the NSW Cancer Plan

Implementation

Implementing the NSW Cancer Plan will continue to rely on collaborative efforts and partnerships. To reduce the incidence of cancers, to increase the survival of people with cancer and to improve the quality of life for people affected by cancer will require the ongoing active involvement and efforts of all partners across NSW.

The Cancer Institute NSW will work with those involved in the planning and delivery of prevention, screening and cancer-related programs and services to bring the prioritised actions of the NSW Cancer Plan to life. Each goal has a number of objectives, strategies and prioritised actions to ensure movement towards the achievement of these goals.

Lead agencies have been identified for each prioritised action. A range of collaborating agencies will work alongside lead agencies to facilitate progress towards the goal, reflecting the statewide, collaborative nature of the NSW Cancer Plan.

Whilst lead agencies will be responsible for managing and directing the actions, the Cancer Institute NSW will oversee the progress of the NSW Cancer Plan and will act as both a lead and as a collaborator where necessary. The Cancer Institute NSW will publically report against a range of indicators while working with lead agencies to report on their progress in relation to the NSW Cancer Plan.

Review

To ensure the responsiveness of the NSW Cancer Plan to evolving cancer control issues and to maintain its flexible implementation, a review and refresh of the NSW Cancer Plan will be undertaken every 2½ years. The first review will take place in 2018.

Monitoring and evaluation

The Cancer Institute NSW will monitor the progress of the NSW Cancer Plan through the:




- Service Compact with the Ministry of Health
- special program reports
- NSW Cancer Plan Performance Index.

A monitoring and evaluation framework for the NSW Cancer Plan will also be developed.

The Cancer Institute NSW's website cancerinstitute.org.au will contain links to the prioritised actions of the NSW Cancer Plan and regular updates on the plan's implementation.

The NSW Cancer Plan Performance Index

The NSW Cancer Plan Performance Index* will report progress against the objectives of the NSW Cancer Plan. Regular updates will be provided and published on the Cancer Institute NSW's website. The following indicators will be used to track and report on the progress of the NSW Cancer Plan.

Objectives	Performance Index - indicators
 <p>Reduce the use of tobacco and tobacco products.</p>	<ul style="list-style-type: none"> • Current smoking in adults. • Current smoking in young people aged 12–17 years. • Current smoking in Aboriginal adults.
 <p>Reduce over exposure to ultraviolet radiation.</p>	<ul style="list-style-type: none"> • Sun protection behaviours among adults. • Suntan preferences for young people aged 12–17 years • Incidence of melanoma.
 <p>Encourage healthy lifestyle changes and support healthy lifestyle.</p>	<ul style="list-style-type: none"> • Adequate physical activity by adults. • Alcohol drinking in adults. • Alcohol drinking in young people aged 12–17 years. • High-grade lesions detected in cervical screening (HPV immunisation program).
 <p>Increase the early detection of breast, bowel and cervical cancers.</p>	<ul style="list-style-type: none"> • Breast cancer screening participation rates and numbers. • Number of eligible women who have never attended BreastScreen NSW. • Cervical screening participation rates and numbers. • Bowel screening participation rates and numbers. • Screening participation rates by Aboriginal adults (breast cancer screening). • Screening participation rates by culturally and linguistically diverse communities (breast cancer screening). • Client experience of BreastScreen NSW (screening and assessment).
 <p>Improve cancer outcomes.</p>	<ul style="list-style-type: none"> • Proportion of patients receiving greater than five radiation fractions for bone metastases, by facility. • Number of centres performing below target volume for lung, rectal, pancreatic, oesophageal and ovarian cancer surgery. • Proportion of patients receiving treatment with curative intent for lung, pancreatic and oesophageal cancers, by LHD. • Proportion of excisions for hepatocellular carcinoma (primary liver cancer) relative to incidence. • Proportion of rectal cancer resections where ≥ 12 lymph nodes are reported in the pathology report (in the absence of neoadjuvant therapy).
 <p>Build globally relevant cancer research capacity.</p>	<ul style="list-style-type: none"> • Ratio of newly enrolled clinical trial patients to cancer incidence. • Number of cancer related peer review publications from NSW. • Use of cancer-related (Cancer Institute NSW custodian) data.
 <p>Foster translation and innovation from cancer research.</p>	<ul style="list-style-type: none"> • Statewide membership of Translational Cancer Research Centres.
 <p>Enhance the experiences of people affected by cancers.</p>	<ul style="list-style-type: none"> • Patient experience of cancer care.

* These indicators are based on currently available data and, wherever possible, reflect international best practice.

Acronyms and abbreviations

Acronym and Abbreviations	Explanation
ACI	Agency for Clinical Innovation
BHI	Bureau of Health Information
CALD	Culturally and linguistically diverse communities
CCNSW	Cancer Council NSW
CEC	Clinical Excellence Commission
CINSW	Cancer Institute NSW
CHeReL	Centre for Health Record Linkage
HETI	Health Education and Training Institute
LHDs	Local Health Districts
MoH	NSW Ministry of Health
NGOs	Non-government Organisations
PHNs	Primary Health Networks
SHNs	Specialty Health Networks
TCRCs	Translational Cancer Research Centres
SW NSW	SafeWork NSW
NSW Health Pillars	ACI, BHI, HETI, CEC, CINSW

Glossary

	Meaning / explanation
Adequate physical activity by adults	Adequate physical activity is defined as undertaking physical activity for a total of at least 150 minutes per week over five separate occasions.
Co-ordinated care	Refers to the deliberate organisation of patient care activities between two or more health professionals involved in a patient's care to facilitate the appropriate delivery of health care services.
End-of-life care	End-of-life care refers to support for people who are in their last weeks or days of life. This is a time when the goals of care are palliative.
Hepatocellular carcinoma	A type of primary liver cancer, most cases are secondary to either a viral hepatitis infection (hepatitis B or C) or cirrhosis (alcohol being the most common cause of liver cirrhosis).
High grade lesions of a Pap test	Cells are not normal but the changes are not yet cancer. This is a marker of increased risk of developing cancer. It suggests there are cell changes in the cervix that require further investigation.
Incidence	Incidence is the number of new (or newly diagnosed) cases of cancer during a given time period in a specific population.
Integrated care	<p>The management and delivery of health services so that patients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.</p> <p>Integrated care is an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care, applied at the system level.</p>
Metastasis	Cancer which has spread from the place at which it first arose as a primary tumour to distant locations in the body.
NSW Ministry of Health	Undertakes regulatory, public health and public health system manager functions in statewide planning, purchasing and performance monitoring and support of health services.
Neoadjuvant therapy	Refers to the administration of therapies before the surgical treatment.
NSW Health Pillars	Provide expert advice and guidance for other NSW Health service providers. Organisations include: HETI, ACI, CEC, BHI and CINSW.

Glossary

	Meaning / explanation
Palliative care	<p>Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:</p> <ul style="list-style-type: none"> • provides relief from pain and other distressing symptoms • affirms life and regards dying as a normal process • intends neither to hasten or postpone death • integrates the psychological and spiritual aspects of patient care • offers a support system to help patients live as actively as possible until death • offers a support system to help the family cope during the patient's illness and in their own bereavement • uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated • will enhance quality of life, and may also positively influence the course of illness • is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
People affected by cancer	Refers to those who experience a cancer diagnosis and those who are affected by the cancer diagnosis of a friend or relative.
Prevalence	Prevalence is the actual number of cases alive, with the cancer either during a period of time (period prevalence) or at a particular date in time (point prevalence).
Primary health care	Primary health care is the first level of contact individuals, families and communities have with the health care system. In Australia, it incorporates personal care with health promotion, the prevention of illness and community development, advocacy and rehabilitation.
Primary liver cancer	Primary liver cancer is cancer that starts in the liver.
Radiation fractions	Refers to episodes of treatment with radiation therapy.
Rapid-learning system	Information obtained in the course of practice drives the process of discovery and ensures a focus on continuous innovation, quality improvement and safety – and is intrinsic to a patient-centred cancer care system. ²⁵
Specialty Health Networks (NSW Health)	Provide front-line service delivery, and clinical, patient and community engagement.
Survivorship	Refers to the process of living with, through, and beyond cancer. By this definition, cancer survivorship begins at diagnosis. It includes people who continue to have treatment to either reduce risk of recurrence or to manage chronic disease and includes the longer term impacts of cancer treatment on people affected by cancer.
Treatment with curative intent	Curative intent refers to treatment and therapies provided with an intent to cure the cancer.

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All about multidisciplinary care

All about multidisciplinary care

Multidisciplinary care (MDC) is considered best practice in the treatment planning and care for patients with cancer. Cancer Australia is committed to improving the uptake of multidisciplinary cancer care using lessons learnt from a number of key national projects.

MDC is an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and collaboratively develop an individual treatment and care plan for each patient. MDC involves all relevant health professionals discussing options and making joint decisions about treatment and supportive care plans, taking into account the personal preferences of the patient.

Based on the ['Principles of multidisciplinary care'](#), Cancer Australia has developed web-based practical tools to assist health professionals and health service administrators implement MDC at the local level.



All about multidisciplinary care

Benefits of multidisciplinary care

The benefits of adopting a multidisciplinary care (MDC) team approach include:

For patients:

- increased survival for patients managed by a MDC team
- shorter timeframes from diagnosis to treatment
- greater likelihood of receiving care in accord with clinical practice guidelines, including psychosocial support
- increased access to information
- improved satisfaction with treatment and care.

For health professionals:

- improved patient care and outcomes through the development of an agreed treatment plan
- streamlined treatment pathways and reduction in duplication of services
- improved coordination of care
- educational opportunities for health professionals
- improved mental well-being of health professionals

“

“The benefits have spread into all our activities... its made a complete difference to the whole specialist network in the hospital.”



All about multidisciplinary care



Principles of multidisciplinary care

The 'Principles of multidisciplinary care' provides a flexible definition of MDC, allowing for variation in implementation according to cancer type and the location of service provision. The principles are designed to be relevant for all cancers, across a range of health-care settings. A summary of the 'Principles of multidisciplinary care' include:

- a **team approach**, involving core disciplines integral to the provision of good care, including general practice, with input from other specialties as required
- **communication** among team members regarding treatment planning
- access to the **full therapeutic range** for all patients, regardless of geographical remoteness or size of institution
- provision of care in accordance with **nationally agreed standards**
- **involvement of patients** in decisions about their care.

Team

Principle of care		Outcome
a	The disciplines represented by the core team should minimally include surgery, oncology (radiation and medical oncology), pathology, radiology and supportive care. The individual patient's general practitioner will be part of the team	The core team is established and known
b	In order to ensure that the patient has access to the full range of therapeutic options, the core team may be expanded or contracted to include services (may be off site), such as genetics, psychiatry, physiotherapy and nuclear medicine	Referral networks established for non-core team specialist services

Communication

Principle of care		Outcome
a	A communications framework should be established which supports and ensures interactive participation from all relevant team members at regular and dedicated case conference meetings	Communication mechanisms are established to facilitate case discussion by all team members
b	Multidisciplinary input should be considered for all patients with cancer, however, not all cases may ultimately necessitate team discussion	A local protocol is established for deciding which cases may not require team discussion



All about multidisciplinary care



Principle of care	Outcome
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Full therapeutic range

Principle of care	Outcome
a Geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of multidisciplinary care for patients with cancer	Systems are established for ensuring that all patients have access to all relevant services
b The members of the team should support the multidisciplinary approach to care by establishing collaborative working links	Systems are established to support collaborative working links between team members

Standards of care

Principle of care	Outcome
a All clinicians involved in the management of patients with cancer should practice in accord with guideline recommendations	Local clinician data is consistent with national benchmarks
b The treatment plan for a patient should consider individual patient circumstances and wishes	The final treatment plan is acceptable to the patient, where possible
c Discussion and decisions about treatment options should only be considered when all relevant patient results and information are available	Final reports are available to all core team members before treatment planning
d In areas where the number of new cancers is small, formal collaborative links with larger units/centres should give support and foster expertise in the smaller unit	Systems are established for the exchange of knowledge and expertise between larger and smaller caseload centres
e Maintenance of standards of best practice is supported by a number of activities which promote professional development	Systems are established for the support of professional education activities

Involvement of the patient

Principle of care	Outcome
a Patients with cancer should be encouraged to participate as members of the multidisciplinary	Patients are supported to have as much input into their treatment plan as they wish



All about multidisciplinary care

Principle of care		Outcome
	team in treatment planning	
b	The patient diagnosed with cancer should be fully informed of his/her treatment options as well as the benefits, risks and possible complications of treatments offered. Appropriate literature should be offered to assist his/her decision making. This information should be made available to the patient in a form that is appropriate to his/her educational level, language and culture	All patients are fully informed about all aspects of their treatment choices
c	Supportive care is an integral part of multidisciplinary care. Clinicians who treat patients with cancer should inform them of how to access appropriate support services	All clinicians involved in the management of patients with cancer ensure that patients have information about and access to support services
d	The patient with cancer should be aware of the ongoing collaboration and communication between members of the multidisciplinary team about his/her treatment	Patients with cancer feel that their care is coordinated and not fragmented

For more information:

- [View checklist for 'Principles of multidisciplinary care \(108\)'](#)





The multidisciplinary care team

The multidisciplinary care (MDC) team should comprise the core disciplines integral to the provision of good care. [Team membership](#) will vary according to cancer type but should reflect both clinical and psychosocial aspects of care and the patient's general practitioner.

The general practitioner (GP) may play a number of roles in all stages of the disease process, including diagnosis, referral, treatment, coordination, and continuity of care as well as provision of information and support to the patient and his/her family.

While it may not be possible for general practitioners to attend multidisciplinary care team meetings on a regular basis, it is essential that the GP is kept informed in a timely manner about treatment decisions.

Geographical remoteness and/or small size of the institution delivering care should not be impediments to the delivery of MDC nor to access to services. Systems should be established to support collaborative working links between team members. It is important that referral links with remote services are established and can be drawn upon as required.

An effective team approach to care ensures smooth transitions for the patient along the continuum of care. Changes to the team should be communicated to the patient and MDC team members at a time which is appropriate to all. Providing appropriate information to the patient will improve patient understanding about their disease and assist with continuity of care throughout the patient's cancer journey.

Examples of team membership

- [Treatment planning: breast cancer](#)
- [Treatment planning: lung cancer](#)
- [Case study: Setting-up a team](#)

Coordination of multidisciplinary care

The MDC team should designate an agreed point of contact. The agreed point of contact may be fulfilled by a nurse or other supportive care personnel. The team should consider who within their team can fulfil this role, if a designated person is not already in place. The role of this person will be to coordinate administrative aspects of the patient's care, which may include:

- ensuring effective communication between team members, other health professionals and the patient and caregivers
- providing information and referral to services and programs to the patient and caregivers
- providing follow-up and support for the patient and caregivers
- providing written information and resources

A lead health professional may also be designated to liaise with the patient and their caregivers, where appropriate, regarding treatment and care planning.



All about multidisciplinary care



"The MDC meeting certainly became much more efficient once the breast care nurse came in."

Establishing a team identity

Practical examples of how to promote team identity may include

- developing a team name and agreed values that reflects the teams function
- establishing a [communications framework](#) to support the team and ensures participation from all relevant team members at regular and dedicated case conference meetings
- agreeing on the purpose of the meetings
- displaying posters identifying team members in public areas
- developing a team identifier such as a logo and letterhead (taking account of local protocols regarding the use of logos)
- providing regular team updates via email or a 'bulletin board' for team communication.

[See also - Case study: establishing a team identity](#)

A communications framework

A communications framework should be developed which encourages and supports input into case discussion from all relevant team members. The framework may vary depending on the type and size of service and should acknowledge diversity and flexibility in the way that case discussion is conducted. Seamless care involves effective and timely communication between all health professionals including the patient's GP. For example, informing the patient's GP about discussion and treatment outcomes prior to patient contact will ensure that the GP provides the patient with accurate, relevant and up-to-date information about their treatment and care.

Multidisciplinary care team meeting

Regular team meetings are an integral component of MDC. A central theme of meetings should be prospective treatment planning.

Once the team is established it may be appropriate to hold meetings outside the usual MDC treatment planning meetings to discuss specific topics of interest or for professional development. Using the meetings as an educational and information-sharing opportunity, as well as for treatment planning, can help both to encourage attendance and ensure sustained interest.

See also a recommended [Multidisciplinary care meeting – attendance register form \(DOC 40 KB\). \(128\)](#)



All about multidisciplinary care



Examples of multidisciplinary care teams

Multidisciplinary care team membership for treatment planning: breast cancer

Core team members	Non-core team members
<ul style="list-style-type: none">• Surgery• Medical oncology• Radiation oncology• Pathology• Radiology• Supportive care – oncology nurse/breast care nurse• General practice	<ul style="list-style-type: none">• Genetic/hereditary counselling• Physiotherapy• Psychiatry/Psychology• Nuclear medicine• Plastic surgery• Palliative care• Social work

Multidisciplinary care team membership for treatment planning: lung cancer

Core team members	Non-core team members
<ul style="list-style-type: none">• Respiratory Medicine• Thoracic Surgery• Medical Oncology• Radiation Oncology• Pathology• Radiology• Nurse Specialist• Palliative care	<ul style="list-style-type: none">• Nuclear medicine• Social work• Physiotherapy• Psychiatry/Psychology• Dietetics• Occupational Therapy

Multidisciplinary care team membership: advanced disease

Allied health professionals	Clinicians
<ul style="list-style-type: none">• Counsellor• Dietitian• Occupational therapist• Pharmacist	<ul style="list-style-type: none">• General practitioner• Gynaecological oncologist• Medical oncologist• Palliative care physician



All about multidisciplinary care



Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Physiotherapist • Psychologist • Social worker • Sexual health counsellor 	<ul style="list-style-type: none"> • Pathologist • Physician • Psychiatrist • Radiation oncologist • Radiologist • Registrars • Surgeon • Urologist

Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community health nurse • Community palliative care team 	<ul style="list-style-type: none"> • Palliative care coordinator • Palliative care clinical nurse consultant • Pastoral care

Other health professionals	Nursing
<ul style="list-style-type: none"> • Care coordinator • Clinical trials coordinator 	<ul style="list-style-type: none"> • Research nurse • Specialist breast nurse • Specialist gynaecological nurse

Multidisciplinary care team membership: advanced breast cancer

Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Counsellor • Dietitian • Occupational therapist • Pharmacist • Physiotherapist • Psychologist • Social work • Sexual health counsellor 	<ul style="list-style-type: none"> • General practitioner • Medical and radiation oncology registrars Medical oncologist • Pathologist • Psychiatrist • Radiation oncologist • Surgeon



All about multidisciplinary care



Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community health nurse • Community palliative care team 	<ul style="list-style-type: none"> • Palliative care coordinator • Palliative care clinical nurse consultant • Palliative care physician • Pastoral care

Other health professionals	Nursing
<ul style="list-style-type: none"> • Advanced breast cancer team coordinator • Occupational therapist • Physiotherapist 	<ul style="list-style-type: none"> • Breast care nurse for advanced breast cancer • Chemotherapy nurse • Inpatient oncology nurse • Research nurse

Multidisciplinary care team membership: advanced ovarian cancer

Allied health professionals	Clinicians
<ul style="list-style-type: none"> • Counsellor • Dietitian • Occupational therapist • Pharmacist • Physiotherapist • Psychologist • Social worker • Sexual health counsellor 	<ul style="list-style-type: none"> • General practitioner • Gynaecological oncologist • Medical oncologist • Pathologist • Psychiatrist • Radiation oncologist • Surgeon

Community health	Palliative and supportive care
<ul style="list-style-type: none"> • Community palliative care team • Community health nurse 	<ul style="list-style-type: none"> • Palliative care consultant/nurse • Pastoral care or religious representative

Other health professionals	Nursing
<ul style="list-style-type: none"> • Occupational therapist • Physiotherapist 	<ul style="list-style-type: none"> • Chemotherapy nurse • Gynaecological nurse specialist



All about multidisciplinary care



Other health professionals	Nursing
	<ul style="list-style-type: none">• Research nurse





Planning a multidisciplinary care meeting

Setting-up a new meeting

When establishing regular MDC meetings for a new team, it is important to gain consensus from all team members on:

- the team responsibilities
- meeting aims and frequencies
- local protocols for issues such as decision making, documentation processes, providing feedback about meeting outcomes, confidentiality and consent.

The planning phase may involve several meetings between team members and should be facilitated by a respected peer. Emphasise on the benefits of the multidisciplinary process will encourage participation. If possible, hold initial planning meetings at a time that is likely to be used for future treatment planning meetings to promote familiarity of timing amongst the team.

Planning meetings can be used to assess current strengths and achievements of the hospital/department as well as to identify areas for improvement or development. If a number of areas for development are identified, it may be necessary to prioritise these, with the aim of working on only one or two at one time.

[See also - Case study: Setting up a multidisciplinary care team meeting](#)

[See also - Team contact list \(DOC 34 KB\) \(128\)](#)

Team leadership and coordination

Team leadership is a key aspect contributing to successful and sustainable MDC meetings. Leadership and coordination may take a number of forms:

- a 'champion' who drives initiatives and is integral in gaining and maintaining support for the meetings; this role is particularly important during the early stages of a team's formation
- a meeting chair who facilitates discussions during team meetings
- a meeting coordinator who coordinates the logistics for meetings.

These roles require energy, enthusiasm, and an ability to communicate with, and gain input from, other team members. Each role may be undertaken by one or more individuals or multiple roles may be fulfilled by one individual.

Once the roles are allocated it is important that role definition is agreed upon at the outset and that other team members are aware of which team member is responsible for which aspects of meeting organisation and coordination. It is also important to have agreed team members to act as 'back-up' for these roles if the primary contact is not available.



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“ (the champion) has strong links with all people in the team... she’s one of these enthusiastic people that every team needs...”

Meeting coordinator

The meeting coordinator role is to:

- organise meetings
- identify patients for discussion during the meetings
- collate information and ensures availability of relevant information sources for presentation at meetings
- record outcomes of case conference discussions
- inform the treating clinician and/or the patient’s general practitioner of the meeting outcomes

The role of the meeting coordinator can be undertaken by an administrative personnel, an oncology nurse, data manager, or registrar. At larger centres, registrars may take responsibility for coordinating meetings on an alternating basis. Regardless of who fulfils this role it is important that all team members are aware of who is undertaking the role and that a back-up is available in situations where the primary coordinator is unavailable.

Timing of meetings

Meetings should be held at the same time and place to maintain routine, avoid confusion and facilitate [sustainability of MDC](#). The duration of MDC meetings will be determined by the size of the institution and the number of cases requiring discussion. In general it will be appropriate to limit the meetings to 45–90 minutes. Any time not used for treatment planning may be used for educational purposes or discussion of other relevant issues. Meetings should be held at a time convenient for all attendees and planned to take account of attendance by off-site personnel.

Venue and resources

Generally, hospital meeting rooms can be used as venues for MDC meetings. Venues should have:

- sufficient space for all participants
- access to power points for use of projectors and light boxes
- a ‘round table’ format.

When setting up new meetings, consider sharing equipment with other departments or groups to minimise costs. Provision of refreshments at meetings can be important, particularly if meetings are held outside normal working hours, during breakfast or lunchtimes or towards the end of the working day.



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[See also - Checklist of suggested meeting resources \(DOC 30KB\) \(78\)](#)

Involving the patient's general practitioner

Communication links with the patient's GP and the MDC team are crucial and should be maintained throughout the cancer journey. The GP of patients due to be discussed at an MDC meeting should be informed of the meeting and encouraged to attend in person or via teleconference. If the GP is unable to attend, a member of the team should communicate treatment decisions to the GP in a timely manner.

[See also - Case study: involving general practitioners](#)

Involving off-site attendees

It will not always be possible for all team members to be present at one site. In regional sites, it may be appropriate to plan meetings at times when a visiting specialist is due to be present. For other sites, issues of distance may be overcome using teleconferencing or videoconferencing.

Considerations when involving off-site attendees include:

- ensure off-site attendees have access to the same information as on-site attendees including access to slides, scans and other information that will be presented at the meeting
- encourage off-site attendees to contribute to discussions
- all team members are aware of teleconference and videoconference protocols.



"We built a lot of trust across the private-public interface – before it was a barrier, and now it is an interface..."

[See also - Case study: implementing teleconferencing](#)

Deciding which patients to discuss

All patients with a newly diagnosed cancer should be discussed by the multidisciplinary team. The level of discussion may vary depending on both clinical and psychosocial factors. Some cases may only require brief discussion while others will require more detailed review and comment. There may also be a need to review existing treatment plans for patients who have been discussed previously. Local protocols to guide the decision-making process should be agreed by the team.

Information sources



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Good preparation of materials and information in advance of multidisciplinary meetings is essential. The types of materials and information required at a meeting will vary according to tumour type but are likely to include:

- all relevant medical history details
- pathology reports and slides
- imaging films and scans
- results of diagnostic examinations
- blood test results
- previous treatment plans, if relevant.

The patient's medical history and diagnostic results can take the form of a 'patient summary' prepared prior to the meeting and disseminated to all team members. This task may be assigned to one of many team members, including registrars. Information about the patient's concerns, preferences and social circumstances should also be presented at the meeting, for example by the oncology nurse (or care coordinator if available) or by the treating physician. It is also appropriate to have access to relevant clinical practice guidelines and other evidence-based information at the meetings.

Collection of relevant information in advance and presentation of results is a task that can be designated, for example, to one or more surgical registrars who regularly attend the meetings. Alternatively, individual clinicians can take responsibility for bringing relevant information to the meetings regarding their own patients. Whichever system is chosen, it is important that the team agrees upon the designated responsibilities from the outset and that back-up plans are in place in case of non-attendance.

[See also - Register of information source providers \(DOC 30 KB\) \(77\)](#)

“We've seen a transition from the presentation of 'a case of breast cancer' with a lot of technical detail, to the presentation of 'a woman with breast cancer', with background details about who this woman is, what's going on in her life, what her desires might be, and how that might impact on decision-making ...”

After the meeting

It is important that systems are in place to promptly inform team members who were not able to attend the meeting about outcomes, such as the patient's general practitioner or referring clinician.

Follow-up with the general practitioner should be via letter and may also include a telephone call or a follow-up meeting with the general practitioner. It is also vital to ensure that responsibility is allocated to a specific individual to ensure that the outcomes of the meeting are conveyed to the patient's GP.

See also:



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- [GP notification letter template \(DOC 28 KB\) \(88\)](#)
- [Checklist for planning a MDC meeting – pre-meeting \(DOC 35 KB\) \(91\)](#)





Case Studies - Planning a meeting

Case study: setting up a team

Challenge

To establish a multidisciplinary care (MDC) treatment planning meeting for the management of breast cancer in a rural/regional area consisting of one large regional centre with one public and two private hospitals, and a number of smaller rural hospitals covered by four main health services.

A number of barriers and obstacles were faced in setting up the team. The majority of stakeholders voiced concerns about the time that would be required to attend MDC meetings and the impact this may have on their clinical practice.

Clinicians were also concerned about breaches of privacy with patients being discussed in a team environment.

In the regional/rural setting, most clinicians work in both the public and private sector. Those with a significant private practice were unwilling to present patients at a meeting held in the public health service. Rural clinicians also identified the lack of oncologists at MDC meetings in rural areas and the need to have linkage to the larger regional centre.

Solution

Establishment of MDC across a large regional and rural area required face-to-face consultation with stakeholders in all sectors, discipline groups and health services. Meetings provided information about MDC and, in particular, the advantages for clinicians and patients and the opportunity to discuss issues and look at the way forward. Within the health services, the executive team was invited to planning meetings to seek support for the necessary changes.

As a result of the consultation, many clinicians recognised that the development of MDC represented best practice and subsequently met to attempt to overcome the obstacles.

Within six months the regional MDC team was meeting on a weekly basis and prospective treatment planning was established. The clinicians were initially concerned about the time commitment, but quickly recognised that most discussion took place at meetings, thus reducing the need for telephone calls and communication at other times.

To overcome clinician concern about discussing private patients in the public sector, an agreement was reached to meet at one of the private hospitals and to date the team has continued with this practice.

Team members have realised that benefit could be gained by videoconferencing to the rural areas and initial



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discussions have taken place to plan this strategy.

Outcome

Weekly meetings are held to prospectively plan treatment and care for women diagnosed with early, advanced and recurrent breast disease. On average, 22 health care professionals attend the meetings, but there are often 28–30 attendees. The core team consists of one or more pathologists, radiologists, surgeons, medical oncologists, and radiation oncologists, along with general practitioners, breast care nurses and social workers. One rural area has commenced videoconference linkage to the regional hospital, which is the main cancer referral centre, to ensure oncology input to treatment planning.

Case study: involving general practitioners

Challenge

Involving general practitioners in MDC.

Solution

To ensure that GPs participated in the planning phase, with a view to their participation in MDC meetings, focus groups were held at clinics in the regional area and through the Division of General Practice in two rural health services. Attendance at these meetings was impressive and though the attendees identified many obstacles to attendance at MDC meetings, they were enthusiastic about participating.

Outcome

GPs routinely attend the MDC meeting in the regional centre and on many occasions in the rural centres. The relevant Division of General Practice is notified of the name of the GPs who are to have patients discussed that week and through this mechanism, GPs are invited to the meeting. The liaison GP from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those GPs unable to attend the meeting.





Case study: establishing a team identity

Challenge

The need to develop an identifiable team and strengthen links between members was identified.

Solution

Diagrammatic representations of clinical management pathways were developed for each hospital site and posters summarising these pathways, including photographs of team members, were displayed in relevant waiting areas. Meetings with all clinicians from across the Collaboration were held early during the set-up phase to emphasise the benefits of a MDC approach and promote the use of the clinical management pathway. A logo was developed specifically for the Collaboration and used on letterhead distributed to all relevant facilities in the region during the implementation of strategies.

Outcome

Promotion of the team through the clinical management pathways and Collaboration logo strengthen the team identity and brought awareness to MDC for both clinicians and patients.





Running a multidisciplinary care meeting

Role of the Chair

Good leadership and facilitation are key factors in the success of multidisciplinary care meetings. The Chair does not have to be the same person in every meeting, as long as the leadership and facilitation roles are fulfilled. The role may be shared between several team members. The Chair should be aware of the need for strong leadership. It is important to recognise that this does not equate to dominance of clinical decision-making. Rather, the Chair's role is to facilitate participation by all members of the multidisciplinary team in clinical discussions and decision making, and to ensure that meetings are not dominated by a few clinicians.

It is the role of the Chair to:

- keep meetings to the agenda
- commence discussions
- prompt the full range of input into discussions
- summarise the discussion and invite any further input before moving to the next case
- negotiate resolution of conflict if necessary
- promote mutual professional respect among all team members.

Managing group dynamics

Mutual respect and positive group dynamics are important factors in effective MDC meetings. Participant's input into discussions should be valued and respected by the other participants. To promote positive group dynamics and understanding of team roles and role boundaries it may be beneficial to:

- clarify role perceptions and expectations of each other
- identify your own and other professionals' competencies
- explore overlapping responsibilities
- re-negotiate role assignments.

Communication skills training

Effective communication between health professionals is vital but may be challenging with an expanded team of professionals. For MDC teams to be effective, all members must communicate effectively with one another.

The way a clinician and the treatment team relate to, and communicates with, a patient can significantly benefit the patient and their family. Benefits may include improvements in psychosocial adjustment, decision-making, treatment compliance and satisfaction with care.

A range of [Communication skills training](#) modules have been developed for health professionals about how best to address issues with patients and improve communication within multidisciplinary care teams.





Treatment planning

It is important for teams to establish a process for communicating case discussion outcomes and recommendations to the patient and their GP. The treatment and care plan should be formal, in writing, and consider the full range of treatment and care options available to the patient, while taking into account the patient's preferences.

Where possible, written care plans should be made available to the patient. In addition, patients' access to a second opinion outside the initial team should be respected and facilitated.

Re-evaluating treatment and care plans should be done at critical points during the course of disease including diagnosis, change in treatment, recurrence, or at the end of active treatment. It is essential that treatment and care plans are assessed regularly because many changes will occur during the course of the patient's disease. Any changes made to the patient's treatment plan should be discussed with the patient and documented.

[See also - Generic treatment plan template \(91\)](#)

A number of steps have been identified to assist the MDC team in effective decision making when developing the treatment plan:

- clarify roles and involvement by relevant MDC team members in the decision-making process
- ensure sufficient and relevant data are presented about the diagnosis through the use of a synoptic report that provides a summary of the essential diagnostic information
- consider all relevant treatment options
- consider psychosocial status and support needs
- identify responsibilities for actioning and communicating the agreed treatment plan.

Documentation

Common documentation processes that suit all team members should be established. Teams may consider using a grid where details from the meeting are filled in by all team members. Documentation can also support accreditation activities at the local level. Regular recording of attendance, frequency of meetings and decisions made, provides a record of the multidisciplinary process. Associated clinical audit processes can also assist in the collection of clinical indicator data for the purpose of quality improvement.

[See also - Checklist for running a team meeting \(85\)](#)

Reviewing multidisciplinary care team process

Each MDC team should establish a process to review and audit team functionality. Team functionality refers to how members of the team work together, how the MDC meetings are set-up and sustained and how team members support each other. Reviewing functionality can include how meetings are organised, the purpose



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of the meeting, team membership, attendance, communication among team members, patients and caregivers, and meeting outcomes. Auditing team functionality is an ongoing process which aims to ensure that the team is working in an effective way and there is optimal team interaction.





Keeping the patient informed

Explaining the concept of multidisciplinary care

Explaining the concept of the 'MDC team approach' is an important part of introducing MDC to the patient. This is usually done by the lead health professional. All patients should be informed about the members of their MDC team, what and how information is shared between team members, and the treatment plan.

It is important to explain to the patient how the meetings work, the meeting structure, whether or not patient names are used in the meeting and issues relating to confidentiality.

Whilst the '[Principles of multidisciplinary care](#)' emphasise the importance of involving the patient in discussion about the treatment plan, the patient does not have to be in attendance at the treatment planning meeting itself. More important is the need to have protocols in place to ensure that patient preferences are considered in developing the plan and that the outcomes of the meeting are discussed with the patient who agrees the final treatment plan.

All patients should be provided with written information about the members of their MDC team, what and how information is shared between team members and the treatment plan. This can be achieved through the development of:

- a brochure explaining the full range of health professionals involved in the patient's care
- a map of possible care pathways
- a photo of team members or list of names
- a prompt sheet for patients to assist them in obtaining all information during consultation with other health professionals.

[See also - MDC information sheet \(DOC 33KB\) \(95\)](#)

Communicating meeting outcomes with the patient

Having relevant information available to the patient not only helps the patient understand the disease, but also helps with decision-making and coping with the diagnosis. As health professionals, it is important to elicit the information needs of patients, as these may not always be forthcoming. This includes information related to the nature of the disease, cancer treatments and care options, side-effects of treatments, impact on daily life, and patients' and caregivers' psychosocial concerns.

The availability of information in different languages can improve health professionals' ability to effectively communicate with patients and their caregivers from culturally and linguistically diverse backgrounds. Information regarding the use of interpreters should be provided to patients and caregivers, if needed. If an interpreter is required, health professionals should explain that family members and friends are not appropriate translators, as they may not understand medical terminology and may have their own reactions and issues to deal with. A professional interpreter should be used.



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Consent

The patient should be informed that treatment and care planning by the MDC team is part of their care and that their case may be discussed with health professionals whom they have not yet met. Consent from patients should be obtained in-line with local protocols regarding consent for the disclosure and use of personal information in the health environment. It is important to identify the level and type of consent required; for example, who is responsible for obtaining consent and ensuring all team members are aware of consent requirements.

[See also - Checklist for communication with the patient \(DOC 35 KB\) \(98\)](#)





Making multidisciplinary care work

Managing change

The success of strategies to implement or improve MDC will depend on the willingness of team members to change established processes and adopt new working practices. This process will be facilitated by ensuring that team members have an understanding of the benefits of the new processes being implemented.

It may be valuable to seek assistance from other groups who have already established regular meetings, with the aim of providing practical advice about overcoming particular barriers. Setting milestones as a team and reviewing progress at intervals will also ensure ongoing engagement in the process by team members. Ultimately the goal will be to embed the culture of MDC into everyday practice so that meetings become habitual and team decision making occurs as a matter of course.

Sustainability

The following factors will ensure sustainability of MDC:

- allocating dedicated funds and personnel to maintain, support and improve MDC strategies
- ensuring MDC case conference meetings are held routinely, so that meeting preparation and participation become habitual for participants
- encouraging commitment to participation in MDC case conference meetings by participants through demonstration of benefits
- enlisting a 'champion' to drive the MDC strategies, particularly in the early stages
- developing contingency plans to allow for changes in personnel and organisational structure
- support from senior health administrators for MDC.



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Tools / templates

Templates to guide MDC development are available below, including practical advice for health professionals and health service administrators about how to implement MDC at the local level. Please download these sample word templates and tailor them to suit your meeting requirements.

Planning a multidisciplinary care team meeting

[Checklist for 'Principles of multidisciplinary care' \(DOC 33 KB\) \(108\)](#)

[Team contact list \(DOC 34 KB\) \(41\)](#)

[Checklist for suggested meeting resources \(DOC 29 KB\) \(78\)](#)

[Register of information source providers \(DOC 30KB\) \(77\)](#)

[Checklist for planning a Multidisciplinary care meeting \(DOC 35 KB\) \(91\)](#)

Running a multidisciplinary care team meeting

[Checklist for running a team meeting \(DOC 32 KB\) \(85\)](#)

[Checklist for communicating with the patient \(DOC 35KB\) \(98\)](#)

[Generic treatment plan proforma \(DOC 34 KB\) \(91\)](#)

[General practitioner notification \(DOC 28KB\) \(88\)](#)

[Multidisciplinary care team meeting - attendance register \(DOC 40KB\) \(128\)](#)

[Multidisciplinary cancer care team information sheet \(DOC 33 KB\) \(95\)](#)



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Additional information and resources

For further information please refer to the following websites.

Cancer learning

<http://www.cancerlearning.gov.au/>

Website funded by Cancer Australia for cancer health professionals providing links to resources and educational activities related to MDC.

Australia College of Rural and Remote Medicine (ACRRM)

<http://www.ehealth.acrrm.org.au/>

The site supports clinicians, administrators and rural health support teams with practical resources, timely content, and advice regarding use of TeleHealth.

Cancer Institute NSW

<http://www.cancerinstitute.org.au/>

Information about MDC initiatives for cancer health professionals in NSW.

Department of Human Services Victoria

<http://www.health.vic.gov.au/cancer/framework/multidisciplinary.htm>

Information developed by the Cancer and Palliative Care section of the Department of Human Services Victoria to support MDC teams in Victoria.





Multidisciplinary care case studies

Case study: setting up a multidisciplinary care team meeting

Challenge

To establish a multidisciplinary care (MDC) treatment planning meeting for the management of breast cancer in a rural/regional area consisting of one large regional centre with one public and two private hospitals, and a number of smaller rural hospitals covered by four main health services.

A number of barriers and obstacles were faced in setting up the team. The majority of stakeholders voiced concerns about the time that would be required to attend MDC meetings and the impact this may have on their clinical practice.

Clinicians were also concerned about breaches of privacy with patients being discussed in a team environment.

In the regional/rural setting, most clinicians work in both the public and private sector. Those with a significant private practice were unwilling to present patients at a meeting held in the public health service. Rural clinicians also identified the lack of oncologists at MDC meetings in rural areas and the need to have linkage to the larger regional centre.

Solution

Establishment of MDC across a large regional and rural area required face-to-face consultation with stakeholders in all sectors, discipline groups and health services. Meetings provided information about MDC and, in particular, the advantages for clinicians and patients and the opportunity to discuss issues and look at the way forward. Within the health services, the executive team was invited to planning meetings to seek support for the necessary changes.

As a result of the consultation, many clinicians recognised that the development of MDC represented best practice and subsequently met to attempt to overcome the obstacles.

Within six months the regional MDC team was meeting on a weekly basis and prospective treatment planning was established. The clinicians were initially concerned about the time commitment, but quickly recognised that most discussion took place at meetings, thus reducing the need for telephone calls and communication at other times.

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Team members have realised that benefit could be gained by videoconferencing to the rural areas and initial



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discussions have taken place to plan this strategy.

Outcome

Weekly meetings are held to prospectively plan treatment and care for women diagnosed with early, advanced and recurrent breast disease. On average, 22 health care professionals attend the meetings, but there are often 28–30 attendees. The core team consists of one or more pathologists, radiologists, surgeons, medical oncologists, and radiation oncologists, along with general practitioners, breast care nurses and social workers. One rural area has commenced videoconference linkage to the regional hospital, which is the main cancer referral centre, to ensure oncology input to treatment planning.

Case study: involving general practitioners

Challenge

Involving general practitioners in MDC.

Solution

To ensure that GPs participated in the planning phase, with a view to their participation in MDC meetings, focus groups were held at clinics in the regional area and through the Division of General Practice in two rural health services. Attendance at these meetings was impressive and though the attendees identified many obstacles to attendance at MDC meetings, they were enthusiastic about participating.

Outcome

GPs routinely attend the MDC meeting in the regional centre and on many occasions in the rural centres. The relevant Division of General Practice is notified of the name of the GPs who are to have patients discussed that week and through this mechanism, GPs are invited to the meeting. The liaison GP from the Division of General Practice attends the majority of meetings and is able to convey information about treatment planning to those GPs unable to attend the meeting.

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Case study: establishing a team identity

Challenge

The need to develop an identifiable team and strengthen links between members was identified.

Solution

Diagrammatic representations of clinical management pathways were developed for each hospital site and posters summarising these pathways, including photographs of team members, were displayed in relevant waiting areas. Meetings with all clinicians from across the Collaboration were held early during the set-up phase to emphasise the benefits of a MDC approach and promote the use of the clinical management pathway. A logo was developed specifically for the Collaboration and used on letterhead distributed to all relevant facilities in the region during the implementation of strategies.

Outcome

Promotion of the team through the clinical management pathways and Collaboration logo strengthen the team identity and brought awareness to MDC for both clinicians and patients.





Case studies - Advanced disease

Case study: discussing palliative care and end-of-life issues with patients.

Challenge

The need to discuss with the patient issues associated with awareness and 'diagnosis' of a palliative state such as worsening symptoms, failure of treatments due to progressive disease or recurrent disease.

Solution

A discussion is held with the patient and palliative care team regarding timely assessment of symptom management, ability to manage illness, changing goals, wishes, and future needs. Discussions regarding EOL wishes, plans and goals are shared throughout the health care team and may be discussed at MDC meetings as planning processes. The discussions are then continued with the patients by members of the palliative care team who are known by the patient. The outcomes of conversations are shared with the entire MDC team to continue the communication process. Documentation of this plan is mandatory.

Outcome

Regular assessment and awareness of individual patient's disease and progression will lead to early and appropriate referral to the palliative care team. This will facilitate smooth transition into the palliative phase, thus allowing planning and respect of patient goals and wishes to be established.

Case study: discussing 'not for resuscitation' orders with patients

Challenge

A conversation is held with the patient at an appropriate time (individually determined by a senior clinician), to discuss 'not for resuscitation' (NFR) orders.

Solution

The initial discussion occurs at a time when the patient is not unwell or under stress (e.g. it is not appropriate



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when diagnosis is first given to them). It is explained to the patient that a discussion about NFR orders is best done before admission occurs. An explanation of the meaning of NFR and the processes involved with resuscitation is given. The issues relating to medical advice, appropriateness of treatment, the patient's right to choice and medical futility can be undertaken as needed. Written information will be provided to all. Admitting doctors should check the patient's 'NFR status' at each admission and ask the patient if they would like to change their status. It is suggested that their status is included in a card also recording their medications.

Outcome

The patient and their caregivers have the opportunity to be properly informed about this difficult and emotive topic. As a result, stress is reduced both for the patient and the family, as well as the doctors involved. This also avoids the distressing situation where a doctor unfamiliar with a patient, and their medical history, prognosis and other details, is required to determine the NFR status of a patient, often in the situation of the patient being acutely unwell.

Case study: initiating a palliative care referral

Challenge

Initiating a referral to palliative care.

Solution

Effective communication within the health care team to help determine appropriate and timely referral to the palliative care team is crucial. The referral is introduced to the patient and their carers by the designated care coordinator explaining the role of palliative care as one of active care that delivers specialised health care to maximise quality of life, whether that be symptom management, pain relief or spiritual, emotional, and psychological support.

Outcome

Introducing the discussion about palliative care is assessed within the MDC team on an individual basis dependent upon the patient's advancing illness and their hopes for the future.





Case study: palliative care referral for advanced breast cancer

Challenge

An advanced breast care nurse routinely assesses a patients newly diagnosed with advanced breast cancer.

Solution

An advanced breast care nurse explains to the patient the role of key team members as providers of support, information, and symptom control. Once the patient is comfortable and aware of the value of this care, the advanced breast cancer nurse may suggest, if appropriate, that a similar support role can be provided in the community, also by a specialist nurse (from the community palliative care provider).

Outcome

Patients begin to separate the supportive care role of palliative care services, distinguishing them from terminal care. Patients become more accepting of supportive care provision in the community from palliative care services.





Case Studies - regional cancer centres

Case study: implementing teleconferencing

Challenge

Lack of access to a full MDC team in a remote area. Issues that were raised included:

- How would the new technology be accepted by clinicians involved in a teleconference?
- Would this create additional work or necessitate a change in practice which would compromise the establishment of a regular meeting?
- Could a convenient time be found and would the meeting participants see the benefit, which would encourage ongoing attendance?

Solution

Telehealth was presented as a solution. A 'champion' was identified at each end of the link who was committed to the process and who would encourage colleagues to attend. The telehealth link was added to a regular team meeting so that the meeting occurred in the telehealth room as standard practice regardless of whether a link by teleconference was planned. Pathologists and radiologists joining the teleconference were provided with images in advance of the meeting so that they could evaluate them before providing comment.

Outcome

Regular meetings via teleconference.

[See also: Case study: Setting up a multidisciplinary care team](#)

Case study: general practitioners and the multidisciplinary care team

Challenge

The patient's GP initiating a MDC meeting in a rural/regional setting.



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Solution

To ensure the patient's GP is involved in the MDC planning, cancer care coordinators were introduced to a rural/regional health service to provide the link between GPs and other specialists in the care team. The patient's GP works closely with the patient's care team and can initiate a care planning meeting by contacting the lead clinician. The GP is encouraged to attend the meetings in person or participate via teleconference.

Outcome

Information presented by the GP about the patient's history and psychosocial issues at the MDC planning meeting has influenced decision-making around treatment and care planning.

Case study: involving general practitioners in multidisciplinary discussion of breast cancer patients

Challenge

To Involve GPs in MDC discussion of breast cancer patients.

Solution

A representative GP from the local Division of General Practice attended the MDC meeting to represent all the patients' GPs. This representative took on the role because of an interest in the area and is therefore knowledgeable medically and in regard to the specific care available in the community. The representative GP also liaised with individual GPs before the meeting to provide any useful GP perspective on the patient's situation. After the meeting the GP's role also included feeding back the meeting recommendations to each patient's GP. This position is funded.

Outcome

Attending the meeting is one GP's regular commitment and is therefore readily achievable. Their involvement allows both input from a GP perspective, and appropriate and timely feedback to the patient's GP.



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Information about MBS items for multidisciplinary cancer care

On 1 November 2006, two Medicare Benefit Schedule items were introduced providing rebates for participation by medical practitioners in multidisciplinary treatment planning meetings for cancer patients.

Who can claim the items?

Item 871 can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is leading and coordinating a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer. The lead practitioner is responsible for ensuring that records of the meeting are kept and that the patient is informed of the outcomes from the meeting

Item 872 can be claimed by a medical practitioner from any area of medical practice (defined in the item descriptor as a specialist, consultant physician or general practitioner) who is participating in a multidisciplinary case conference to develop a multidisciplinary treatment plan for a patient with cancer.

Only **treating medical practitioners** can claim the items – that is those who have treated or provided a formal diagnosis of the patient’s cancer in the past 12 months or expect to do so within the next 12 months.

Under this definition, a ‘treating medical practitioner’ would include the pathologist or radiologist who provided a formal diagnosis of the patient’s cancer prior to the meeting, or a radiation oncologist who will prescribe radiotherapy for the patient but does not expect to have contact with the patient until some months after the meeting.

Non-treating clinicians, allied health providers and support staff are not eligible to claim the item. This includes doctors who may provide an opinion in the meeting but who are not members of the patient’s treatment team.

Under this definition, a surgeon who provides an opinion in the meeting but who will not be operating on the patient would not be eligible to claim the item.

Other relevant MBS items

Items 721 to 732: [multidisciplinary care plans](#) (medical practitioner other than specialist or consultant physician)

For more information go

to: <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>





Frequently asked questions about MBS items 871 and 872

What meetings do the items apply to?

The items apply to discussions during a multidisciplinary team meeting held for the purpose of developing a cancer treatment plan. The items should not be billed against community or discharge case conferences. Meetings may be face-to-face or held via teleconference or videoconference.

What is the minimum number of practitioners who should be involved in the meeting?

The multidisciplinary meeting must involve at least four medical practitioners (including the lead practitioner). Participants must be from different areas of medical practice and may include general practice. Allied health practitioners must also be present.

How many people can claim the item for one patient?

Only one medical practitioner can claim item 871 for each patient discussed at the multidisciplinary case conference. There is no limit to the number of treating medical practitioners who can claim item 872 for each patient discussed.

How many patients can be claimed for at one meeting?

There is no limit to the number of patients who can be discussed during a multidisciplinary meeting. However, discussion about each patient discussed at the multidisciplinary meeting should last at least 10 minutes.

Which patients do the items apply to?

The items apply to private patients being treated in public or private hospitals or in the community who have a malignancy of a solid organ or tissue, or a systemic cancer such as a leukaemia or a lymphoma. The items do not apply to patients whose only cancer is a non-melanoma skin cancer.

How many times can a patient be billed?

In general it is expected that a patient will be discussed at no more than two case conferences each year. Therefore it is unlikely that an individual patient would be billed more than twice in one year.



All about multidisciplinary care

What is the schedule fee?

- The schedule fee for item 871 is \$80.30 per patient
- The schedule fee for item 872 is \$37.40 per patient

How should the patient be billed?

For a patient to be billed by the lead and participating medical practitioners, the patient must understand that the meeting will take place and which practitioners will be billing them (see [Gaining patient consent](#)).

Each billing practitioner should send a separate bill to the patient unless the patient signs a Medicare form for bulk billing. Medicare forms cannot be signed until after the multidisciplinary meeting has taken place and the other requirements included in the item descriptor have been met. If the post-conference discussion is conducted with the patient by telephone, the lead practitioner or designate will need to arrange for the patient to visit the hospital and sign the form. If this is not possible due to issues of distance, it is the responsibility of the lead practitioner to make arrangements with the patient to sign the form.





Gaining patient consent for billing

It is the responsibility of each billing practitioner to ensure that the patient is informed that a charge will be incurred for the multidisciplinary meeting. This task may be delegated to one member of the team representing all billing practitioners. Regardless of who gains consent the explanation should include:

- explaining to the patient the nature of the multidisciplinary meeting and asking the patient whether he or she agrees to the meeting taking place
- informing the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers
- providing an opportunity for the patient to specify what medical and personal information he or she does not want to be conveyed to the other members of the multidisciplinary care team
- informing the patient that he or she will incur a charge for the service provided by the practitioner(s) for which a Medicare rebate will be payable
- informing the patient of any additional costs he or she will incur.

If consent is delegated to a member of the treatment team who is not a billing practitioner, and if the patient identifies information he or she does not wish to share with some or all members of the multidisciplinary team, the lead practitioner should be informed accordingly.

See also - [Keeping the patient informed](#)

